



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

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

WEDNESDAY, 8 JULY 2009

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Wednesday, 8 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, Cormann, 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

ARMITAGE, Dr Michael, Chief Executive Officer, Australian Health Insurance Association..... 1
CARNEY, Dr Barbara, Director Policy and Research, Australian Private Hospitals Association..... 13
DEEBLE, Dr John, Private capacity..... 29
McAULEY, Mr Ian Alexander, Fellow, Centre for Research in Policy Development..... 20
ROFF, Mr Michael, Chief Executive Officer, Australian Private Hospitals Association..... 13

Committee met at 9.01 am**ARMITAGE, Dr Michael, Chief Executive Officer, Australian Health Insurance Association.**

CHAIRMAN (Senator Moore)—This committee is continuing the inquiry transferred from the Senate economics committee into provisions of the Fairer Private Health Insurance Incentives Bill 2009 and the two related bills as well as the Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009.

I welcome back Dr Michael Armitage from the Australian Health Insurance Association. I know that you understand all about parliamentary privilege and the protection of witnesses, Dr Armitage. Thank you very much for your submission. We also have the *Hansard* record of the economics committee inquiry, to which you gave evidence. If you would like to make a short opening statement, we will then, as normal, go to questions from the committee.

Dr Armitage—Thank you. In the interests of time I will not repeat my opening statement.

CHAIR—Does the same one stand, Dr Armitage!

Dr Armitage—I will merely say that I am here on behalf of all health consumers because, in our view, this decision, if implemented, will affect people in both the public and the private sectors.

Senator CORMANN—Good morning, Dr Armitage. As an opening question: did you see this measure coming?

Dr Armitage—No, we did not because we had, as is now well publicised, assurances from the Prime Minister that the rebate would remain in its present form—in other words, not means tested.

Senator CORMANN—When you say ‘assurances’, in fact there was a very emphatic pre-election commitment to retain the existing private health insurance rebates. In fact, it was a commitment that was repeated earlier this year by the minister for health, was it not?

Dr Armitage—That is correct.

Senator CORMANN—So how do your members feel about the fact that the government has broken its promise on the private health insurance rebates?

Dr Armitage—We are disappointed. The explicit letter stated that there would be no change to the present system—it is still the present because it has not yet been legislated—of the rebate. We felt that that was, if you like, a cast-iron guarantee, so we are disappointed about that. We are also disappointed because, whilst this is not a popular view of our industry, we are really interested in health outcomes, and we are confident that this will lead to poorer health outcomes. So we are disappointed in that as well.

Senator CORMANN—Given that the Prime Minister was going back on his word, did he or his minister contact you to give you the heads-up that they were about to break their promise?

Dr Armitage—I was contacted on the Thursday before the budget by the minister, and she indicated that a story that was to be in the paper the following day in fact came from a definitive source and that—

Senator CORMANN—A definitive source? Does that mean an official leak?

Dr Armitage—I was told that the story was in fact correct.

Senator CORMANN—You were told by the minister that the story that was to appear in the paper the next day was in fact correct?

Dr Armitage—I cannot remember the exact words but I was left with the impression that it was in fact what was going to happen.

Senator BOYCE—And was the story from the minister?

Dr Armitage—I am not even sure of the detail but, as I say, I was left under no impression—

Senator BOYCE—‘Sources’ said.

Dr Armitage—Yes. I was left under no impression but that the story that would be in the paper the following day was in fact what was in the budget.

Senator CORMANN—And the minister had that conversation with you on a confidential basis at the time? Was it an embargoed piece of information?

Dr Armitage—No, it was a mature conversation between two people who have had many discussions in the past about these matters. She said that she hoped that I would not be taking any advantage of the fact that I

had been given the information. To be frank, it was too late for me to do anything about it anyway. It was about eight o'clock or nine o'clock at night, I think.

Senator CORMANN—You were given the information too late to do anything in terms of the media the next day—

Dr Armitage—Absolutely, and I understand that. That is standard practice.

Senator CORMANN—It is interesting that a minister would ring you to confirm that a leak is in fact an 'official' leak. I find that rather interesting. In that conversation, did the minister give you an explanation as to why the government was about to break its pre-election commitment?

Dr Armitage—I cannot remember the exact answer to that question, Senator, but we had a long and detailed discussion about the tiers of which everyone is now aware. I indicated that there would be no question but that this would affect the numbers of people privately insured and that it would also lead to a lot of people downgrading their cover; it would have a flow-on effect to the public sector. Then I indicated that this was disappointing, given that we had the commitment in the letter from the Prime Minister.

Senator CORMANN—What was the minister's explanation in her conversation with you as to why the government was going down that path?

Dr Armitage—I was not making notes about it because I was a little taken aback about it; I did make notes about the detail of the tiers. From memory, I think her statement was that the government had chosen to do this as a way of saving money.

Senator CORMANN—Saving money to fund, I guess, the spending in other areas of the budget. What is your assessment of the overall trend when it comes to policy decision making of this government on private health insurance matters?

Dr Armitage—In fact, what I said to the minister in that conversation was that this was, if you like, a 'second strike' against the industry, and I indicated that, as an elected government, they had every right to do that, despite the promises. However, I did make the very strong assertion that it was particularly disappointing, given that we as an industry sector are the only other payer other than the government—given that the community pays both us and the government and then pays some gaps. We are the only other institutionalised payer. I said it was disappointing that we had had many discussions with the minister about positive things we could do to put a cap on what appears to be the inexorable increases in costings in the private health insurance sector and we had not had a single positive outcome from those discussions.

The minister was in fact good enough to acknowledge that that was a legitimate criticism and she said that she wished to keep discussing that with us. Our view is that, if the government can get its act together to hit us in one area, we cannot see any reason why it cannot get its act together to help us in the other area, because the changes that we have suggested would lead to an improved public and private sector.

Senator CORMANN—When you say that it is a second strike against the industry, it is in fact a second strike against 11 million Australians with private health insurance, is it not?

Dr Armitage—Absolutely. In everything I say where I define the industry, I regard the industry as (a) 11 million Australians but (b) the largest consumer group in Australia. We are a group of people who have voluntarily decided to pay for a particular benefit. The vast majority of us regard that as a major benefit and cherish it, and that is the response which we are getting from our members.

Senator CORMANN—Do you trust any assurances from the government that moving forward there will be no further strikes against privately insured Australians?

Dr Armitage—It would be difficult to have 100 per cent trust before any budget, given what has happened to us in the last two—particularly this decision.

Senator CORMANN—The first two and the only two.

Dr Armitage—Absolutely. But we are realists and we understand that governments do things. We do not necessarily agree with them. It would be difficult to have 100 per cent trust given that we have such a definitive letter from the Prime Minister, which has now been shredded.

Senator CORMANN—And definitive statements of course three or four months ago from the minister, too.

Dr Armitage—The minister has made a number of statements since the election.

Senator CORMANN—Which were very definitive that there would be no change.

Dr Armitage—Correct.

Senator CORMANN—Can you perhaps talk us through the operating environment for private health funds at present. I think it is fair to say that you are operating in a difficult economic climate which impacts on your members or your prospective members in their capacity to take out private health insurance. There is reduced investment income for funds; there is the impact of last year's Medicare levy surcharge changes; there is this year's change on top of that. Can you describe for us how the environment for private health funds has evolved over the last two years.

Dr Armitage—Certainly. You have hinted at many of our major challenges. Our independent regulator is PHIAC, the Private Health Insurance Administration Council, and they have reported that our net margin last year was about five per cent. Fifty percent of that came from income earned from contributions which had been made. Many people pay their contributions on a yearly basis on day one of the financial year, and accordingly—

Senator BOYCE—What percentage, Dr Armitage?

Dr Armitage—I am not sure, but it is significant. Everyone who contributes their funding, if they are not using it, has actually paid in advance, whether it is one month, three months, six months, 12 months or whatever. So rather than having that lying around doing nothing, the funds have that out and try to earn money which they can then use in a business sense. It would be no surprise to people to hear that that 50 per cent of the net margin which previously came from international investments and so on will not be there this year. That puts us under immense pressure. With the Medicare levy surcharge decision from last year, there is now evidence to show that we are not getting the same number of people joining private health insurance, and that is a very significant component for the financial health of the industry protecting those 11 million people. When someone joins they are, for I believe quite legitimate reasons, unable to claim on a number of conditions immediately; otherwise, you would have gaming of the system. So in fact their money contributes to part of the resources that the funds can use. So that is difficult.

We also believe we have seen an increase in utilisation of about one per cent in total and we fear that this is a case of the 'use it or lose it' phenomenon, where people make the decision that they will not renew their private health insurance but, before they lose their private health insurance, they will have their knee fixed or have whatever operation they choose. So we are seeing an increasing utilisation. And, as I have said, we are faced with increasing costs which cause our outlays on behalf of our members, the benefits, to go up. Again, our independent regulator said last year that our outlays on behalf of our members went up by approximately 12 per cent—I think it was 11.9 per cent or something like that; that is money paid out directly on behalf of our members—and our premium increase went up by 5.99 per cent.

CHAIR—Dr Armitage, you actually made a number of statements there. Some of those were based on things you have said before. I am just picking up on the one about the 'use it or lose it' phenomenon. I know in your previous evidence you said that you use surveys a lot. Do you have any surveys which indicate that that is a fact, or is that something that, from your meetings and discussions, you believe is happening?

Dr Armitage—As I believe I said—and I am not sure that I said it was definitive—

CHAIR—No, you did not. In a list of things you put it as one of the—

Dr Armitage—Absolutely, and we still believe that is a fact. The issue for us is that it is a trend that we are seeing. It is an inexplicable: why has there suddenly been an increase in usage in the last four to six months?

CHAIR—Sure. There has been so much discussion about 'what ifs' and so on in this discussion. On that one, you opened by saying you believe people who had already made the decision to leave private health were doing that and that is just something that the industry believes rather than has proven.

Dr Armitage—Certainly it is a very well-recognised phenomenon in insurance capacity around the world, not only in health insurance. Firstly, it is a very, very common thing to do in human nature; secondly, it is factual that there has been an increase in utilisation. And so we are attempting to make some judgments.

CHAIR—Okay. I just wanted to get that on the record.

Senator CORMANN—So your membership trend essentially has slowed down already?

Dr Armitage—Absolutely.

Senator CORMANN—While the government does not give us a percentage figure anymore in terms of the estimates, it actually expects the percentage of Australians with private health insurance to go down over the forward estimates.

Dr Armitage—Correct.

Senator CORMANN—Your costs continue to go up, for whatever reasons. The trend is that moving forward the number of people will be less.

Dr Armitage—There is no question about that. The forward estimates show that the government expects the number of people insured to be 9.7 million over the next four years.

Senator CORMANN—Are you aware what happened to net margins in the most recent PHIAQ quarterly data?

Dr Armitage—I am not.

Senator CORMANN—Could you perhaps take that on notice, just in terms of the health of the industry.

Dr Armitage—Certainly.

CHAIR—Senator Cormann, you can put that on the record if you know the answer.

Senator CORMANN—I do not know the answer. I suspect it has halved.

CHAIR—You could ask PHIAQ rather than have Dr Armitage have to follow that up.

Senator CORMANN—Okay. The government have accused the industry—in fact I think they have pointed quite directly at some statements made by AHIA in the context of the Medicare levy surcharge debate—and they have accused us as well, of crying wolf on this measure because last year people like you, people in your position, were predicting that a lot of people would drop out of private cover as a result of the Medicare levy surcharge change, and it just has not happened. What is your comment in relation to that?

Dr Armitage—At no stage did we make a prediction of numbers. We have been accused of it but we did not make a prediction. All we ever did last year was analyse the Treasury figures and put behind those the information which we knew as an industry. In fact, if the Treasury budget prediction were correct, many more people would leave than Treasury actually said. If the budget were not to have a hole in it, there would be a greater number of people leaving. That was the only statement we made, because we did not feel it was in our interests to be predicting at that stage.

What has happened, however, is that the number of people joining has decreased. We believe we have approximately 200,000 fewer members now than we would have had if there had been no policy change, and that is a significant effect on the quantum of money which the industry has to pay for health care for those 11 million Australians who are insured. And of course the big concern for us is that, because the Medicare levy surcharge relates to taxable income, we think that the biggest effects of last year's Medicare levy surcharge legislation will be felt in the next three to six months as people are doing their tax for the last 12 months. It is also very important to note that all of those predictions that were made by analysing Treasury figures were made on the original government legislation, which was considerably watered down by the Senate.

Senator CORMANN—Yes. Under the original measure, Treasury estimated that 644,000 fewer people would be in private health. That became 492,000 people. It is a figure that the minister herself referred to at the time. Are you aware that Treasury and Health still expect that lower number of people to be in private health as a result of the Medicare levy surcharge?

Dr Armitage—My understanding is that that is a figure that Treasury confirmed in Senate estimates.

Senator CORMANN—For this budget.

Dr Armitage—Correct.

Senator CORMANN—Essentially the estimates have not been changed, so there is still an assumption that, as a result of last year's change, nearly half a million fewer Australians will be in private health insurance.

Dr Armitage—It is my understanding that Treasury has confirmed that.

Senator CORMANN—Treasury also conceded, during Senate estimates, that they excluded about 1.4 million Australians with ancillary cover—I think you call it general treatment cover—from their modelling because they did not have access to income data for that proportion of the privately insured. Related to that,

they made an assumption that hardly anyone out of those 1.4 million would drop their general treatment cover. Would you care to comment on that?

Dr Armitage—We have publicised the fact that we believe there will be a very significant number of people leaving ancillary cover because there is no Medicare levy surcharge penalty against it. If the argument from the government is that people will not leave private health insurance because the stick for a small percentage of those people affected in the tiers has been increased, that argument falls away in relation to the ancillary cover because the Medicare levy surcharge does not apply to ancillary cover. That is No. 1.

No. 2 is that we are very fearful that, in the same vein, the biggest effect of this legislation, if it passes in its present form, will actually be people downgrading their cover, because again people can downgrade with no Medicare levy surcharge penalty. If the argument is, 'This will happen because we have increased the stick,' if people can take what is a legitimate financial decision in difficult financial times without the stick being there, we think logically the government must acknowledge that there will be a lot of people who will downgrade.

When people downgrade, they do one of two things. They may take a policy which has a lot of exclusions. That is fraught with danger. A younger person traditionally will say, 'I'm not going to need cardiac care or orthopaedic care,' but we find that in fact many younger people do need cardiac care. We presented a list last year of the highest claims for people under 30, and a third of those 30 highest claims came from insertion of pacemakers for people under 30. We all understand that young people think they are invincible, but the fact is, if they have downgraded their policy to exclude cardiac care and they are then one of those people who need cardiac care, they have got two decisions to choose from: they can pay huge amounts of money in the private sector or they can go to the public sector.

So they take exclusions or they take a policy with large front-end deductibles. Both of those they can do without any further Medicare levy surcharge stick. If that is the case and they then need an operation—a young, fit person may think, 'I'm not going to need orthopaedic care,' and then go skiing and then need an anterior cruciate ligament repair or something—again they are faced with the same choice: they can either pay a large front-end deductible and go to the private sector or they can go to the public. We think that the downgrading is a major effect. For Treasury not to model it is disingenuous because it just does not reflect the reality of what is going to happen.

Senator CORMANN—I think that even critics of the private health insurance rebates before the economics committee inquiry, like Mr McAuley, have conceded that the most rational thing for people to do is to go for a cheaper policy or to drop their general treatment cover. The question then is, because the government's figures do not include that assumption at all—and they said that to us in estimates—what is going to be the impact on public hospitals? If we take them one by one, if people increase the number of exclusions, what happens? If somebody is no longer covered for cardiac, is no longer covered for orthopaedic, is no longer covered for whatever else they might exclude, what will happen? They would have to present to public hospitals would they not?

Dr Armitage—Absolutely. The issue for the public sector in that circumstance is: if, for argument's sake, a young person has made a decision to downgrade their cover to exclude cardiac care and they are then one of the under-30-year-olds who need a pacemaker inserted, that is an urgent operation. That cannot wait for six months.

Senator CORMANN—And they would move somebody out of the—

Dr Armitage—What happens is: someone who has previously been privately insured would still classify themselves perhaps as being privately insured because they have a policy; it is just they have chosen to downgrade to a policy with exclusions. So they would classify as being privately insured, but then they would go straight into the public hospital. Because it is an urgent operation, they would then put people who have a less urgent operation who were previously on the waiting list down the list further.

Senator CORMANN—They will displace them. The government tell us 2.3 million Australians will be impacted by the private health insurance rebate reduction measure. They say that 25,000 combined policies will be dropped—that is hospital and ancillary policies—and 10,000 people will drop the ancillary component out of their combined policy. And the government say another 5,000 people will drop their general treatment cover. They also say that they expect about 8,000 additional public hospital admissions. But that does not take the downgrading affect into account at all, does it?

Dr Armitage—Correct. We think that is a flaw in that argument. We think the major flaw in that argument, though, is that the people who are privately insured whose income is not in the tiers represent eight million

Australians. So those eight million Australians will be affected by the people who leave or downgrade their cover, because their cover, the cost of their premiums, will have to go up. That is simple long division. So eight million people are not in the tiers but are going to be affected by it. We think that is going to lead to an even greater increase in those effects we have just been discussing, focusing only on the people in the tiers.

Senator BOYCE—You have described the Treasury modelling as substandard. Are you speaking only in relation to their not modelling the changes to ancillary insurance?

Dr Armitage—What I am distressed about is the fact that they are able to say, ‘We will only model first-round effects.’ If that is what they have to do, that is fine. I understand if that is the expectation.

Senator BOYCE—That is acceptable to your association?

Dr Armitage—No. I understand if that is the rules. My understanding is, however, that second-round modelling is possible if they wish to do it. What I am disappointed in is that every single Australian knows that this legislation is going to have a lot of secondary effects and I think it is only legitimate for every effect of the legislation to be modelled; Treasury could do that, but they have chosen not to. I think it is really disappointing that, for something which we contend will affect the health care of all Australians, public and private, all the effects are not modelled. They should be. If at the end of that modelling, the government’s decision is still to do this, well, we would contend it is the wrong decision but at least they would have the modelling. At the moment, they do not have the modelling. The fact is that, although the modelling may not have been done, the effects will still happen.

Senator CORMANN—Treasury have told us—and they circulated a briefing, which I think went to the industry as well as being tabled at estimates—that they expect that the cost of private health insurance to those that will face reduction in rebate or the abolition of the rebate altogether will be an additional 14.3 per cent to 66.7 per cent. That is an increased cost of 14.3 per cent to 66.7 per cent as a direct result of the reduction or the abolition of the rebate. If people wanted to avoid that increase by downgrading their cover, what sort of front-end deductible, what sort of additional out-of-pocket expense, would they have to incur?

Dr Armitage—It depends on exactly what sort of policy they take. If they take a front-end deductible of \$500, for argument’s sake—because that would avoid them having any Medicare levy surcharge component—obviously they would have to pay another \$500 on any procedure that they might have previously had done. They could take more, but then they would have a Medicare levy surcharge component.

Senator CORMANN—So to avoid the 14.3 per cent to 66.7 per cent increase in cost you can either exclude treatment which you may well need or you can agree to pay more at the time when you actually access the service?

Dr Armitage—Those are ways in which people will downgrade their policies—to avoid paying the increase and also not to be affected by the Medicare levy surcharge stick.

Senator CORMANN—People make judgments to take front-end deductibles, but once they actually access a service it often comes as a shock, does it not, that they have such a large expense that they did not expect?

Dr Armitage—Our view is that gaps are a real dilemma for our industry. We have campaigned long and hard on having informed financial consent being mandatory, but that has not been legislated. We think that is a major failing. It is sadly a fact that, no matter how many times our industry might inform a consumer that the effects of this policy will be X if you need an operation, a percentage of those people either do not hear because they do not want to or they do not hear because they are just not listening or whatever, but the fact is, if they need an operation, they are faced with a larger bill than they might otherwise have faced and they get angry and distressed about it.

Senator CORMANN—And usually that is at a time, obviously, of a lot of emotion and—

Dr Armitage—It is a time of illness, exactly.

Senator CORMANN—That is right. So how does increasing gaps, increasing out-of-pocket expenses, at the time of accessing the service impact on the perception of value of private health insurance?

Dr Armitage—It makes a very bad and lasting impression on people. In fact, often once the bills have been paid for that particular episode, they say, ‘I was privately insured for X years and I was faced with all this and I did not expect it, so blow it; I might as well rely on the public sector.’ What happens is that there is then a fallout from those people. Sadly—hell hath no fury like a woman scorned—they then talk everywhere to their

friends about what a dud deal they got. We would contend it is not our fault, but the facts are that that leads to a falling out from private health insurance and a dissatisfaction with the industry.

Senator CORMANN—Some people before this hearing have suggested the private health insurance rebate has not taken pressure off public hospitals. Can you comment on that? Hasn't it absorbed a much larger proportion of the growing demand?

Dr Armitage—The private sector pays for 57 per cent of all surgery done in Australia. The allegation from our opponents is that that is not essential surgery and it does not matter. The facts are that we pay for 55 per cent of all breast cancer surgery, 55 per cent of all cancer chemotherapy, 70 per cent of all same-day mental health care and 75 per cent of all major ear operations such that people do not go deaf. None of those are discretionary illnesses. If you suddenly took away the support from the private sector and you had 55 per cent of all breast cancer surgery suddenly descending on the public hospitals—and 55 per cent of all cancer chemotherapy and 70 per cent of same-day mental health treatment—it would be chaos. The public sector simply cannot cope with that.

CHAIR—Who do you mean when you say 'we'?

Dr Armitage—The private sector.

CHAIR—Private hospitals or private health insurance? I just get confused. Can you identify 'we'.

Dr Armitage—Certainly. That includes a component of DVA and it includes a component of self-funded private people. I think about 80 per cent of that comes from the private health insurance sector.

Senator BOYCE—Just to clarify: the number of breast procedures and chemotherapy procedures that are done in public hospitals would more than double—

Dr Armitage—It would more than double. If private hospitals were not there, there would be a 55 per cent increase in breast cancer operations. That is not the need for breast cancer operations. They would have to be done, so they would be done. Every state health minister would ensure they were done. Our contention is that all of that load has been removed from the public sector. What we are able to prove from looking at figures is that the increase in usage of the private sector has been much greater since the rebate was introduced than the increase in cases in the public sector, and that delta between the two is breast cancer and cancer chemotherapy and all those things I mentioned before—and many others; I just mentioned some of the most important.

The difference in the increase between the public and the private sector has been funded by the rebate. It is why people are privately insured. I get regular communications from our 11 million members who say to me things like, 'I am a pensioner and I could not be privately insured without the rebate. You protect it.' I had an email recently from someone who said, 'I am a pensioner. I have really bad asthma and my husband has cancer. The only reason we are able to "survive" in the private sector is because of our private health insurance.' That means their load is directly not impacting on the public sector. I make the point that these people are pensioners. More than one million people with private health insurance have an income of less than \$26,000. We are always depicted by our opponents as being supporters only of the wealthy. It is simply not true.

CHAIR—Dr Armitage, are those people that you have just mentioned going to lose their rebate?

Dr Armitage—No, but they will pay more.

CHAIR—In terms of the rebate issue, they are not going to lose it?

Dr Armitage—No, but they will pay more.

CHAIR—I just wanted to get it on record.

Dr Armitage—Senator, you are absolutely correct, and at no stage have I said that they will lose their rebate. What I have said is—

CHAIR—They have a rebate.

Dr Armitage—they have a rebate. It is the reason that they are able to maintain private health insurance and if numbers of people—and even the minister admits—leave private health insurance, simple long division dictates that those people will end up having to pay more.

Senator CORMANN—Dr Armitage, what will be the second, third, fourth and fifth round effects of the two successive budget measures now, including on lower income people, because of the increased gaps that

people will face because of increased premiums, et cetera? What are going to be the second, third, fourth and fifth round effects of this change as we move forward?

CHAIR—And do you have them prioritised in that way?

Dr Armitage—I can give a good stab at prioritising it.

CHAIR—In terms of the question, are you going to respond with second, third, fourth, fifth?

Senator CORMANN—Just to clarify, the point I am trying to make given the chair's comments, Treasury has only assessed first round effects which is a very limited way of assessing the impact of public policy. The contention of the opposition is that there will be flow-on consequences that will build on each other and exponentially will result in higher premiums, fewer members and more pressure on public hospitals. I guess I am looking for you to explain to us what the flow-on consequences of this policy will be beyond the first round effects assessed by the Treasury.

Dr Armitage—Inexorably, prices of private health insurance premiums not only will rise for those people in the tiers who are losing some of their rebate but will increase for everybody. Inexorably, that leads to people leaving the sector. That is just what happens; it is as simple as that. People will leave the sector which means in future years fewer people will join because the costs are higher and more people will leave. As that snowball runs down the hill the premiums keep increasing and the numbers of people leaving also increase. What that means is that because we, as I indicated a few minutes ago, pay for many surgeries which are not discretionary, it will lead to, inexorably, an increase in the number of people in the public sector. Those are all of the effects which we see that any rational person will understand. That is why we are disappointed that the Treasury has chosen not to model it. We understand that they could have if they wished but they have chosen not to do so. We believe that they should do so because they are, as I said, inexorable effects. The most relevant of all of those, taking up the chair's perspective, is the increase in premiums and no-one can deny that that is simply long division.

Senator CORMANN—But increase in premiums would, of course, have flow-on impacts on all the other things.

Dr Armitage—Of course. I am just prioritising.

Senator SIEWERT—You say there will be more people joining. When we had the department in front of us during the previous inquiry they estimated there would be an extra 130,000 people who now are paying, or would be liable to pay, the extra surcharge. Their proposition was that that would, in fact, encourage people into private health insurance. From what I can see that is exactly the reason the government has done it; having a bet both ways really. What is your response?

Dr Armitage—Firstly, the research which we have done in relation to other matters indicated that the Medicare levy surcharge 'stick' seemed on research that we have done to be excruciatingly sensitive if it went up to 1.5 per cent. I have to say we did not test 1.25, but we tested 1.5 and two per cent and in fact two per cent seemed to make little difference—1.5 was the trigger that got people over the line. In the first instance, we are not sure that 1.25 will be a large enough stick, if you like. The second thing is that it does not actually come in until tier 2, so in fact there are a large number of people who will not be affected by the stick and they take no account of that but again the gaping hole—

Senator SIEWERT—We can check that. I thought they were doing it on all of it.

Dr Armitage—No.

Senator SIEWERT—They said 130,000 people. You are saying it is not 130,000 people.

Dr Armitage—We have not done research on that exact quantum but previous research would indicate, as I say, that the figure that needs to be there for the penalty to be a big enough stick is 1.5 per cent. As I indicated, it does not apply in every tier and, as I have also indicated before, the fact is those sticks do not apply when people either downgrade or if they abandon ancillary cover. The thing that seems counterintuitive to us is that the government has said so frequently since it was elected that it wants to do things in the preventative sphere. Those are things like dental care, making sure that physiotherapy is able to stop people needing orthopaedic operations on their backs and all those sorts of things. That is what we pay for in ancillary cover and people can just abandon it with no penalty and that is what they will do. It is human nature. It seems to me as though the move is counter to everything that the government is actually wanting to do in relation to some of its major thrusts to keep people out of hospital.

Senator SIEWERT—But you have not done the work to look at how many people are actually going on. Have you looked at the data where the government has said that 130,000 people are potentially affected or will be encouraged into private health insurance. You have not actually looked at those figures

Dr Armitage—No. We have done our own figures where we have the Ipsos survey and the previous committee quizzed me ad nauseam about the Ipsos survey and I would draw to the attention—

CHAIR—We aren't going to.

Senator BOYCE—We don't do ad nauseam!

Dr Armitage—Perhaps I should say in deference to the previous committee it questioned me a lot in relation to the Ipsos survey. It is factual that the department uses the Ipsos survey as well to make its decisions. In fact a number of the things which were reported in the Senate estimates committee from two of the officers in the department were based around the Ipsos survey, so we have no hesitation in claiming that as a legitimate source. We then did another body of research which gave us an income spread for those people who were privately insured. When you have Ipsos and Roy Morgan they are both very respectable surveys and we were then able to put all of those numbers against the increases in costs in private health insurance. I have always said that the increase in the Medicare levy surcharge will see some people make a decision not to leave. But the fact is, as I have said several times today, people can downgrade or drop ancillary cover and not be penalised. It is an effect that will happen and it ought to have been modelled.

Senator SIEWERT—What level of cover would the million people who have an income under \$26,000 have?

Dr Armitage—It is again counterintuitive. Many of them have full cover. I think it is again probably expected that a lot of them are pensioners because they are the age group and the demographic which tends to use hospitals more often and so they cling to it. I have had emails in last week or so where people have said to me, 'I would rather forgo food than forgo my private health insurance.' These are people on incomes of less than \$26,000 and this decision will mean that they will all have to pay more. I believe I understand why the government is doing it, but I think the secondary effects are so great on eight million Australians who are below the tiers. They are not in the income brackets; they are not even contemplated. So, to directly answer your question, those people often have much more comprehensive levels of cover than a young person. A young person will take cover for all sorts of different reasons; those people take cover because they think they are going to need it.

Senator FURNER—Following on from Senator Siewert's question about the 130,000 that will be captured by the changes to the Medicare levy surcharge, I understand that it is broken down into tier 2 of approximately 90,000 to be captured by the 1.25 per cent and 40,000 to be captured by the 1½ per cent in increases. Surely it is reasonable to assume that they will be taking up the private health insurance based on those changes.

Dr Armitage—Not having seen the work, I ask you: is that people taking up private health insurance or people who will not leave private health insurance because of those sticks?

Senator FURNER—That is people captured by the changes as a result of the introduction of this particular bill, with the view that there is a likelihood of that number of people taking up PHI.

Dr Armitage—In the first instance, as I say, our research would indicate that 1.5 per cent is the sensitive level, not 1.25, and if they do that then that is great. We would like to see more people privately insured, and we would encourage that. However, that pales into insignificance next to the three-quarters of a million people who are likely to downgrade and the three-quarters of a million people who will drop ancillary cover.

Senator FURNER—So, based on these figures, there is a likelihood of those who are captured by the 1.5 per cent increase, 40,000, taking up PHI.

Dr Armitage—Our research would indicate that that is an exactly correct conclusion.

Senator FURNER—When you talk about your research, you are talking about Ipsos and Roy Morgan surveys?

Dr Armitage—No, this was work we had done two or three years ago in relation to the Medicare levy surcharge to, if you like, detect its sensitivity. In fact, to be frank—because our view is that the more people are privately insured the better it is for the 11 million Australians who are privately insured and for those Australians who rely on the public sector—we were looking to bring a policy perspective to the government that would say, 'If you increased the private health insurance levy to X, you would have this additional number of people joining.'

Senator FURNER—So you have not done any recent surveys or studies in relation to the effects of the Medicare levy surcharge.

Dr Armitage—No.

Senator FURNER—Mr McAuley makes the summation that people hung onto the PHI in spite of what has been an increase of 40 per cent in premiums for the insurance.

Dr Armitage—I have seen that argument put. I am absolutely sure that, if you looked at the cost of health care in the public sector, it would be at least the same, if not higher. It is disingenuous to say that the costs have gone up by 40 per cent in the private sector and not in the public. The facts are these. If you look at health inflation, it is across the board. Health inflation, for years, ran at a level well above what CPI was running at, and that affects every single person, whether it is public or private. So it may have gone up by 40 per cent, but if it has gone up by 40 per cent in the private sector, as is your assertion, then it would have gone up by that or more in the public sector. If the implication is that the funds have been profiteering because of that, it is simply not true, because PHIAAC is a very tough regulator and ensures that the premium increases that are asked for each year do not allow profiteering.

Senator FURNER—Remaining with the views of Mr McAuley's submissions, in particular, he calls it the 'endowment effect'—that people tend to hang on to their insurance, whether it be health insurance or other forms of insurance, affecting the likelihood of change. I wonder whether your survey delivered any response in that regard.

Dr Armitage—The answer that I would give to that is that I have seen lots of academic studies, but when you actually ask someone, particularly in the face of the global financial upheaval, we think that academic studies are just that. If someone is struggling—for argument's sake, a pensioner—then they are not looking at an endowment effect; they are looking at whether they can actually afford it if the price goes up. So there may be theoretical effects—I do not dispute that—but our contention is that if you ask people, which is what our surveys did, you will actually get a much more relevant effect.

Senator FURNER—But that seems contrary to your earlier statements about people looking at changes in their eating habits to hang onto insurance rather than drop it.

Dr Armitage—Yes, but I thought the assumption was that people would not bother to make a decision—if that is what you are talking about as an endowment effect: 'I've got it, so I'll just keep it.'

Senator FURNER—Surely that is a decision, whether you keep it or—

Dr Armitage—I am not an academic, but I would have thought that an endowment effect just meant someone thinking, 'I'm kind of happy with it, so I'll keep it,' without actually making a direct decision. The point I was making before was that pensioners are making everyday decisions that they are faced with. It is not an academic treatise; they are actually saying, 'Can I afford this?' if the price goes up. That is where we think that those eight million people below the tiers will actually be affected by this decision.

Senator BOYCE—Following on from that question, Dr Armitage, you said in your submission that older Australians make up 13 per cent of your membership pool but receive about half of the benefits paid. Could you just speak a little on the particular effects of this legislation on older Australians.

Dr Armitage—Certainly. There is no question that, as people age, they have more infirmities themselves and they see their friends having more illnesses. They tend to want to make decisions about their discretionary expenditure which will protect their health. One of the easiest of those they can make is to be privately insured, and large percentages do, because of the advantages of choice of hospital, choice of doctor, choice of time—which is probably one of the most important. Older people are often not those who have changeable income. They cannot just work longer hours and earn more. They are often on fixed incomes. Their expenditure patterns are quite defined. Even though they may not be captured in the prospective three tiers of this legislation, it will still have an effect on them. The effects are that, particularly if you have got a fixed income—

Senator BOYCE—Or a falling income.

Dr Armitage—I was just going to say that 'fixed income' is possibly not the right term. They may have investments and superannuation and so on, all of which have been affected by the outcomes of the upheaval in the last couple of years. So their income may even be down and they are going to be excruciatingly sensitive to any necessity to increase premiums. They will be faced with a very nasty decision, even though they have not been part of the modelling.

Senator BOYCE—I am also assuming that, based on that, older Australians would make up a higher proportion of hospital patients as well.

Dr Armitage—There is no question—that is the case.

Senator BOYCE—You mentioned earlier that the industry had been making suggestions on positive ways to remedy the current insurance situation. Could you tell us some of those suggestions, please.

Dr Armitage—Certainly. The one which we think is most easily fixed relates to prostheses. If someone has a joint—a hip or a knee—replaced in Australia, there is a one in four chance of it needing to be replaced.

Senator BOYCE—A revision.

Dr Armitage—A revision. If you have it done in Scandinavia, there is a one in 10 chance of needing it done. If our rate in Australia were the same as in Scandinavia, there would be a very big saving to the health system but, more importantly, there would be a very big saving in health outcomes—or a very big bonus in health outcomes, rather than a saving. All of the figures as to which joints are the best to use are available. The National Joint Replacement Registry, which until now the government has funded—

Senator BOYCE—This committee has just completed an inquiry into that change.

Dr Armitage—Yes. The Australian Orthopaedic Association contributes all the data, and full marks to them for doing so. That actually tells an astute observer which are the joints which perhaps should be used ahead of the others, and yet there is no closing of the loop in that. The big dilemma for all health consumers in Australia is that a survey done by the National Joint Replacement Registry said that, of the 100 newest joints utilised—I think it was in the year before last—not one of those new joints gave an improved clinical outcome. Seventy per cent of them gave a worse clinical outcome, and yet they are all more expensive.

That is the sort of thing. There is such easy—I hate to use a cliché—low-hanging fruit which would be of such benefit to health consumers. We have been suggesting this to the minister to the extent that I can rehearse it in my sleep and we get nowhere. It requires legislative change but those are the sorts of things that would certainly benefit both public and private sectors. Infection is another thing. If you have a hip done and it does not need a revision, it will cost \$15, 000 to \$20,000. If you get an infection in it, it will cost you \$100,000. We think mechanisms to prevent infection should be more rigorously prosecuted.

Senator BOYCE—Have you spoken to the minister about the performance of hospitals regarding infection? Are you looking for a league table there?

Dr Armitage—We actually think league tables would be a good idea provided they were available to the public. A league table which the public cannot see, we think is not worth doing. As you can see I used to be a medical doctor, I still pay insurance but I have not practised for ages, but everyone who is involved in the medical profession can get a league table with just one phone call to their friends. If they need an operation, they ring someone and they say, ‘I’m going to have an operation with Dr Smith, how is he or she going lately, are they good, bad or indifferent?’ They will get an opinion immediately from someone who works with Dr Smith. If that information is available to a very select group of people and they then make decisions about their health outcomes depending upon that, we can see no reason for all consumers not having that information.

Senator BOYCE—So this would apply to both practitioners and hospitals?

Dr Armitage—I think for it to be of its greatest effect that would be the case. Again, from my former medical profession I know many absolutely world-class surgeons, doctors, GPs and so on in Australia. I do not think they would have the slightest hesitation in having their results published provided they were risk adjusted and that can be done. We have actually experimented with it in Australia. It can be done, academics can look at it and pass opinion on it. I am confident that the best doctors would be happy to have that done.

Senator BOYCE—And your reason for wanting the table done for practitioners and hospitals is that it would improve performance and therefore drive down costs?

Dr Armitage—There are endless studies that have been done overseas which would indicate just that. Our view is that if the results were published of the league table and someone thought that there was a chance of needing a hip revision in hospital A, 15 kilometres away from where they lived, and a much-diminished chance at hospital B, 30 kilometres away from where they lived, they would probably choose hospital B. We understand that local care is good because relatives can see you and so on but consumers are very smart about health outcomes. We think if that was published that would lead to that effect. Of course the really good benefit is that hospital A then says, ‘We have to improve.’ So the whole standard would lift. That is what we

are really after. We did not actually want to 'punish', that is the wrong word to use, but we are trying to see the rising tide lift all boats.

Senator BOYCE—Thank you.

CHAIR—Thank you, Dr Armitage. I am sure we will speak again.

Senator CORMANN—Hopefully not after next year's budget!

[9.59 am]

CARNEY, Dr Barbara, Director Policy and Research, Australian Private Hospitals Association

ROFF, Mr Michael, Chief Executive Officer, Australian Private Hospitals Association

CHAIR—Information on parliamentary privilege and the protection of witnesses is available, I am sure you have it. The committee has your submission. Thank you very much. Would either or both of you like to make an opening statement and then we will go to questions from the committee?

Mr Roff—I would, thank you. I would like to thank the committee for the opportunity to appear today. I am here representing private hospitals, which are a vital partner to the public sector in the provision of a wide range of services and contribute significantly to the balance and sustainability of the Australian healthcare system.

The first point I wish to make in relation to the legislation in question is that these proposals constitute a fundamental breach of promise by the government. This entails renegeing on clear commitments that were made not just in the lead-up to the last election but were repeated by a range of senior government figures, from the Prime Minister down, on numerous occasions both in public statements and private meetings since the election. It is also worrying to note that since these proposals were first leaked prior to the budget there has been no commitment from anyone in the government that these represent the endgame in terms of changes to policy settings related to private health insurance. There are now serious concerns within the APHA membership about what further changes may be made in subsequent budgets when commentators concur that substantial cuts to expenditure will be required to meet government spending targets.

A range of service planning and infrastructure development decisions have been made by private hospital operators in both the for-profit and not-for-profit segments of the sector on the basis of the repeated commitments given by the government that they would maintain the current policy settings. If these legislative proposals proceed for developments planned but not yet underway, there are now doubts over whether they will go ahead. For those already underway, there are now doubts over whether they will prove to be viable.

Before I moved to comments about the proposals themselves I would like to make some comments in relation to the process. Firstly, there seems to be an unnecessary rush, which perhaps has been tempered slightly by this committee, to move to a vote on legislation which, if passed, would not take effect for almost 12 months. This is particularly the case when you consider a number of key pieces of advice commissioned by the government. The first of these is the final report from being a national Health and Hospitals Reform Commission which was delivered to the government only eight days ago and which has not yet been released publicly. In its interim report, released in February, the commission said:

Australia's mix of public and private financing is generally regarded as one of the strengths of our system. We believe that this balance should be maintained.

They also stated:

... since we have not finalised our reform proposals, the financial implications have not been assessed. These tasks will be completed as part of the formulation of a road map for change in the lead up to finishing our final report.

It now appears the government has charged down the road without the promised map.

The second piece of advice is the recently commissioned Productivity Commission study on the performance of public and private hospital systems, due to report in November. As a specific term of reference, the commission has been asked to advise the government on the most appropriate indexation factor for the Medicare levy surcharge thresholds. Of course, the legislation in question already contains an indexation measure. This begs the question: why is the government moving so hastily to have the legislation passed when it will not receive advice on a key aspect of that legislation until November?

The core of these proposals is to introduce a means-testing methodology in relation to access to private health insurance rebates on the basis that it is fairer. However, in effect the policy principle underpinning support for private health insurance is the same as that which underpins the policy in relation to government support for independent schools—that is, no government could afford to fund schools and teachers for the entire school aged population, at least not without significant increases in tax or spending cuts in other areas. Therefore, governments provide funding to independent schools so their services become more accessible in recognition of the fact that parents who choose private education for their children are taking pressure from the taxpayer funded government schools. In the same way, people who choose to insure their health care take

pressure off the public hospital system and the taxpayer. The government has assisted those people with the cost of their private health insurance. The only difference between the two policy areas is the delivery mechanism for the support. For health insurance, the price is reduced by providing a rebate direct to the consumer. For independent schools, the price is reduced by providing grants to the schools to offset their operating costs.

Of course, all Australians who utilise the services of independent schools get access to the reduction in price regardless of their income. We fail to see why the same policy rationale should not continue to apply to support for health insurance. We also note statements by the minister and others in government to the effect that they would not expect their electorate staff to subsidise their own private health insurance. Of course, at the same time, they are quite happy for their electorate staff and other low-income earners to subsidise their treatment in a public hospital, should it be required. In relation to the proposals themselves, we believe they represent a shift from a system that is simple, transparent and easy to understand and that works to deliver a balanced public-private system to one that is confusing, complex and costly, with the potential to fundamentally destabilise the current balance system.

We have received a briefing from Treasury officials in relation to the methodology behind their modelling. We believe that the information provided raises serious questions about the accuracy of the predicted outcomes of these measures. These issues are covered in our submission, so I did not intend to go into detail, except for on one point. Treasury have advised they have used their personal income tax microsimulation model to estimate the number of people in the affected income ranges. This is the same model they used to estimate the impact of the changes to the Medicare levy surcharge introduced in 2008. These estimates have proved to be inaccurate, a fact actually conceded to us by Treasury. Yet the same model has been used to estimate the impact of changes that are infinitely more complex than those implemented last year. Against this background and considering the other issues in relation to the modelling raised in our submission, we do not believe the estimated impacts of these measures can be given any credibility.

In summary, we contend that the policy underpinning the legislation is incoherent and ill devised and that the measure should not proceed. It has the potential to remove choice in health care for many, increase complexity and discourage people from taking responsibility for their own healthcare costs. We cannot afford to take that risk with the future of our healthcare system.

CHAIR—Thank you.

Dr Carney—To amplify one point that Mr Roff made, Treasury have not only used the same model as they used to model the effect of the changes to the Medicare levy surcharge thresholds in 2008. In our briefing with Treasury and Health officials on 1 June, Treasury emphasised that they used the same sample population from the 2005-06 tax statistics. That raised concerns with us, firstly because one would assume that more recent information from the tax office is available, but also because since the modelling in 2008 was done there has been an increase in membership of the privately insured population of 900,000, yet Treasury in constructing their sample did not take this increase into account. We understand that there have been some adjustments made to that sample—although Treasury would not disclose what those adjustments were—but the failure of the modelling to take into account those changes, and the fact that the same sample was used that produced an erroneous outcome less than a year ago, call into question quite seriously the validity of the Treasury estimates.

CHAIR—Thank you.

Senator CORMANN—I will ask you the same opening question as I asked Dr Armitage: did you see this measure coming?

Mr Roff—And I will probably give a very similar response: we did not see it coming. We did not anticipate it because we believed at the time the assurances that were being continually provided by government. As I indicated in my opening statement, they came from the Prime Minister down in both public statements and private meetings with me and members of my association. We took those assurances at face value. I think the first time I was made aware of it was on the evening of the Thursday before the budget was released, when I received a phone call from the minister to advise me about a newspaper report that would be published the following day.

Senator CORMANN—You mentioned in your opening statement that there is no commitment that this is the endgame. Have you sought assurances from the government, after this most recent broken promise in

relation to the private health insurance rebates, that this ought to be the final change? Have you had that discussion with the government?

Mr Roff—We have asked the question. I do not think we have received an answer.

Senator CORMANN—What does the government say when you ask that question?

Mr Roff—Well, they have not answered it as yet.

Senator CORMANN—When you say that they have now answered it as yet, have you put that question in writing?

Mr Roff—I understand we have put the question in writing, yes.

Senator CORMANN—So you have not had a direct conversation. Have you had a direct conversation with the minister since the budget?

Mr Roff—Not with the minister. I have had conversations with a number of her staff. They went more to trying to elicit some detail about these proposals rather than what might come next.

Senator CORMANN—The only conversation that you have had with the minister about this broken promise was on the Thursday night before the budget confirming that the leak that was being reporting in the next day's paper was in fact an official leak.

Mr Roff—With the tenor of the conversation, I do not know that they were the actual words used. I think it was something to the effect that there will be a report in the paper tomorrow, these are the broad details and it is broadly consistent with a proposal that will be in the budget.

Senator CORMANN—When this inquiry was before the economics committee some witnesses who were supportive of the government's proposed changes have suggested that the private health insurance rebate was in fact bad public policy because it had not taken pressure off public hospitals and because it had shifted professional staff resources away from public to private hospitals. Do you have a view on these claims?

Mr Roff—I do actually. Both claims are commonly made. If you look at what has happened, particularly since the rebate lifetime health cover and the Medicare levy surcharge came in, it is quite interesting. Between 1999-2000 and 2007-2008 the number of separations or episodes undertaken in private hospitals has increased by 981,900 per year. That is almost one million extra episodes of care per year. Over the same period the additional workload in public hospitals has increased by just over one million episodes per year. So there is a 46 per cent increase in separations from private hospitals and a 28 per cent increase from public hospitals. That increase in utilisation is directly attributable to the growth in health fund membership. You just have to ask yourself: where would those additional million patients—and remember it is a million patients every year—be treated if it were not for these measures?

The other one that you mentioned is in relation to staff and it is true to an extent that there is not necessarily a public health workforce and a private health workforce; there is a health workforce and they are very mobile. Once again, if you look at the figures, this time between 1999-2000 and 2006-2007 looking at the total number of nurses employed by each sector. Over that six- or seven-year period the increase in total nurses employed in private hospitals was 2,131 or an increase of 8.3 per cent. In public hospitals total nurses employed increased by about 25,000 or 31.6 per cent. You could almost make the argument in the opposite direction that each sector is treating almost one million extra patients a year but the increase in nursing staff in private hospitals has been about eight per cent compared to about 32 per cent in public hospitals.

Senator CORMANN—Interesting. In terms of the Treasury modelling, the same witness who I have just quoted—that is, the witness who was supportive of what the government is trying to do—also made the point that the:

... most rational response would be to shift to a cheaper policy

given the structure of the private health insurance rebate reductions and the rate of increases to the Medicare Levy Surcharge. What is going to be the effect of that on private hospitals?

Mr Roff—Once again, we think this is a significant deficiency in the Treasury modelling because in our briefing they were at pains to keep repeating to us that we have assumed rational behaviour by people as a response to these measures. I would have thought that rational behaviour on a price increase of a minimum of 14.3 per cent would be to try and reduce the price—

Senator CORMANN—Of up to 66.7 per cent.

Mr Roff—Up to 66 per cent. This is where the argument about downgrading comes in. They have assumed that people will either keep their insurance or drop their insurance and there will be no other decisions made, where obviously a rational decision would be to try and lower the premium. There are two key ways that that can happen: either by taking out a front-end deductible or an excess, or by taking a policy with exclusions that does not provide benefits for treatment of particular services. Both of those cause problems for my members.

Under the contracting arrangements between private hospitals and health funds, it is actually the private hospital that collects the deductible from the patient. Obviously, that is an administrative burden that has been transferred to the hospital, so the more people who are being treated in a hospital who have a deductible, the greater the administrative burden for the hospital. It also shifts financial risk onto the hospital in circumstances where it is not possible to collect the deductible before treatment, before admission or on admission. There is range of circumstances where that happens, whether it be a transfer from another hospital, an admission after hours or on the weekend, or just an emergency or high priority admission where somebody has not necessarily gone through the normal pre-admission clinical process.

The other problem is that it undermines the value proposition of health insurance, and this came out in the earlier evidence. Even though somebody signs up to a policy with an excess, they may not necessarily recall that they have an excess or the level of their excess. I am constantly getting reports back from my members that when patients who have an excess are admitted and are asked to pay the \$200, \$500 or \$700 on admission, they actually forget that it is something to do with a product they have chosen. They seem to believe that it is an additional charge being imposed by the hospital rather than a function of the type of health fund product that they themselves have chosen.

CHAIR—That is under the current system? That is now, before there has been any change?

Mr Roff—Absolutely, but what I am saying is that if more people are taking out these sorts of policies, those problems will be exacerbated. It is probably exclusionary policies, though, that cause us more concern. We have been on the record for a number of years as saying that we do not think that exclusionary policies should be allowed. Principally, that is because people are not adequately able to self-assess their own risk for requiring particular services, perhaps with exception of maternity services. A lot of young and healthy people think that they do not need a policy that covers mental health services, when we know that people in their late teens to early twenties are high onset periods for mental health issues.

Similarly, with orthopaedic services they will equate hip replacements with being for elderly people, when of course sporting injuries and the like lead to a lot of orthopaedic procedures. We then find, once again, that these people are not able to access these services in private hospitals or they try to access them only to discover on admission that they are not covered because they have forgotten that they have ticked a particular box. Then they are forced to either pay out of their own pocket, which can be prohibitive, or wait for those treatments in the public sector.

The other issue for private hospitals is, once again, where we have urgent admissions that may be after hours where it is not possible to verify a patient's eligibility. For example, they may be suffering from chest pain and be taken into a cardiac care unit and given cardiac surgery over the weekend, only to find out on the Monday that they actually had a cardiac exclusion on their health fund policy and they have just incurred \$30,000 or \$40,000 worth of services. Those sorts of things do happen.

Once again, if we see an increasing number of people with exclusionary policies, there will be those financial issues for the patients in the hospitals. There is also the utilisation issue, because it will place increasing demand on the public sector.

Senator CORMANN—The government have said to us that, as a result of this measure, they expect 8,000 additional public hospital admissions. But that does not include, of course, the impact of people going for cheaper cover, more exclusions and not being able to access orthopaedic, cardiac and other treatments in private hospitals any longer. That is right, isn't it?

Mr Roff—Absolutely. We found it curious, I guess, that Treasury refused to speculate on those sorts of issues because they classed them as second-round effects. The department of health was quite quick to come up with a back-of-an-envelope calculation, but once again that does not estimate the impact of people downgrading their cover and therefore not having access to particular services in the private sector.

Senator CORMANN—I have got to go through this quickly because I only have a limited period of time. How are these successive budget changes impacting on investor confidence? You touched on it in your opening statement but I am just wondering about investor confidence in terms of investment in private

hospitals. You have made a general statement that there is a question mark now in terms of new investment and perhaps in terms of what is currently planned, but can you give us a bit more detail on what it means—the fact that there are successive changes and that there is no clear understanding of what the endgame is going to be.

Mr Roff—There actually has been a significant amount of capital investment over the last two or three years that is coming to fruition. In fact, I am attending the opening of a major hospital redevelopment tomorrow.

Senator CORMANN—It has been quite a good era for private hospitals.

Mr Roff—Correct. There have been growing levels of health insurance coverage, there has been growing utilisation and there needs to be increased capacity to meet what was the forecast growth into the future. One of the big problems, I think, with the investment environment is that we do not know now what the growth forecasts into the future are. We are relying partly on the information put out by the department of health that there will be 9.7 million people with health insurance for the next four years. We do not know what will happen after that. If their intention is that there are just 9.7 million people with health insurance—

Senator CORMANN—Which is a reduction in coverage.

Mr Roff—If you take that out about 15 years, you get back down towards 30 per cent of the population if you overlay the ABS population growth statistics on top of it. So, yes, we do not know if we are looking at a static number of people with health insurance. We do not know if that is going to be growing. We do not know if it is going to be declining. We can take what the department of health says on face value but that does have an impact on people wanting to take on debt to develop new facilities or to redevelop existing facilities to try and improve capacity.

Dr Carney—If I could just add slightly to that answer: the other uncertain factor is that the department of health have told us that they have agreed a figure in the contingency reserve with the department of finance and public administration and that that undisclosed figure in the contingency reserve has an assumption that there will be increased moneys needed to pay for the cost of the private health insurance rebate. But, because those figures are not disclosed, it is impossible to know how that relates to what is in the forward estimates that states that the population covered will be constant at that figure of 9.7 million. So it is a very difficult environment for investors.

Senator CORMANN—It is very difficult for you to plan ahead essentially in terms of what your future demand is going to be and what your future supply ought to be. You talked about the discussions with the health department. What has been done by the health department since this budget measure was announced? Are there any activities being undertaken to implement this measure?

MR Roff—A couple of weeks ago I think they held some information sessions just talking about the proposals as they have been outlined. I did receive a letter just a day or two ago from the department inviting me to join an implementation group for these measures with the first meeting to be held on 23 July which I thought once again was slightly curious—

Senator CORMANN—How can they implement this? The parliament has not made a judgment on this legislation. That is not a question for you. That would be a question for the department.

MR Roff—I found it strange that they were looking to implement a measure that had yet to go through this committee process let alone be debated or voted on in the Senate.

Senator CORMANN—Interesting. Looking ahead what are some of the things that you would be concerned about in terms of the private health insurance agenda that might be around the corner? Given that we had the Medicare levy surcharge change last year which the government still expects will result in half a million fewer people with private health insurance and given the private health insurance rebate change this year. What are your concerns in terms of what else might be around the corner?

MR Roff—How long is a piece of string!

Senator CORMANN—Let me rephrase that. You mentioned in your opening statement that you are concerned that this was not the end game. There must be something in your mind that you are concerned about and there must be something that you would be putting to the government that is really important for you moving forward to ensure that private health remains viable.

MR Roff—The obvious things to look at are further adjustments to this new regime if it is implemented, so changing thresholds and further reducing the amount of the rebate that applies within each threshold. There

could be once again changes to the surcharges; there could be changes to Lifetime Health Cover. We just do not know. We suspect given the savings targets that have been announced by government that this will be an area of expenditure that will remain under scrutiny, under review and subject to change.

Senator CORMANN—They are all things that the government has previously ruled out saying that they would not happen. To sum up your recommendation to this committee is that the parliament should not be supporting this legislation—is that right?

MR Roff—Absolutely. I think one of the key problems with it is the sheer complexity. We are now moving to a system with effectively 10 tiers. You have what I call tier zero which is where there is no change and then in each of the other three tiers different surcharges apply and different levels of rebate depending on age. I think one of the things that is going to happen is that this may lead to an increase in employment in the tax agency sector. People are going to need someone to explain to them exactly what it means if they fall within a particular income bracket and whether or not it is worthwhile to have health insurance and what sort of things they should consider. I think a lot of people are going to throw their hands up in the air and say, ‘This is all too hard.’ I know because I was involved in some of the discussions around the design of the original rebate scheme that one of the key considerations was to keep it simple. The administration of this scheme is going to be enormously complex. The tax office is receiving \$60 or \$70 million to administer it and tell people about it, how is the average punter supposed to react?

Senator FURNER—Mr McAuley indicates in his submission this view of an endowment effect, of people hanging onto what they already have. He relies upon several indicators. He says a survey in 1998 by the ABS showed 47 per cent of respondents held onto their PHI as a result of changes back then and that in 1999 it was 45 per cent of the population, even though in real, inflation adjusted, terms the original value of the 30 per cent subsidy had been eliminated by real premium rises. What surveys have you done in your organisation to refute those sorts of outcomes?

Mr Roff—There are probably three separate elements to that question. I do not know how you can refute what is really just a bald assertion about an endowment effect without any evidence that—

Senator FURNER—I just explained the evidence that Mr McAuley relied upon. They are ABS surveys and data.

Mr Roff—I might just refer to Dr Carney, who has had some significant experience in the general insurance industry and who may be able to make some relevant comments.

Dr Carney—On the first part of your question, Senator, I am not sure when the 1998 ABS survey was conducted—whether it was conducted before the 30 per cent rebate was the then government’s policy or whether it was conducted after that. That would have quite a serious moderating effect on those results. Dredging back into the memory banks here, I have seen the 1999 survey, but not since it was published, and I recall that the bureau at that time did have some qualifications around those results.

I know comments have been made, including in the evidence from your previous witness, about the endowment effect across the board on insurance. Before joining the Private Hospitals Association I spent a number of years in the general insurance sector. General insurance products are very, very sensitive to price, however you slice the demographics. The most sensitive products are comprehensive car insurance and household and contents insurance, which is one of the reasons the level of underinsurance in Australia for home contents is so significant. I do not think there is any reason to believe that the same considerations of price and decisions would not be made by those people who have private health insurance. So it is difficult, without a lot of very significant samples and quantitative analysis, to see how exactly that effect would work. I do take your point that a decision to not change is a decision. But if analogies are going to be drawn across the whole spectrum of insurance products, then I think it is worth while bearing in mind that there is a considerable price sensitivity.

Senator FURNER—Okay. I will not go into any questioning about the research you have as to car and household insurance. I take on board that people would either vary their insurance as a result of changes in premiums—

Dr Carney—Or drop it. Of course, people will also look around for a different insurer.

Senator FURNER—Or go to a broker.

Dr Carney—Not necessarily. What I am saying is that a fair degree of caution should be exercised in relying on assertions about consumer propensity in this area.

Senator FURNER—On this view about 8,000 people moving to the public sector as a result of a change to PHI and those matters, COAG announced last year a \$64 billion injection into state health systems. Surely that is going to support assistance in emergency circumstances and other factors to assist people who may drop out of PHI into the public sector.

Mr Roff—I am not aware of any statement by COAG or by this government that part of the funding was to pick up additional patients who may drop out of the health insurance sector. I understand that the New South Wales government have approached the federal government asking for some clarification about potential increased demand in their public hospital system.

Senator FURNER—There certainly was an announcement back in December 2008 that \$64 billion over five years shall be made available. That is in DoHA's submission. I guess that is something we will need to question the department on when we get to them in Melbourne tomorrow.

Mr Roff—They also have in their submission a statement that any increases in health insurance premiums will be more than offset by tax cuts, but I do not remember the announcement of the tax cuts being linked to this measure in any way, either.

Senator FURNER—Earlier you made the parallel between the funding of schools and the funding of health. What was the point you were getting at there? It seemed an odd assertion that there were some parallels between private health insurance and schools.

Mr Roff—To boil it down, the federal government provides funding for both the public education system and the private education system. Part of that is probably in recognition of the fact that to just have a fully public education system would be beyond the realm of government, without significant tax increases. The government does provide support to private or independent schools to make them more accessible to a wider range of the population, in recognition of the fact that anyone who uses it is taking pressure off the public education system. It is the same thing with support for private health insurance, in that people who choose to use the private system take pressure off the public system, which they are entitled to use and have paid for through taxation. The only difference is that with health insurance there is a direct subsidy to the consumer, as opposed to a subsidy to the institution that provides the service, as is the case in education. Access to the subsidised services in education is not means tested, but the government is imposing a means test in the health sector.

CHAIR—You might have to take this on notice, but how many people who currently go to your hospitals have complete coverage? You have raised the issue of the administration costs and the complexity of the system. I just want to find out how many of people who are currently admitted to private hospitals have 100 per cent coverage? There are already admin imposts on the hospitals to look at the variation, but I am just interested in that process.

Mr Roff—I can take that notice.

CHAIR—Do you have an objection to means testing as a concept or just specifically in private insurance?

Mr Roff—I was just drawing the parallel between what happens in terms of government support for the education system, as opposed to government support for the health system.

CHAIR—On one level this change is a means testing of a current entitlement. That is the basis of the whole thing. I am just wondering whether you have an objection to means testing as a principal generally or just specifically in private insurance.

Mr Roff—I have an objection to means testing in relation to this measure, when there have been repeated public and private assurances from the government that that would not happen and when planning decisions have been made—

CHAIR—I think your point about the fact that there has been a change is well made in your submission and your evidence. On that basis, thank you very much for your contribution. If there is anything you think you should have mentioned and you have not had a chance to, which happens sometimes, please get in contact with the committee.

Proceedings suspended from 10.39 am to 10.52 am

McAULEY, Mr Ian Alexander, Fellow, Centre for Research in Policy Development

CHAIR—Welcome back, Mr McCauley. You understand parliamentary privilege and the protection of witnesses. We have your submission. You gave evidence at the previous inquiry, which is on record. That is all part of the process we have. Do you have an opening statement?

Mr McAuley—I will certainly make it brief, because there is time. Last time I was on very short notice and there was not a written submission. This time I have made a written submission. The points I make in that submission are that the proposals, contrary to some of the publicity, actually increase the incentives for people on high income to hold private insurance. They do indeed provide some incentive for people to switch to lower priced policies—I do not use the term ‘downgrade’, very deliberately. That incentive has always been there under both the old and the proposed regimes, and there has not been a great response in that regard.

Modelling of elasticity, modelling of what is rational, is all very well, but in fact in insurance markets, particularly health insurance markets, there is no evidence that people are responding in what we would say is a cold, hard-headed, rational way. In fact, if they did, increasing through the surcharge the incentives to hold private insurance would, I think, probably draw in some of the 300,000 taxpayers in those income brackets who are currently paying the surcharge. If we are perfectly rationally we would actually see some increase in private insurance take-up. I also suggest, based on research, that there is very unlikely to be any significant change in membership of private insurance. There may be some switch to lower priced policies, but that incentive has always been there.

As Senator Furner has already pointed out, there is what is known as the endowment effect—we tend to hang on to what we have; we do not sit down rationally and calculate the costs of benefits for every purchase. One very strong phenomenon is that if we can afford it we tend to overinsure. One would believe that people with higher incomes, who are also people with greater wealth, would go for some higher level of self insurance, and when we look at the people in households above the income threshold of \$150,000 we find that on average people in those households have around half a million dollars in reasonably liquid wealth. Some of that is superannuation, which is accessible of course to people in the pension phase, and \$300,000 of it is in shares, investments et cetera. So we are dealing with a fairly wealthy population who could afford some level of self insurance. Yet, irrationally I would say, the evidence shows that the higher the income and wealth the more insurance people take, which is another reason I suspect there will not be any significant shift to lower priced policies. As I say, we are not rational.

I will just run through a few points in our experience with private insurance. Following the incentives introduced in 1997, the means test and the surcharge, insurance levels tended to fall. Abolition of the means test saw only a very slight response, but there was a big response to lifetime rating and ‘run for cover’. We do not know what—different academics have different views on whether it was the run for cover or the very strong publicity—but certainly something kicked people into taking private insurance at that stage. An ABS survey in 1998—I know the timing of that was questioned; it was actually after the surcharge and the means tested rebate—found that 40 per cent of people took insurance because they wanted ‘security protection/peace of mind’. Only one per cent responded in terms of the incentives. As has already been pointed out, over that period since 1999 real increases in the price of private insurance have eliminated the original 30 per cent rebate, so we are now back in real terms to where we were before the rebates. Although insurance levels went through some slight dip they have come back up again, and so far there has been no discernible effect from the raising of the income threshold for private insurance.

I would also like to comment on the analogy with private education which the previous witness made. Yes, indeed there are subsidies for private education, but they are paid directly to the parent or the school; they do not go through a financial intermediary. One of the extraordinary things about private health insurance particularly affecting this group of higher income people is that those who are truly self-reliant and pay for their own health care out of their own pockets get no assistance. They get the assistance only if they pass the funding through a financial intermediary, which is a rather strange form of assistance for the private sector. The other area where the analogy does not hold is that in education, although there are temporary shortages of teachers, it is easy to get the resources to cope with an expansion in one sector or the other. If the private schools expand, that does not necessarily permanently deplete the public schools of teachers; they can recruit more.

But, of course, what has happened with private health insurance is that, given other policies and other factors which have restricted supply of specialist nurses et cetera, once demand shifts to the private sector so too do the real resources shift to the private sector. That is one of the reasons why there remains the increasing

problem of growing waiting lists in public hospitals. Indeed, one could say that in the unlikely event that this reduced demand for private insurance, and therefore reduced pressure on the private sector, it would actually release resources for the public sector. I am not suggesting that is likely to happen, but we must see health care in terms of a limited number of resources. Wherever the funding goes, the resources will go, and simply shifting the funding around does not necessarily do anything to increase the total resources available.

In my assessment of the policy I would say that it has some good elements and some bad elements. The bad elements are that, contrary to what some other witnesses may say, it does not reduce our dependence on private insurance, which is a very expensive way to fund health care and a very expensive way to fund the private sector. There are many ways of funding private hospitals without using private health insurance as, say, the single payer options in other countries, particularly countries like Sweden, show, as does our own funding through the Department of Veterans' Affairs. We can have a thriving private sector with a single payer. We know from international experience that private health insurance is an inflationary way of funding health care. In fact, since I prepared my submission another report by Kinsey in the USA on their policies has commented on the high moral hazard associated with private insurance.

But the policy does have some good aspects in that, if people do indeed shift to lower-priced policies, particularly policies with higher deductibles, there will be more self-reliance by people, which means they will be paying more for their own health care. They will be making more informed market decisions because they will be paying those deductibles. It also removes, not entirely but partially, one of the great perverse incentives in our present system in terms of ancillaries. It would be perfectly rational for people to drop their ancillary cover, particularly if they have the resources to pay for their own ancillaries. We have the rather inequitable situation now, particularly for dentistry but also for physiotherapy and other services, whereby those who pay for their own ancillary services—and that includes the 55 per cent who do not have private insurance and do not have other means of support—pay out of their own pockets, while those who do have subsidised private insurance have to pay fully for these services. It is starting—but only starting—to dismantle a government function which has really taken away the incentive for people to be self-reliant in some of these markets and has increased what I call 'corporate reliance'. In my submission I say that it has interposed what I call the 'nanny corporation' as a funder of health care.

Senator CORMANN—How important is the role of private health insurance as part of our mixed health system?

Mr McAuley—At present in terms of total funding in Australia it is not large. It is in the order of seven per cent to nine per cent of total recurrent funding in health care. I know there is a notion that it relieves budgetary pressure on the government, and that is certainly correct. I know that that is a point that Mark Fitzgibbon frequently makes, particularly looking into the future, but of course we still have to pay for health care, whether we fund it through official taxes, through our own pockets or through private health insurance. To the extent that there is community rating, to the extent that it redistributes risk and compensation for risk, it is what some would call the privatised tax. I would suggest that, to the extent that we want to share our healthcare expenses, the most efficient way to do so is through official taxes.

Senator CORMANN—Which would be like an entirely public system. Are you advocating that we should have public insurance across the board, like a free, universal access to Medicare, nearly exclusively?

Mr McAuley—I suppose it depends on which side of the bench I am addressing. I do not have any ideological conviction in this regard. If I were addressing, perhaps, the Liberal Party and quoting from the platform that says:

... the need to encourage initiative and personal responsibility—

I would say that a government of that persuasion should try to encourage people to fund some part of their health care from their own savings, from their own initiative. Therefore do what the Swedes have done and tend to make the public insurance a safety net and require people to pay something from their own pockets. If I were advising the other side of the table, I would probably say go for the single universal payer without co-payments.

Senator CORMANN—You are now saying what you would advise both sides of politics, but what is your own view?

Mr McAuley—I do not have one, Senator, and that is not through agnosticism or a lack of consideration of the issues. But we have never gone to the Australian public, as the Romanov commission did in Canada, and said, 'What do you want to pay from your taxes? What do you want to pay from your own pocket?'

Senator CORMANN—Okay. Sorry, I am not meaning to be rude and interrupt you but I do not have a lot of time, so if you can keep the answers concise. In 1983 we had about 63 per cent of the population privately insured. That went down to 30 per cent. At the moment it is about 44 or 45 per cent. Do you think that there is an ideal percentage in terms of proportion of population cover to keep the system in balance?

Mr McAuley—I would not say so because, when we look at international experience, we can see countries such as Britain and the Nordic countries with very, very low levels of private insurance and a system in some sort of equilibrium.

Senator CORMANN—In those countries that you mention private health insurance is something that is only taken out by the very rich. Whereas you have, essentially and nearly exclusively, a public and universally free access type system. Do you agree with that?

Mr McAuley—In those countries private insurance is only taken up by the very rich. Canada, for instance, prohibits private insurance for services which are covered by their public program. So private insurance tends to cover only what I call the supplementary level of services so it does not interfere with the principle of universalism.

Senator CORMANN—You mentioned in your previous evidence how many young people are not aware of their entitlement to free public hospital care. Do you think that a system that is nearly exclusively based on free access to public hospitals is able to meet all of the available demand, given the limited resources and unlimited amount?

Mr McAuley—I would say no. We know from the stress on all healthcare systems which are free,—and on any system that is free—particularly if it is something desirable such as health care and something open ended, then you do get excess demand and queuing. But the point is, of that stress, a service is free at a point of delivery, and that is of course a moral hazard which is common to all insurance, private or public.

The question I would suggest—with respect to the senators who are obviously the political representatives—to put to people is not whether we have private or public funding but how much do you want to share in healthcare expenses, how much do you want to pay out of your pockets. We have absurd situations right now where we have free public hospitals but we have to pay \$32 for a pharmaceutical. We have certain services like physiotherapy where most people have to pay fully unless they get a reference from their health insurance fund. We have a complete mess of free and paid-for services. We have inconsistent safety nets—some on family bases, some on individual bases and some financial year some calendar year. There is no underlying set of principles because we have not put the question to people of: ‘What do you want to pay out of your own pockets? What do you want to share?’

Senator CORMANN—And, of course, the answer would be very different depending on who you are and what circumstances you are in. To go back to this measure, you have mentioned that the most rational response to this measure would be to shift to a cheaper policy and to drop ancillary cover.

Mr McAuley—Yes.

Senator CORMANN—I happen to agree with you that that is the most rational response, given that the private health insurance rebate reductions are balanced with increases in the Medicare levy surcharge. But that rational response is not something that Treasury has assessed or included in their assumptions. It is a significant effect of this policy measure that has not been assessed by Treasury, is it not?

Mr McAuley—It is a shortcoming in Treasury’s modelling; I will certainly agree with you, Senator. Yet I would say the other shortcoming in Treasury’s modelling is that they really have not considered adequately what I would call the whole inertia in people’s behaviour.

Senator CORMANN—Okay. Treasury assume a whole range of related savings from the people they expect to leave from two successive measures—for example, from reduced rebate payments. Let us assume that you and I are correct and that the most rational thing to do is to go for the cheaper policy and to drop ancillary cover. What it will mean, as you mentioned earlier, is that people will have higher front-end deductibles or they will have more exclusions in terms of the services they can get access to.

Mr McAuley—Yes.

Senator CORMANN—More front end deductibles is increasing expense at the time of accessing a service. It is increasing the gap. Surely it will have an impact on the value proposition that people perceive.

Mr McAuley—It certainly would, but by what normative standard would we say it is undesirable that people do have to consider what is coming out of their pockets when they decide to take an elective procedure

or even make the choice between, say, different surgeons? It is hard to think of a normative standard by which I would say that is undesirable.

Senator CORMANN—I am not trying to put words in your mouth, but what I hear you say is that it is quite okay that the out-of-pocket expenses at the time of accessing a public hospital service will go up as a result of this measure.

Mr McAuley—To come off the strict academic detachment and to come back to my own values, I would say for people who do have significant liquid assets it is not only quite okay, it is probably quite desirable that they enter into the market transaction and do take some personal responsibility.

Senator CORMANN—Rather than taking personal responsibility by taking out health insurance, you think the better way is to take personal responsibility at the time of accessing the service by paying for the increased expense at that time?

Mr McAuley—Most certainly. I was not see taking health insurance, particularly when it is so heavily subsidised, particularly when the surcharge in the proposal overcompensates for the price of insurance—I would not call that personal responsibility. After all, insurance is the means we use to buy out of the discipline of markets. The virtue of markets is they do put the pain on us to allocate resources at the time of making a transaction. Insurance buys out of markets.

Senator BOYCE—Not just metaphorical pain, perhaps!

Senator CORMANN—But, with the 30 per cent rebate, for every \$3 that the government puts in there is \$7 that the private contributor has to put into the health system. I think some have talked about \$1 becomes \$3, an equation of one times two. For every person who leaves, we do not only lose the private health insurance rebate contribution, we also lose the private contribution.

Mr McAuley—We do indeed, but that is very much in the immediate term. In the longer term, of course, what we find in countries, and the USA is the exemplary case, is that private health insurance actually increases the total amount we have to pay for health care. While that equation is roughly correct, I would remind senators that the administrative costs of private health insurance are much greater than the administrative costs of the tax office plus Medicare. So over time—and this is what has happened in the USA and is now happening in the Netherlands—because the private insurers lack the market clout to control utilisation and costs and provide necessary public goods, the overall cost of health care rises. That means essentially that what we are not paying through our taxes we are paying through other transfers.

Of course, that is the problem that the Obama government is dealing with right now. A related problem in the USA, which is not getting so much publicity, is that its rather parsimonious programs of Medicare and Medicaid are now costing, in terms of percentage of GDP, about the same as Britain's comprehensive NHS. So eventually, because of its lack of cost control, private insurance actually drags up the budgetary cost of health care. But the stronger argument is that it drags up the total cost of health care. What is the difference, apart from brandings, whether people pay their taxes to HCF or the Australian tax office?

Senator CORMANN—So your view—to summarise that—is that, rather than put it into a private health fund, whatever funding is lost to the health system as a result, people should be asked to pay that through their taxes and it should go into the overall tax pool?

Mr McAuley—To the extent that we want to share our healthcare expenses, yes. But I would not extend it to say we should necessarily have a completely free, tax funded system. That is a normative question which neither I nor any other academic, I would suggest, has the capacity to answer.

Senator CORMANN—I want to go back to the most rational response, of shifting to a cheaper policy. We have dealt with front-end deductibles. The other part is increasing the number of exclusions. If somebody no longer has access, through their cheaper private health policy, to cardiac surgery, orthopaedic surgery or mental health treatment, they will have to present to the public system, won't they?

Mr McAuley—Yes, they would most likely present to the public system, although I am puzzled to know why that has been raised by the private health insurers themselves. I would have thought they would have welcomed the people who contribute and do not draw. But that is certainly correct. The rational thing to do, particularly for those in good health, is to take an exclusionary policy and never tell anyone about it.

Senator CORMANN—It is something that I raised with Treasury and Health during the Senate estimates process. It is not actually a cost that has been assessed by Treasury as part of this budget measure, is it?

Mr McAuley—Not as far as I can see.

Senator CORMANN—I think it is fair to say that Treasury have expressly stated that they did not assume that there would be downgrading, that people would drop cover. You would have reviewed the *Hansard* evidence, I am sure.

Mr McAuley—The answer I have is that, already for people on high incomes, there is this incentive—a strong incentive, as I show in those tables—to shift to a lower priced policy, or what they call downgrade, but people are not doing that.

Senator CORMANN—But what is happening here is that there will be an immediate and automatic increase in the cost of private health insurance premiums of between 14.3 per cent and 66.7 per cent, so there is a one-off price event which will increase the base moving forward. Don't you think that that will lead people to make a rational decision at that point in time?

Mr McAuley—It may, but it would be very brave to be categorical about that, when we look at the history of the previous incentives, which were well announced and where people obviously did not do what would have been individually rational.

Senator CORMANN—But you have said that the most rational thing would be to do this.

Mr McAuley—Most certainly.

Senator CORMANN—You have also said that Treasury modelling works on rational assumptions, yet they have not assumed this.

Mr McAuley—No, they have not. I do not have great insight into Treasury, but I would suggest that, given the two false starts back in 1998-99, when Treasury made such confident predictions and got it horribly wrong—

Senator CORMANN—Just remind us what happened then, because that is when the Private Health Insurance Incentive Scheme was introduced, which was a means-tested scheme, was it not?

Mr McAuley—Yes.

Senator CORMANN—There was aspiration that it would result in significant increases in coverage, which it did not.

Mr McAuley—And then nothing happened, the means test was lifted and there was a very feeble response. I do not remember but it was insignificant. As you say, Senator, initially there was a means test and the surcharge and there was no response, in fact membership continued to fall. The next thing was that the means test was lifted a year later, membership rose very slightly. Then there was the advertising campaign 'run for cover'—

Senator CORMANN—Lifetime Health Cover came in.

Mr McAuley—and up it went from 30 to initially about 43 per cent. We do not know what was the trigger. It might have been Lifetime Health Cover but I would still stress that for young, fit people under the age of 55 actuarially even lifetime cover was not particularly attractive and yet a lot of young people jumped into that.

Senator CORMANN—I think the prevailing view was that there was a combination of three measures that acted together, but I am not going to get into that argument with you now. To close off you mentioned how in real terms, because of premium increases since then, the value of the 30 per cent rebate has been eroded but in real terms income has increased over that same period as well, has it not?

Mr McAuley—It has most certainly. There have been both nominal and real increases in income over that period of course until last year did result in the surcharge becoming more effective.

Senator CORMANN—So you cannot really compare the cost of premiums now with the cost of premiums in 1998-99?

Mr McAuley—We can in terms of straight price—what economists call price elasticity. It is hard in terms of income elasticity but there is the very fact that we are talking about higher incomes leading to people taking more insurance. The people affected by these measures are undoubtedly in both the higher income and higher wealth brackets of Australians. I would say unfortunately—some might say fortunately—that they would not have much cause. They will not rationally go and drop their private health insurance.

Senator CORMANN—The reality is that if it were not for the private health insurance rebate, premiums today would be up to 66.7 per cent more expensive.

Mr McAuley—It is very hard to know what premiums would be because we would have to know the demographics of those who keep insurance and those who do not.

Senator CORMANN—We know what the effect of the 30, 35, 40 per cent private health insurance rebate is in terms of the cost.

Mr McAuley—We know the immediate cost effects. What we do not know is who they attract, who they keep out and of course it is the demographic mix within insurance particularly when it is community rated and regulated that determines the ultimate fee.

Senator CORMANN—So it could actually be more expensive is what you are saying because fewer young people might have been attracted, so the risk profile would have been more expensive because it was an aged demographic—is that what you are saying?

Mr McAuley—If that happens. I think the private insurers should be grateful that a lot of young people do not consider.

Senator CORMANN—But if young people had not joined to the extent that they have over the last 10 years, it is fair to say that private health insurance premiums would be higher.

Mr McAuley—Yes, most certainly. Actuarially everyone under about age 55 contributes and everyone over draws. To the extent that one group leaves, the other group will have to pay more.

Senator CORMANN—If measures like this make it harder for young people to join or encourage younger people to leave then it will actually result in increased costs for those over 55 who are drawers, as you described them.

Mr McAuley—Again the qualification is if they have that effect, but I am arguing that they will not have that effect.

Senator CORMANN—The minister for health has argued that the people first likely to leave are the younger people.

Mr McAuley—Yes, but how many younger people are in those income brackets? There would be some but certainly not many, particularly now that Macquarie Bank is shedding staff.

Senator SIEWERT—I want to get to this issue about the comparison with private education. The other thing that is obviously different is that parents pay a significant amount of money to send their kids to school.

Mr McAuley—Certainly.

Senator SIEWERT—Which is not what happens in health.

Mr McAuley—That is a great difference. I would hardly say that enrolment at King's School or Geelong Grammar is subject to moral hazard. It is still quite an expensive decision to make whereas taking elective surgery does have a degree of moral hazard.

Senator SIEWERT—I would suggest it is a fairly fallacious comparison to make.

Mr McAuley—I would not use the term 'fallacious', but I would say it is attractive until we start to think through the differences. When we think through the differences, they are very significant.

Senator SIEWERT—There are a million people with private health insurance who have incomes under \$26,000. The Australian Health Insurance Association was saying that those people will certainly drop their ancillary cover. Do you think that is likely to happen, particular among older Australians who are on pensions?

Mr McAuley—Again, it is a hard question. Ancillary cover, apart from ambulance cover, has never been particularly good policy. Every ancillary service, apart from ambulance, is capped such that the insured person is left bearing the open-ended risk. So the insurer covers a certain amount and the insured covers the rest. Perhaps we can see the reason for that when we consider services like physiotherapy and dentistry, which are very open ended. It has never been a particularly good product. Rationally, anyone can afford to be without it would do well to be without it. The only thing that holds people in ancillary cover, I would imagine, is the 30 per cent rebate.

Senator SIEWERT—It was put to us this morning that private hospitals do 55 per cent of the cancer surgery—and I did not note all of the percentages, but I will get them from *Hansard*—and the argument was that a large amount of required surgery, not elective surgery, is done by private hospitals such that if people drop out there is a further burden on the public system. Do you think that is a valid argument? If so, what should we be doing about it?

Mr McAuley—It is certainly a valid argument that, if fewer people use the services of private hospitals, more will use the services of public hospitals. But, of course, the counterargument to that is that resources will shift back from the private to the public sector, and when I say ‘resources’ I mean doctors and nurses in particular. We already have an excellent model in the Department of Veterans’ Affairs, where 70 per cent of hospital services are contracted to the private sector. Good public policy would see private hospitals delinked from their extraordinary dependence on private insurance. To emphasise the point about the loss of personal responsibility, before the rebates came in, about a quarter of people who used private hospitals, not including workers compensation, were uninsured—in other words, paying from their own pockets. That has now dropped to 12 per cent. So it should be possible—and, of course, Premier Kennett stood up with the example when he was Premier—for the private hospitals to compete with the public hospitals and offer services on DRG basis, drawing on two sources of funding, one being government funding through the health agreements, the other being personal payments. It is a very strange policy arrangement, when you stop to think of it, that we have these two channels of funding, one for public, one for private, when the rhetoric of both main political parties has been for competition to exist. We have the public and private sector hospitals isolated from each other, and they are not competing.

Senator SIEWERT—You made comments earlier about other funding models. I know you said you do not necessarily have an opinion about private health insurance, but what would you suggest would be the best model for funding the provision of health care through the hospital system?

Mr McAuley—Again I would say we should not really see the funding of hospitals as separate from the funding of other aspects of health care. I will qualify that I am not going to fully answer your question, but let us say that the ideal funding for health care should be that, to the extent we want to share—and I stress ‘to the extent we want to share’—the funds through a single national insurer, to the extent that we want to take some individual responsibility, and that will depend on what I might call the left-right tenor of the Australian community, we should pay through our own pockets without insurance, because, when some have insurance and others do not, it tends to push up the price and crowd out those who do not have insurance.

We have not really assessed, in what I would call community consultation, citizens juries or whatever other mechanisms, what people really want. If you go to the public and say, ‘Do you like a free health care system?’ of course they do, but, if you went to them and consulted them about the options, as the Romanow commission did in Canada, I think we would be able to make a much more democratically informed answer on that question. But, whatever it is, I would not see private insurance as part of that funding mix.

Senator FURNER—With regard to the uptake, the figures are different. I think Treasury indicates 130,000 going from the Medicare levy surcharge onto private health insurance. I think the figure in your submission is slightly higher than that estimate. What is your position on the number of people that will most likely take that up? Secondly, AHIA this morning indicated that the incentive would have to be 1.5 per cent. Based on DOHA’s figures, there would only be 40,000 of the 130,000 falling under that tier 3 of taking up that option—and 90,000—as opposed to being under the 1.25 per cent. What is your view on both those examples?

Mr McAuley—We do not know the composition of that 130,000, 190,000 or whatever the figure is, except I do notice, when I look through the taxation stats, that they tend to fall into the lower income categories of those who have to pay the surcharge. Perhaps they are people without particularly good accountants. There will also be a cohort in there who have a conviction that they do not want to live in a gated community, that they want to share their healthcare expenses with other Australians, and therefore they do not take out private insurance, knowingly bearing a cost for doing that. Of course, the higher one’s income is under the surcharge, the more one pays for that act of solidarity or altruism. I am sorry I cannot answer that question except for that observation that it does tend to be among the lower income people within that higher income bracket.

Senator FURNER—Also, AHIA in their submission this morning indicated there would be an exiting of people out of the private and into the public, and they used the example of breast cancer operations. Your submissions indicate there is some sort of fear factor built in promoting insurance. Is that an example of a fear factor of promoting private health insurance in that respect?

Mr McAuley—The research on both general insurance and our experience with private health insurance and those surveys by the Australian Bureau of Statistics certainly show that fear, in its broadest context, is the motivation for taking up insurance of all types rather than any rational consideration of costs and benefits. When it comes to the specific conditions, such as breast cancer, what we tend to find—and clinicians will be far better positioned to respond than I am—is that it depends on what services are available where. Those severe conditions are not the sort of conditions where people consider the length of waiting time, because in

both public and private systems people do get priority service. So that will be driven very much by consideration of what is available rather than whether it is public or private.

Senator BOYCE—Mr McAuley, earlier today we had evidence that insurance in the household and car areas was quite responsive to price changes. You are saying that private health is very different?

Mr McAuley—It is much more heavily regulated than those two categories of insurance. That, of course, is through community rating. What I do know about the categories of general insurance is that there is a very large degree of price dispersion in general insurance. Here in Canberra there has been some excellent research done by ASIC in relation to the insurance before the bushfires of some years ago. ASIC found that for identical policies there were price differences in the order of 40 per cent.

Senator BOYCE—And you are saying that is not the case—

Mr McAuley—That is not the case in private health insurance. The price differences are much more minor.

Senator BOYCE—But the packaging would perhaps be quite different in an attempt to, I think, appeal to particular demographics. Is that the case?

Mr McAuley—All insurance products come with certain bundles. It is one of the marketing strategies by insurers. Obviously the packaging is different: house and contents is somewhat different from hospital plus ancillary.

Senator BOYCE—So in your view health insurance is not as responsive to price changes as other forms of insurance—is that the case?

Mr McAuley—Certainly there is less capacity in health insurance to do what insurers call ‘practising adverse selection’. If I have two cars at home and two teenage children, I am going to go for the maximum insurance I can get and hope that the insurance pays up. In health insurance, with the exception of pregnancy, we do not know what is going to hit us around the corner. We cannot make rational decisions about that.

Senator BOYCE—Isn’t that the point of insurers in any area?

Mr McAuley—It varies. In, say, car insurance, we can make judgments—

Senator BOYCE—You can be fifty-fifty confident that your teenager is going to prang the car—is that what you are saying?

Mr McAuley—Yes. I can and do practise adverse selection in terms of general insurance. I cannot make a perfect prediction, but I can be more confident about my predictions in terms of general insurance.

Senator CORMANN—But you can be very confident that at some point in your life you will need access to healthcare services.

Mr McAuley—I do not know. I may have the good fortune to be struck down by a truck as I walk out of here and never need healthcare services.

Senator CORMANN—But that is a little unusual, isn’t it?

Mr McAuley—Or I may need intensive chemotherapy.

Senator BOYCE—But surely, in any area of insurance, the person purchasing the insurance is making what may be a relatively unsophisticated decision but nevertheless a risk management decision about that insurance, aren’t they?

Mr McAuley—I think you have said both ‘unsophisticated’ and ‘risk managed’, and those of course are the two extremes. The sophisticated approach considers risk and practises some degree of adverse selection; the unsophisticated says, ‘What can I afford?’ and takes it out. What the evidence tends to show in both general insurance and health insurance is that the more income and wealth we have the more we insure.

Senator BOYCE—But presumably, also, the individual might perceive themselves as having to insure as well.

Mr McAuley—If we have the \$2 million Point Piper home, yes, we will take out more insurance, but what we also find is that a person with a \$2 million Point Piper home is more likely to have comprehensive insurance without any co-payment or deductible. That is where wealth and income take effect, and this of course is why these present measures are highly unlikely to result in any significant behavioural change. People will decide what they take based on what they can afford.

Senator BOYCE—I guess the contention is that the cost of what they can afford will change. But going back to your views on why private health insurance does not make sense either from a left-wing or a right-wing perspective, would you apply this to other forms of insurance?

Mr McAuley—Not necessarily. Health is special in terms of what we were just talking about. In terms of the fact that we are in what the philosopher Rawls calls ‘an original position’, I may be able to make some assessments about my risk of house fire depending on whether I live in Marysville or in the centre of Melbourne, but when it comes to health I do not know whether I am going to have 40 years of healthy life or whether I am going to be struck by a very expensive condition. We cannot make a guess about our future needs, so we are much more, in what I would call a democratic sense, willing to share those risks with others in a broad pool, whereas in other insurance we are more capable—certainly not perfectly capable—of making more rational decisions.

CHAIR—Thank you, Mr McAuley. If there is anything you think you want to add after you go, please be in contact with the secretariat.

Mr McAuley—Thank you very much, Senator.

[11.41 am]

DEEBLE, Dr John, Private capacity

CHAIR—Our final witness in this part of the hearing this morning is Dr John Deeble. Welcome back. You understand parliamentary privilege and the protection of witnesses, as you are a fairly regular visitor to us.

Dr Deeble—Indeed.

CHAIR—We have your submission. We also have a copy of the evidence you gave to the other committee, which is on record. Do you have an opening statement?

Dr Deeble—Well, of course. You have two papers of mine?

CHAIR—Yes, I think we do.

Dr Deeble—Before I start, I have addressed the committee on this issue. I have not tried to argue, and would not believe that this was an inquiry into, the existence of a private health insurance rebate extending to the particular matters which this bill addresses. In my first submission, I set out that while I have many reservations about the structure of the private health insurance rebate it is what we have got.

CHAIR—I think you detail a couple of those reservations, Dr Deeble.

Dr Deeble—And also I would say for the record that I am not opposed to the support of a private sector of health. I do not think that the rebate structure does that in the best possible way, but I am not opposed to it. If you want a reason for us having it, it is really very simple: in Australia we have a public hospital system, which does most of the emergency work. Forty-nine per cent of public hospital patients are emergency admissions; eight per cent of private hospital patients are emergency admissions. The public system does most of the emergency work, it does all of the medical education, it does the most complex cases and it has the most complex equipment. To my knowledge, there is no private hospital that has the equipment that a teaching hospital has, except when it is associated with a public hospital and uses the public hospital equipment—and I have valued the capital hospital systems in three states.

But the public hospital system historically was set up to care for poor people—and this goes back a very long way, but history is what has determined what we have now—at a time when that was the only care the poor could get; the rich had a doctor but the poor people went to hospital. The result is that our system has a public system which has not got the capacity to treat everything that people want. For whatever reason, it has not got the capacity to do all the elective surgery. We have a private hospital system that does do the elective surgery well.

These two systems are complementary to each other; they should not be regarded as competitive. I started working in hospitals 53 years ago and it is a matter of astonishment to me still that Australia cannot manage to solve this problem in a way which is satisfactory to the community. It will never be satisfactory always to the competing providers but, nevertheless, we have not reached a satisfactory solution to the problem. The rebate is one way of accommodating this. It is not the best possible way, I think, but it is a way of doing so.

To give some background to what the issues are: the question is not an ideological one. We have two systems and we have to try and make them work together. Regarding them as competitive is, I think, the worst possible way to look at it. As I said in my first submission, I accept Treasury's calculations absolutely. Again—if I can indulge myself, having been around this for a very long time—as to the question of whether and why people are more or less susceptible to price, the why is not as important as the fact. The fact is: they are. Private health insurance is much less sensitive to price than almost any other insurance you can imagine. Your last witness was talking about the reasons for that. Well, the reason is this: whereas if you lose your house you lose money, if you fail to get health care you may lose your life, and they are two quite different propositions. Health insurance is seen not as a way of getting money back but as a way of getting access to health services. That is the difference between them. That makes health insurance seem like an essential. Whether it is paid for in one way or in another, it is nevertheless regarded as essential. That is why the community provides health services to people—it does not do it because it is a nice idea. I also think that the changes that are proposed will have almost no effect and if there is an effect it will be tiny in the extreme, and I will explain why later.

The levy and the surcharge are devices which have been used to separate the two systems and, effectively, means-test the public one. As I said in my first submission, the levy was never intended to be and has never been the cost of public hospital care. Being chairman of the planning committees for both Medibank and

Medicare, and dealing with the politicians at the time, I do know this. It funded the extra medical benefits that were incorporated in Medibank and Medicare. The public hospitals were always funded out of tax. The extra levy was to fund the bit of the Medicare benefits that was taken over—the half that was switched from the funds to government payment.

It follows then that the relationship between the levy, the surcharge and the premium is completely contrived and has no logic at all. It just happens that the numbers can be made to work in a certain way if you want to achieve a certain result but it does not have any logic. Also I did point out that it would have been fairer actually in the first place to have made the levy on tax paid because that looks after the progression of the tax as people's incomes rise. But in the circumstances of the time, in 1973, it was really impossible to do that, so it was made as a levy on taxable income—a flat levy not progressive like income tax. I know there are a lot of people who say that all taxation is theft and we should have a flat tax and progressive tax is evil, but I think most people would agree that some degree of progression in the tax scale is equitable—that is, that the richer people pay a higher amount of their extra income.

I would also say, and I am skipping a bit, that I do not have any argument with the income thresholds proposed. I did not have time to work out the taxation statistics to see just how many people were in those various groups, but I am sure with a little bit of thought I could work it out from the taxation submission. Somebody has to determine what is a high income or a high enough income for something like this to operate. I think it will not be entirely equitable because the rebate applies.

Even though I said that the relationship between the levy, the threshold and the rebate is contrived, there is a basis on which it could be examined. All of the arguments in this and all of the debate is about hospitals. But the hospital part of the private health insurance operations is only 60 per cent of it and there is some logic in comparing that with a levy—however that levy was contrived or what its purpose was. The dental, paramedical and the raft of things that are included in extras, such as all kinds of parallel medical and health services, have no public parallel. Medicare does not provide them. Governments do not provide them. The federal government provides no dental services at all. If it does so, it is through grants to the states.

The total premium includes the ancillaries that 97 per cent of people who have hospital insurance also take—there is no logic in that being included in the rebate. It is and a lot of the calculations are made on the basis that somehow or other we should compare the total levy and the total rebate with the hospital part which is only 60 per cent. Is that satisfactory? Do you understand that, senators, or am I too obscure? As I said all of the academic work and all of the experience confirms the figure that the Treasury, from a substantial review of the literature, has selected which is 0.2 which means that for a 10 per cent increase in price, demand will fall by two per cent.

It is not sensitive to price, for all the reasons that I just said. It is associated with illness, with the threat of death. Everybody believes that, while most of their health care is for relatively trivial self-correcting complaints, there is always the possibility that they will get something that is a threat to life—and that is what they are concerned about, not the insurance, the small amount of money. By the way, if you insure for a house you may insure for \$500,000 or \$600,000, but everybody's annual health expenditure is something of the order of \$2,000. It is not the same sort of thing at all. In one case you are insuring against a very rare event with a very high cost and a very high potential loss. In the other one you are insuring against a series of small events but with the possibility that one of them might be big—but it will not be big in the order of \$500,000; it will be big in the order of its consequences for your health.

I think the Treasury's estimate for elasticity of demand with price is probably even a little high. I was a health insurance commissioner for 16 years and I was on the board of Medibank Private in that time and, for one reason or another, I was the person who did most of the rate setting. I can tell you, as I have said in the first submission, that we could vary up to 10 to 15 per cent away from our competitors with no marked effect on our market share; and when we all raised prices, together or separately, we lost no market share and the total market share did not vary. There was a significant decline in private health insurance in the early 1990s, which carried on until about 1995-96, which was more associated with income. There was a recession in the early 1990s. When people's incomes drop, they will drop private insurance; when their incomes are rising, they will take it. But that is not a price effect, that is an income effect. So, as I have said, I can confirm off from personal experience that the effect price on demand and market share for any individual company or the whole industry is very, very low indeed—it has very little effect. I do not say that it will not ever, and I do not say that over time the overall price level might not matter, but it has no effect to speak of in the short run.

The second paper I have given you, which I hope you have had a chance to look at, is trying to reduce the question we are looking at to the simplest possible propositions. By the way, it also shows that there is an enormous amount of misunderstanding and, I hate to say it, rubbish in some of the other submissions. I hope I am not going to be pilloried for saying that, but I must tell the truth. All I have done in this paper is to take the hospital part of the health insurance premium and compare that to the levy, because that is where there is a logical link. There is no logical link for the other part. I have calculated what the average premium was in 2007-08 for a family insurance premium, and that average price was \$1,905. The sources and the calculations are shown as very easy, simple divisions—there is no rocket science in working that out. Using the past trend in real prices, I have then projected forward to 2011 what the price will be without inflation, and that is \$2,000. I have produced a table there which shows what the rebate would be, what the net cost after the rebate would be and what the Medicare levy surcharge would be. Under the present rules that is the first four things. The key column is the bolded one, which is the net cost after rebate.

The proposed ones are very simple to calculate; everything is very easy. You can see that in fact there is no change in the net cost up to \$150,000. There is an increase of the vast sum of \$200 for the next one, the \$150,000 to \$180,000 for a family. There is another \$200 added to the \$80,000 to \$240,000, and it reaches the full premium of \$240,000. Those are very, very tiny changes.

CHAIR—I think maybe someone—

Dr Deeble—What we have is confusion in percentages in absolute amounts. By the way, if you look at the Medicare levy surcharges on the side, the Medicare levy surcharge would go up in the proposed one by nearly \$1,000 in the first and second tiers and then by nearly another \$1,000 in the other one.

I notice that a number of the submissions that you have are saying that the Medicare levy surcharge did not go up enough. This is because they have got confused—and, in a sense, the Treasury is confused too—because, while the Treasury has calculated the percentages, there is a big difference between the percentage on \$2,000 and the percentage on the income of \$200,000. That is the numerator and denominator effect. So, while the net cost after rebate only goes up by \$200, the Medicare levy surcharge goes up by \$2,000. I must ask whether that was the government's intention. Did it matter that that was what the result would be? It is extraordinary. It would make certain that no person earning over, say, \$240,000 ever stayed in hospital under Medicare, because the penalty of \$3,600 is quite unrelated to anything that the cost of that hospital stay might include.

My reason for saying what I did about the first one and putting this forward is that it is a more equitable outcome. If you look at that net cost after rebate, in the first place, it does not vary with income at all. In the proposed one it does. It is not markedly, but it is more like the income tax—that is, it is progressive. As I said in my submission, if there were no public subsidies to private insurance or if you thought that the public and private sectors of health care were entirely independent and competitive then fairness would not matter. They would do their own things. But they are obviously not that. The whole thrust of the PHI rebates has been that private insurance is an integral and necessary part of the whole health system, and that is the reason that parliament has legislated for the rebate.

It is not always self-evident that everything in that statement is true, but if it was so that it were a necessary and integral part of the Australian healthcare system then fairness would be just as important in the private sector as in the public. You cannot have it both ways. You cannot say that it is an integral part but we will pay for it entirely differently and, basically, I have to say, in a way that favours the rich. For those people who rely on Medicare, who pays what is determined by their tax rate. This does not quite do that, but it gets closer to it, and that is the reason why I have said that I think it will be a more equitable result.

I conclude by emphasising that the \$200 a year that applies in the second tier is actually equivalent to one cup of coffee a week, \$4. Even the maximum one is only equivalent to three cups of coffee a week. Is anybody seriously suggesting that the kinds of catastrophic results that are suggested in, say, the Health Insurance Association's submission could ever result from such a tiny change? The insurance association—and the other ones are much the same—suggest that the dropout numbers will be 10 times the amount that the Treasury has calculated. Apart from the fact that none of them have any information on the income of their members and therefore can make no calculations at all, if they did have it that would be implying a price elasticity of not 0.2 but two, 10 times greater. It would have to be highly income sensitive, very sensitive indeed, to produce that result.

The association suggest that something like 770,000 people would lower their coverage, and they also suggest that some might drop their ancillary coverage. The ancillary, as I said, is not really linked to this at all.

I have no way of knowing how they could possibly come up with the results. Bupa say that a million of their customers will be affected by this. They only cover 2.5 million, so something like 40 per cent of their customers must be above the income level from which these things apply, and much the same applies to the Health Insurance Association's calculations. As I said, I do not know the number of people in the various groups, but I would doubt if the percentage of people with incomes over the new threshold would be more than 20 per cent of taxpayers. It could even be less than 20 per cent, and it is certainly not 40 per cent of their members. I would have thought it would be lucky if it was 20 per cent of their members.

CHAIR—Thank you. We have about 15 minutes for questions.

Dr Deeble—I felt I had to go through the submission, because it was a little bit complicated. The message is: you can reduce it to a very simple thing and you do not need all sorts of science. Those figures that I have calculated can be demonstrated very easily. Would that produce the sorts of results that are being suggested? It could never do so.

CHAIR—There may well be some questions on notice on particular issues that need to be raised with you.

Senator CORMANN—I have listened to your opening statement and read your submission. Would it be fair to say that you are a long-time critic of the private health insurance rebate and the structure of it?

Dr Deeble—I have never said that there should not be a rebate. I think that the way it is structured could be made a lot better. This is a fairly complicated reason—

Senator CORMANN—What do you think should happen to the rebate in an ideal world?

Dr Deeble—In an ideal world I would keep a rebate of some kind but I would make it a lot more conditional. That is, if it was true that a rebate was an essential piece of public policy then I would not just give it away with no conditions and no reason why the private and public sectors should cooperate.

Senator CORMANN—But the rebate is given to individuals, of course, and so—

Dr Deeble—It is structured that way so that no conditions can be put on it. I am speaking from a healthcare point of view. From a healthcare point of view, I think it is very important that the two sectors work together. The government cannot buy out the private sector and the private sector cannot expand to fill all of what the public sector does. So the two of have to work together and they have to work together doing what they do best.

Senator CORMANN—Can I quickly go through my questions because we have had a reasonably lengthy opening statement. Is it fair to say that, when the now Rudd government said before the last election that it would retain the existing rebates, you were somewhat disappointed?

Dr Deeble—I was surprised.

Senator CORMANN—Why do you think they changed their mind?

Dr Deeble—I cannot speculate on what people are thinking at any time.

Senator CORMANN—Fair enough. That was probably an unfair question. I agree with the comment you made that the private and the public systems should not be seen in competition. I think they are complementary. If you take a step back from the public policy challenges in health, would you agree with the proposition that our challenge is to ensure timely and affordable access to quality hospital care for all of the Australian population?

Dr Deeble—Yes. If you do say that, then you are saying that there is a universal need.

Senator CORMANN—I agree totally that there is a universal need. But if we can go through this, because I have got a sort of thought process here.

Dr Deeble—If there is a universal need then I do not think you can have the two systems working in totally different directions.

Senator CORMANN—I totally agree: they have to work in a complementary way. The question then is: if we agree on the premise that our policy challenge is to ensure timely and affordable access to quality hospital care for the population, do you think that an entirely free and publicly funded system would ever be able to achieve the timely aspect? It would be affordable because it is free, but would it be able to achieve the timely aspect at a proper standard?

Dr Deeble—I cannot answer that question, not because I would not try to. It depends on what you think a proper standard is. If a proper standard is anything that a doctor thought it might be a good idea to do, without

any particular hospital policy, without particular peer review—which is certainly true of the big public hospitals—

Senator CORMANN—Do you think that under the current system—

Dr Deeble—In other words, if it is to write a blank cheque for anything that anybody wanted and any doctor would be prepared to do, then I do not think we should be pursuing that.

Senator CORMANN—You are going to the question of what is timely and whether people—

Dr Deeble—Timely. And remember that, even though the two systems should be regarded as one, when a scarce supply like doctors works more in one sector than in the other then, for the sector that loses, its capacity diminishes.

Senator CORMANN—Let us just keep exploring that line of argument: there are limited resources, there is unlimited demand and there is the question: ‘What is timely?’ If there are not sufficient services to meet what could be spontaneous demand then some people will always have to wait in a free public system, won’t they, until they are a high enough priority according to whoever determines that?

Dr Deeble—Under insurance either way—public insurance or private insurance—the cost as such for an individual thing does not matter; your insurer gets it. It has the same effect whether it is public or private sector. If you had said, ‘Which would I prefer?’ I would prefer, if possible, that the capacity to pay had some effect but not too much.

Senator CORMANN—But isn’t that where the private system comes in? There is a group of people who, if they can afford it, should take additional responsibility.

Dr Deeble—Oh, not a problem. I said I did not have an argument with the income levels, because I think the income levels—if I am correct in my interpretation—would push something like the top 20 per cent almost irrevocably into the private sector. But I would still like to see those sectors working together. It is not at all difficult, you know; you can make it happen.

Senator CORMANN—On your comments in relation to membership trends: you mentioned that the drops in membership only happened in the early nineties, not from the changes in 1983. I read quite a lot of commentary by Senator Graham Richardson who was the health minister in 1994 or 1993, and I think he released a discussion paper on private health. Do you remember that?

Dr Deeble—Well, whatever it was, I am sure it could have come from the other side of the House!

Senator CORMANN—Graham Richardson was actually the first federal health minister who proposed the Medicare levy surcharge on people above certain income levels who did not take out private health insurance, and his assessment at the time was that there was a much larger drop in membership following the 1983 changes than the government had anticipated at the time. In fact, there was quite a steep drop in the first two or three years but there was a further drop later on. In the early nineties it was about two per cent down every year, and that was why even the previous Labor government was looking at making some changes in terms of the incentives—isn’t that correct? I mean, you are a historian around health funding.

Dr Deeble—I was around them all that time. I always thought—but I will not say that the government necessarily thought this—that the natural level of private insurance was likely to be closer to where it had been in Queensland for 50 years with, basically, a free public system—

Senator CORMANN—What was that?

Dr Deeble—and that was about 33 per cent. I thought it would reach that and it would probably stabilise about there, because I thought that even with an unsubsidised premium there were sufficient people who would be prepared to pay a bit more to have quicker access. That is really what it is about—quick access. It is the waiting times that upset people. I think it is generally understood that if you are a real emergency, a life-threatening emergency, you will be treated—whatever happens, in whichever system. It is the other, non-life-threatening but discommoding conditions that people worry about.

Senator CORMANN—Access to cancer treatment in the public system is a bit unsatisfactory, I would have thought.

Dr Deeble—I find that quite astonishing and hard to understand. I would have thought that, of all of the conditions that anybody could suffer from, the response of the public system to cancer treatment—the fact that there are a large number of breast operations done in the private sector is irrelevant; it is just that that is the way they have ensured themselves.

Senator CORMANN—No, that was not my question. In the public system I know for a fact that people have to wait for cancer treatment, and it is a terrible thing for the patient. I mean, if you have got to have a hip replacement you have got some discomfort but you can wait. If you have got cancer and you are worried about a ticking time bomb and you cannot have timely access to the treatment your doctor tells you that you need, that is a terrible thing, isn't it?

Dr Deeble—Well, yes. Let me try and get the order of things clear. There are some things which are discommoding and uncomfortable. There are some things that are a bit worse than that. And then there are the other ones which are very complex and difficult to treat. The public hospitals will do those medical cases better—those cases where you have got an unspecified something, not a specific thing like a hip or a knee that does not fit, the medically simple things. They may be technically difficult, and the surgeons have got to be very good in doing them, but they are medically a fairly straightforward proposition. Those are the things that I think the private sector does very well.

Senator CORMANN—Going quickly to the Treasury modelling—I am mindful of time—you said that you accept the Treasury calculations absolutely. There are a couple of flaws that people have brought before this committee and that I have previously identified. One is that Treasury has not assumed that there would be any move towards cheaper policies to circumvent the combined impact of reduced rebates and the increased Medicare levy surcharge. Don't you think that that is a flaw in the Treasury modelling?

Dr Deeble—Would you say that again?

Senator CORMANN—Essentially, Treasury have told us, and I think it is generally acknowledged, that they have not assumed that anybody would downgrade their cover—that there would be no move to cheaper policies. Given that there is a rebate reduction which will increase the cost of health insurance by up to 66.7 per cent, which is a mathematical fact—

Dr Deeble—By the way, the 66.7 per cent is rubbish.

Senator CORMANN—It is not rubbish.

Dr Deeble—It is.

Senator CORMANN—If you have a 40 per cent rebate now and the cost goes from 60 to 100, it is a mathematical fact that that is an immediate increase of 66.7 per cent.

Dr Deeble—Yes, thank you. It is 66.7 per cent of a very small amount. Where the confusion over all of these calculations is—

Senator CORMANN—When you say 'small amount', you mean the \$2,000 or \$3,000 premiums?

Dr Deeble—Yes.

Senator CORMANN—So that is okay?

Dr Deeble—You have to be 70 plus for that to apply to you, and you have to have an income of over \$240,000 a year while being 70 plus. I am 78 and I have nothing like that.

Senator CORMANN—We are distracting from the main argument. Let us just go for the most likely scenario. People losing the 30 per cent rebate will mean an increase of 42 per cent. Let us just say it is at the lower end of the scale, a 14.3 per cent increase. Whatever the increase is, it is rational for somebody who wants to avoid that price impact to look for options. I agree with you that dropping cover is not a likely scenario because they will be hit with an increased Medicare levy surcharge. However, what would be a rational response is to go for a cheaper product in order to avoid the 14.3 per cent up to 66.7 per cent increase. That impact has not been modelled by Treasury at all. Isn't that a deficiency?

Dr Deeble—The percentage increases are irrelevant. The amount is important. How much is it that they are avoiding? As I have shown, it is a matter of several hundred dollars a year. The sorts of people you are talking about, with the very high rates at very high ages, you could, I would have thought, almost count on the fingers of one hand.

Senator CORMANN—Are you suggesting there is not going to be a move to downgrade cover and go to the cheaper products as a result of this change?

Dr Deeble—No, I am not denying it, but I am wanting to know why you consider it a bad thing?

Senator CORMANN—Sorry?

Dr Deeble—I am not denying that some people may do it. The incentive is not as great as it is made out to be—it is, after all, a couple of hundred dollars a year. But, if they did, what is the problem?

Senator CORMANN—That is the question. The problem is this: cheaper products means more exclusions. It means higher front-end deductibles. It means higher out-of-pocket expenses.

Dr Deeble—If the government were concerned about that they could easily legislate to limit the amount of exclusions. If they did, I see that this would bother the health insurers a lot. When I was at Medibank Private I would have understood all about it. Nevertheless—

Senator CORMANN—If they did that, what would be the effect on premiums for everybody else still in the system? It would push them up further.

Dr Deeble—I do not know. You would be saying that the people who drop down would be the low-risk people and so you would not get as much money out of them, and you always make a profit on the low-risk people to subsidise your bad ones. You do not know who they are going to be, but you know that in any one year there will be a few bad ones and a lot of good ones and at any point of time the good ones really do subsidise the bad ones. So, if the low-risk people were the people who went down, you will have got less money out of them but you will not have had to pay out on your insurance either. So I do not think it would have a significant effect. Anyway, I agree with the Treasury—and, by the way, the Treasury were misleading in one thing that they said in their submission. It is not wrong; it just gives the wrong impression. They said the reason nobody would drop out from the two top tiers was that the Medicare levy surcharge rose by the same amount as the other. It did not.

Senator CORMANN—It was raised by more.

Dr Deeble—It was raised by the same percentage but the sums are so much bigger that—

Senator CORMANN—Yes, that is right.

Dr Deeble—it is not a correct statement, and it was not a correct statement for the other one.

Senator CORMANN—So the stick is actually increasing by much more than what they are suggesting to compensate. I agree with all of that, but it reinforces the point I am trying to assess with you. I agree that people in those two income tiers will not leave, but the most rational response is that they will go for a cheaper product. You say that government could legislate to prevent more exclusions and prevent more out-of-pocket expenses at the time of service, but the only effect of that would be to push up the premiums, wouldn't it?

Dr Deeble—Senator, there is inherent in what you are saying—and this is a debate; there is nothing personal about it—

Senator CORMANN—No, it is not personal at all.

Dr Deeble—You are saying that it is desirable for everybody to have 100 per cent cover, but at the same time there is the issue that people are free to choose what cover they have. If they choose which cover they have as a result of a very relatively small change in price, I do not know that you can say that they should not do that and I do not see that you can say—

Senator CORMANN—I am not saying that they should. That is probably the point on which we are misunderstanding each other. I am not saying that they should not do it; I am saying that if we think that it is a plausible scenario, we should assess it so that we can make a public policy response in terms of the likely flow-on consequences. Because it has not been assessed, we cannot make an informed decision. If people are going to have more exclusions and they are going to have to go to public hospitals, what is going to be the impact on public hospitals?

Dr Deeble—There is no way anybody in the world can do that. I am sure the Bupa and others have done it, but I am sure that they are wrong. I know them, because I have been there.

Senator CORMANN—Do you think Treasury is going to be right?

Dr Deeble—I do agree that Treasury has not considered downgrades, and they have not done it because presumably they did not think of it or they did not think it was important. But I cannot see how anybody else could assess what the downgrades might be. They have no data on people's incomes. They have done some surveys, I am sure, but I am quite certain that the question was asked in such a way that the person would have thought that they were going to lose all their rebate and not just a little bit. I think there is an effect that is not calculated, but I do not know how anybody would do it and I would not say that that should be a reason for deferring the whole consideration on the possibility that some people might downgrade their cover.

Senator FURNER—Dr Deeble, I take you to the view that has been expressed today about the possibility of 130,000-odd thousand people who will be affected by the changes to the Medicare levy surcharge and who will move to the PHI as an incentive. What is your view on that occurring? Also, what is your view on the view expressed by earlier witnesses that the incentive must be 1.5 per cent—

Dr Deeble—That is right.

Senator FURNER—which is a bracket of some estimates from DHA, being about 40,000 of the 130,000 in the captured bracket?

Dr Deeble—I cannot say I am familiar with the issue you raise. What was the proposition—that the levy surcharge is not high enough?

Senator FURNER—The view is that there are 130,000-odd people who will be captured by the changes under the surcharge that will be used as an incentive to move them up to private health insurance. Tier 3 was that 40,000 of those 130,000 would be in the bracket of \$120,000 to \$240,000. That is the 1.5 per cent official levy.

Dr Deeble—They pay the surcharge.

Senator FURNER—Yes, they pay the surcharge, so they will be getting an increase on the surcharge, enticing them to move onto private health insurance.

Dr Deeble—Yes. That is why I said: does the government really understand what it is doing? At a surcharge of \$3,600, for anybody who remained in there at that level it is almost a fine. It is a punishment. So of course they will go into private health insurance, apart from a few people on principle—and I have to say I was one of them.

Senator CORMANN—A conscientious objector!

Dr Deeble—I did not pay it because I had to be consistent with my principles and I thought the public system was good, but I would have been in a position to pay for private insurance or the private services that I had. You volunteer to pay the surcharge.

I think the surcharge should be related in some way to the cost. It should not be a surcharge that is way beyond any relevant cost. It should be one that makes it a choice. The present surcharge, at one per cent, effectively gives most people free hospital insurance at that point, because it is approximately equal to what the premium would be. If you wanted to have something that did the same thing, then you would only increase the surcharge in line with the increase in the cost of the insurance; you would not push it way up to where it is. By the way, those figures that I have shown you are for hospital alone. Of course, the surcharge covers the ancillaries, which I do not think should be covered at all, but that is a different question. Ancillaries are one-third of their total revenue, so you would have to add about one-third to those figures to compare them with the surcharge.

Senator FURNER—Okay. What is your view on the assertion that has been made that, as a result of the likelihood of an exiting from private health insurance, there will be an increase in premiums?

Dr Deeble—Since I do not think there will be an exit, since I would be very surprised indeed on the grounds of the information I have provided and my knowledge of the industry, I would find even the 25,000 suggested by the Treasury an upper-limit estimate. When I last appeared before this committee—and I will never appear again; I said that last time but I will not appear again—for the hearing on the original surcharge changes, when there was an enormous outcry from every private insurance interest you could imagine about how the world was going to fall in, I said the maximum effect could be a five per cent rise in premiums and a two per cent loss of membership, but I did not expect that. I suggested something like one per cent, and I think I said that would increase premiums by something in the order of \$2 a week.

Senator CORMANN—Treasury still assumes that half a million people will leave.

Dr Deeble—In fact, I was right. There was no change.

Senator CORMANN—It is a bit early to assess, don't you think?

Dr Deeble—I think you have to wait for a tax year to go by, because it is when people see that they have to pay the surcharge that they will make decisions. But the question was: what will the effect be? I thought it would be almost nothing. I was right, and I do not think I will be wrong on this one either.

Senator FURNER—I think the fundamental point you made today and all through your submission is that people insure their health because of their wellbeing. It is quite different to other types of insurance, whether it

be your home or your car. You do not take a gamble: you decide to insure your health because of the possibility of being affected somewhere throughout your life by whatever the case might be.

Dr Deeble—People have the impression, and it is theoretically a wrong impression, that you have to have insurance in order to get health services. That is in people's minds, that you have got to be insured or you cannot get services. That is not right. You can get any service you want if you pay for it. What you are insuring against is not having the money to pay for it or not wanting to pay for it when the time comes. But underlying it is that difference from anything else; I know of nothing else like that. You insure cars, you insure houses, you insure anything. This is trying to guarantee access to services that could save your life. Ultimately, there is no comparison.

CHAIR—Dr Deeble, we will have to end there. There may well be some questions to you on notice, and if you think of something you want to add, please be in contact with the committee because we will continue to work on this over the next week or so.

Dr Deeble—I think the numbers are all I want you to look at.

CHAIR—Thank you, Dr Deeble.

Committee adjourned at 12.35 pm