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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

FRIDAY, 10 JULY 2009

PERTH

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Friday, 10 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 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

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Committee met at 8.52 am**BRANSBY, Mr Rob, Managing Director, HBF****WALTON, Mr Andrew Robert, Manager, Public Affairs, HBF**

CHAIR (Senator Moore)—Good morning, everyone. Our committee is continuing our inquiry into the provisions of the Fairer Private Health Insurance Incentives Bill 2009 and related bills. Senator Judith Adams cannot be with us today, but she was particularly keen for me to put on record that she would like to have been here but was not able. She is checking out the hospital system in Perth at the moment. I reinforce to the witnesses that all your evidence is on *Hansard*, so it will be available to other senators. It is just because of other commitments that we have not got the full committee. It is always a bit worrying when you think there are only a couple of people who have turned up.

Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. Either of you may make an opening statement; we will then go to questions.

Mr Bransby—Firstly, I would like to thank the committee for the opportunity to be here today. HBF is a leading health fund in Western Australia, and I am speaking today on behalf of over 800,000 Western Australians who are HBF members. HBF is a not-for-profit fund which has provided health cover for Western Australians for well over 60 years. HBF is by far the largest health fund in Western Australia. Fifty per cent of all Western Australians with private health cover are our members. Partly because of the position we have long held in Western Australian communities, we are rather different from other health funds: our concerns extend beyond those who choose to insure their health through us. If you look at our annual report you will see that HBF's stated mission is to 'lead the way in improving the health and wellbeing of everyone in the Western Australian community', so we invest a good deal of our energy in initiatives that address major chronic issues affecting the Western Australian community as a whole—issues such as obesity, smoking, alcohol abuse, poor diet and lack of exercise. We partner with organisations such as the Cancer Council, the Heart Foundation and the Red Cross to encourage changes in behaviour that will help people live healthier lives.

We have campaigned for changes in WA's smoking legislation, we have spoken out to encourage Western Australians to drink responsibly and we have helped run events that encouraged tens of thousands of Western Australians to exercise. These are activities that we have initiated on behalf of all Western Australians, not just HBF members, and the single motive behind all of them is to improve the health and wellbeing of our community. I mention this simply to illustrate that we have a track record of speaking and acting in what we believe are the best interests of the Western Australian community as a whole, not only those of our members. So, while as a not for profit fund we feel compelled to speak out in the best interests of members—interests which we believe are clearly under threat with the proposed changes in the private health insurance rebate—we also believe we are representing a wider constituency.

Western Australia has the highest take-up of private health insurance of any state. In fact, last year Western Australia became the only state where over half the population holds private health cover. In Australia as a whole, the figure is around 45 per cent. So it is fair to say this state has more to lose than any other with these proposed changes. Let me make it very clear: HBF has no political alignment. The position we have taken on the proposed changes to the rebate is based on our assessment of the impact in terms of the health outcomes for all Western Australians, and we believe these will be detrimental.

I recognise that in the current economic climate governments must make tough decisions in order to find savings, but I believe that penalising those who have done the most to relieve pressure on the public health system is seriously misguided. We know that many of our members already make significant personal sacrifices to hold private health cover. Many do it because they believe that taking personal responsibility for their health care is the right thing to do, not only for themselves but for those who depend on the public health system. The financial impact of this measure on thousands of our members who will be directly affected is relatively easy to gauge, although of course we are not privy to their incomes. If the measures were to go through in their current form, we estimate that around 32,000 single members and 139,000 Western Australian families will experience either a reduction in their rebate or the loss of the rebate altogether. In all, we believe that over 170,000 of our policies will be directly affected. These are people who overnight could find that their premiums had risen by up to 43 per cent.

I have no doubt that many of our members who are affected by these changes will look for ways to minimise the impact of this shock. Some will exit private health. Others will downgrade their cover. Either way, the effect will have a reduction in their access to quality health care. The key to keeping down the cost of

private health insurance is ensuring that as many people as possible contribute to the pool of funds available to pay claims. Any change to the rebate which encourages members to leave would be certain to lead to higher premiums for all those who stay.

The committee will already know that the Australian Health Insurance Association estimates that 241,000 Australians are likely to drop their private health cover and another 728,000 will downgrade their private hospital cover if the measure passes. What is more, the association's research suggests that an additional 774,000 Australians will decide to drop their health cover for ancillary services such as dental and optical services. I have no reason to question that the impact in Western Australia will be any less dramatic than in the rest of the country. If the association's modelling is correct then thousands of our members will choose to depend solely on WA's public hospitals. As for those who would drop their ancillary cover, many of these will subsequently forgo dental, optical and other care that they otherwise would have had and also need.

HBF has been very successful in attracting younger members to private health insurance through our ancillary products. Ancillary cover is an entry point to private health insurance for the young and healthy, but these products will be the first to be dropped if this measure is introduced, and our ability to attract younger members will be badly harmed as a consequence. It is well understood that health inflation is outstripping CPI. In 2008-09, the benefits we paid to our members increased by 11.9 per cent over the previous year. This year, we expect them to increase by a further 6.4 per cent. For health funds to continue to pay these levels of benefits it is essential that the burden be carried by as many members as possible. A reduction in the rebate will lead to an exodus of those members who judge that they are least likely to need to use their cover. The younger and fitter members are the very members which funds like mine need to retain if we are to see even greater pressure on premiums.

Anyone who drops their private health cover will of course be an additional person who is dependent on an already stretched public system. What is more, for anyone who chooses to drop their private health cover the government will save the 30c in the dollar that was their rebate but will also lose the 70c that the individual had previously contributed to this country's healthcare. The ultimate impact on the public health system is very difficult to gauge. But it seems very possible that the balance between Australia's private and public health systems will be profoundly and adversely affected. This is a balance which has delivered health outcomes that are the envy of much of the world.

When it was introduced in 1999, the 30 per cent rebate made private health insurance cover affordable for millions of Australians. At that time, the private health sector was in what looked like a death spiral. The proportion of the Australian population with private health cover had dropped from around 70 per cent in the 1970s to around 30 per cent and was still falling. The rebate, together with lifetime health cover and the Medicare levy surcharge, arrested that decline, restored the balance between the private and public system and relieved the pressure on public hospitals. I wonder why any government would risk these tremendous gains for the sake of raising revenue in the short term, particularly at a time when Australia's ageing population is certain to place increasing strain on the country's health services.

In summary, I believe that the changes which are being discussed would not only cause considerable hardship for all of our members but threaten the balance between Australia's private and public health care which has served this country so well. I thank you for that opportunity.

CHAIR—Thank you, Mr Bransby. Mr Walton, do you wish to add anything at this stage?

Mr Walton—No, thank you.

Senator CORMANN—Just before I get onto questions, I thought I would place something on record again. I have previously worked for HBF and I am also a member of HBF.

CHAIR—Thank you, Senator Cormann. You have put that on record before, but it is good of you to do it again.

Senator CORMANN—Mr Bransby, did you see this measure coming?

Mr Bransby—Not at all. When we sat back and did our planning last year we never considered that this measure would be coming in and did not factor it in when we set our premiums for this particular year.

Senator CORMANN—And why is that? Is it because you had an understanding that there were some firm commitments in place?

Mr Bransby—We certainly had had some commitments from the government the previous year that we would be retaining our rebates and so forth, so we planned accordingly. We rely very heavily on consistency in public policy when making planning decisions for our organisation.

Senator CORMANN—You have talked us through some of the high-level numbers in terms of who it would affect your members. Have you done any internal modelling to assess how it will work its way through your forecasting?

Mr Bransby—We have used the numbers produced by the association. Given that we are seven per cent of the Australian market, we have just used that modelling across our fund and come up with the same outcome. We do not see that it will be any different in Western Australia.

Senator CORMANN—But moving forward as you put together your next rate change application, presumably you will have to come up with some firm assumptions as to how it will impact on things like membership trends overall, in terms of the number of people downgrading cover, in terms of—

Mr Bransby—We are working on that round now. We will be using the same assumptions that come out of the association in terms of the impact on our fund. That will be significant losses in ancillary cover and significant downgrading of product. But we cannot give you the accurate numbers because we have not done that work yet. But we are looking for significant reductions in those areas.

Senator CORMANN—You mentioned earlier that this time last year you appeared before another Senate committee to discuss the changes to the Medicare levy surcharge. Those changes ultimately passed were somewhat watered down compared to the original measure. However, since that measure was implemented in October last year, what have been your early observations of what the changes to the Medicare levy charge thresholds have been?

Mr Bransby—There is no doubt that the market is smaller. It has been widely reported that 200,000 fewer Australians joined the sector as a result. We also believe that the full impact of the changes in the surcharge have not come through yet. The trigger point will be tax time, which is about now. So we are forecasting an exodus from private health insurance in the second half of this year as a result of that. At this stage, the early impacts are fewer people joining the sector.

Senator CORMANN—You had the changes last year. You have the changes to the rebate this year. You have the general economic conditions. How would you describe your operating environment now compared to two years ago?

Mr Bransby—It is extremely challenging. There is no doubt that with the current economic conditions people are looking at every cent they spend these days. Unemployment is rising. That was reported widely yesterday. Any disincentive to be in this particular sector right now is discouraging people from joining the sector. Our product and our proposition are under threat. It is a very challenging time.

Senator CORMANN—You mentioned in your opening statement how people are facing increases if they lose the rebate of about 43 per cent. But there is a proportion of your membership that potentially will face increases of up to 66.7 per cent, isn't there? Treasury has quantified the number losing the 40 per cent rebate as small—two per cent. Nevertheless, the highest increase that somebody will face as an immediate result of this is 66.7 per cent is it not? The 43 per cent figure is based on losing the 30 per cent rebate. But there are the 35 per cent and 40 per cent rebates.

Mr Bransby—Oh, yes. Absolutely. There is a percentage of members—probably the pensioner groups and so forth—who will be impacted even more adversely than 43 per cent.

Senator CORMANN—To be fair, pensioners will not face the 66.7 per cent increase because they would not be in the income bracket. As members leave and members downgrade their cover, how will those below the income thresholds be impacted? Do you foresee that there will be an impact on premiums for them?

Mr Bransby—Over 80 per cent of our policy holders are probably below the \$75,000 threshold. However, when those above the threshold downgrade revenue will come off. That will cause premiums to increase. The payment pool stays the same size. Anyone who leaves the sector or downgrades because of rebates no longer being there will cause the revenue falls. Therefore, that can only push costs back onto premium levels for the whole pool. I would see bigger increases for that larger pool of people in the future as a result of that.

Senator CORMANN—Even though you might lose members or have members downgrade their level of cover, do you expect that your expenses will go down?

Mr Bransby—Not at all. Our claiming pool will be the same size. To minimise premiums and to support the claiming pool—our expenses; our benefit payments—you need as much participation as possible to hold premiums at a realistic level. I would expect that the lower end will be impacted significantly. Remember also that there is probably a million Australians with household income of less than \$26,000 who have private health insurance. I feel for those individuals.

Senator CORMANN—They are presumably most likely to try and hang on no matter what. If wealthier people downgrade because of this measure, then they will be the ones who will have to cover an increased burden. Is that correct?

Mr Bransby—Absolutely. As the managing director of a health fund, I see lots of complaints and lots of complimentary letters that come through from our fixed income pensioners and low-income families. They clearly say that they would rather not eat than get rid of their private health insurance cover. Those people will stay, there is no doubt about it, because they see the value in it. And they are the ones who will be penalised.

Senator CORMANN—You very quickly went through those figures in terms of the number of members who you expect to downgrade. Can you quickly tell me that again? How many people do you expect will downgrade?

Mr Bransby—Those numbers are Australian Health Insurance Association numbers. Do you want me to repeat those?

Senator CORMANN—Just as far as they relate to HBF.

Mr Bransby—We do not have those. All we have done is used the same analysis. But I can take that question on notice and send that through.

Senator CORMANN—What I am interested in is if you have done any internal modelling in terms of this. Clearly, if you make an assumption about how many people will leave that will flow through in terms of how much revenue you will lose. How much revenue you will lose will give you some indication as to what the premium change impact would be moving forward. If you can take on notice a question as to what your expectations are, that would be good. I am not looking for your rate change moving forward. I am just looking for that part of your rate change that you think will flow from this measure.

Mr Bransby—We are doing that piece of work as we speak, because we are coming into a rate presentation.

Senator CORMANN—This measure will come before the Senate some time in August.

Mr Bransby—We can do it by then.

Senator CORMANN—Can you talk us through what a member downgrading means for that particular member at the time that they access services? What down downgrading mean?

Mr Bransby—There are two things. Firstly, there is no surcharge applicable to ancillary products. The first thing that you would probably do is drop ancillary products, because there is no penalty to dropping them. So if you do not need any of that, you can give it up. There is a revenue pool there that produces surplus results. Given that 80 per cent of our members have both products, they supplement each other. But I would suggest that if you did not see the value in an ancillary product there is no stick, if you like, to make you continue on with that product. I expect there to be a significant drop off. That may be whole hospital cover.

If you felt that the price was excessive and you were young and healthy and never saw a need for it you might take on a bigger excess. So you would reduce your premium and pick up some of the front-end risk on any hospital statements. You would look for every opportunity to take the premium down as low as you possibly could and probably pick up some of the risk through excess in certain products we have. You may drop your ancillary cover to reduce your total premium and then you may take a high-risk product to take more cost out of that brand.

Senator CORMANN—Or you might increase the number of exclusions on hospital products.

Mr Bransby—That is right.

Senator CORMANN—What are the proportions of the benefits you pay in ancillary? It is mostly dental; is that right?

Mr Bransby—Fifty per cent of ancillary benefits are in the dental space.

Senator CORMANN—And what is the other 50 per cent made up of?

Mr Bransby—Optical and other ancillary services.

Senator CORMANN—So people who drop their ancillary cover would have to either access dental services in the public system—

Mr Bransby—Absolutely.

Senator CORMANN—or fund it themselves?

Mr Bransby—Or maybe just not do it at all. If they did, they could fund it themselves or access the public system, if it is available—as with dental, for example.

Senator CORMANN—What are the most typical exclusions of your hospital products? What do people exclude to reduce the cost of their health insurance premiums?

Mr Bransby—There are 50 to 60 different iterations of a health insurance—

Senator CORMANN—If you give me the names—

Mr Bransby—For example, if you felt that you were pretty healthy you might drop heart cover. You can drop knee cover and all those sorts of things. You can do all sorts of iterations for stuff that you would not expect to happen. For example, you can have a policy without any heart cover.

Senator CORMANN—So if one of your members who is otherwise privately insured but has excluded heart cover has a heart attack, do they have to go into the public system?

Mr Bransby—Straight into the public system, yes. For any exclusion you do take, if you do suffer from that illness in the future then you are going to place additional burden back onto the public system.

Senator CORMANN—In your experience, is there sometimes confusion in these sorts of circumstances where members actually arrive at a private hospital thinking that they are covered for something that they are not?

Mr Bransby—Absolutely. There is no doubt. This will force people to have a look at their policies and look for alternatives to make it cheaper.

Senator CORMANN—How much do you usually pay, on average, for heart surgery—a bypass or one of those little machines? What costs are we talking about?

Mr Bransby—In total or—

Senator CORMANN—Yes—in total. What sort of benefits do you pay out for heart surgery?

Mr Bransby—About \$167 million.

Senator CORMANN—Sorry. I meant on a procedure-by-procedure basis.

Mr Bransby—I would have to take that on notice. I cannot tell you, but it is quite significant.

Senator CORMANN—Just the prostheses for some of these procedures is about \$50,000 or \$60,000; is that right?

Mr Bransby—Yes.

Senator CORMANN—If someone has that particular procedure excluded—

Mr Bransby—It is a big cost back on the public system, yes. Anything to do with the heart, for example, is very expensive. We can take on notice what the specific costs are for specific items. But you are right—a stent is probably \$10,000 to \$15,000. We can get you some more details, if you would like. It is very expensive, yes.

Senator CORMANN—Treasury has actually made an assumption that people will not be downgrading their cover. Are you surprised by that assumption?

Mr Bransby—Yes, I am, actually. Anecdotally, the talk I hear coming through the system is that people will be looking at the whole proposition and will be looking at every opportunity to downgrade. If you do not see value in ancillary, for example, and you are in that middle-income bracket, you would probably struggle to find value and maybe you would self-insure. I would also suggest that if you did get a substantive increase on an already relatively expensive product you would look at the proposition again to see whether you could take some cost out of it. So I am surprised at the numbers that have come out of Treasury on downgrading.

Senator CORMANN—Is it fair to say that, given the way the policy structure is reducing the rebate, increasing the Medicare levy surcharge in certain income tax brackets, the most rational response would be to

downgrade your cover? Isn't that the most rational thing about someone could do if they wanted to minimise the impact of the cost increase?

Mr Bransby—It does sound like a rational response.

Senator CORMANN—Just looking at the proportion of private hospital admissions versus public hospital admissions, obviously one of the key arguments in favour of policy supporting the private health framework is that it helps relieve pressure on the public system. Some people have suggested before this inquiry that increasing private health insurance membership has not contributed to taking pressure off public hospitals. Can you comment on that?

Mr Bransby—Naturally if you have participation rates in excess of 50 per cent, which we have in Western Australia—and our private hospital system in Western Australia is fully utilised—then if there is any reduction in that and you put that burden back into the public system then it would sort of get the balance askew. So my personal view would be that the balance is probably right.

Senator CORMANN—It would have been before your time, but do you have any historical information in terms of what private hospital utilisation rates were in the late eighties and early nineties compared to now?

Mr Bransby—We can access that. We can actually provide that data to you but I do not have it with me.

Senator CORMANN—I think you will find that a lot of the growth in demand has been absorbed by private hospitals. I note your comments in your opening remarks in relation to the work that HBF does trying to reduce tobacco smoking. Does HBF have a view about the opposition's proposal to increase the excise on tobacco as an alternative to means testing the private health insurance rebate? What are your views on that?

Mr Bransby—We have actually publicly stated that we support the increase. We think the greatest deterrent to people smoking—and we do try to encourage Western Australians, particularly, not to smoke—is to increase prices. We publicly support any deterrent to people smoking and the impact that may have on the health system in general.

Senator CORMANN—So if the parliament went ahead with the alternative of increasing the excise on tobacco rather than means testing the private health insurance then you would support that?

Mr Bransby—Yes, we have publicly supported that.

Senator CORMANN—What sort of impact do you envisage this broken promise on private health insurance rebates having on community rating? What do you think the impact will be on community rating? Will it put pressure on community rating?

Mr Walton—What aspect of community rating are you referring to?

Senator CORMANN—Obviously the healthier and the better risks are leaving and the claimant pool of worse risks stays the same. Aren't you going to be under more pressure to find products to keep the young and healthy in and make it cheaper for them and essentially increase the burden on those who I guess are worse risks? Won't there be a temptation for the industry to try and capture the costs that are faced by the more expensive risks somewhere? You will not be able to do it with the younger and the healthier because they will just leave or downgrade their cover.

Mr Bransby—We certainly are very strong supporters of the community rating. We think it is the only way that our system works. So any means testing outcome that would encourage a change in behaviour would be adverse, I would have thought, in terms of how you mix your product up. So, yes, you are probably right; we would be looking for ways to encourage people to join the sector and obviously the young and the healthy would be the group we try to attract. So it could have some impact.

Senator CORMANN—You mentioned before that when people downgrade their cover one of their options is to increase front-end deductibles. That means there will be increased out-of-pocket expenses at the time of accessing the service. How do you think that will impact on people's perception of value?

Mr Bransby—I think it puts it under threat. There is no doubt that the biggest concern and the biggest threat to our value proposition is out-of-pocket costs. You only experience those when you utilise your cover so I think it will have a detrimental effect on the value proposition of the product. There is no doubt about that.

Senator CORMANN—Do you think it will just be a first-round effect in terms of membership and premiums or do you think there will be a series of effects—perhaps second, third and fourth? Do you think there is the potential for an accelerating downward spiral similar to what was experienced in the eighties and early nineties?

Mr Bransby—I absolutely do because if you are a non-claimant, the excess products and the upfront deductibles would not have an impact until you became a claimant. So it is overtime when you use it that you would really start to question the value of it. We have had a strategy at HBF of trying to minimise out-of-pocket expenses to clearly preserve the value proposition. This does not encourage that.

Senator CORMANN—Are you aware that Treasury have said during Senate estimates that they excluded 1.4 million Australians with private health insurance—those with ancillary cover—from their modelling because they did not have income data associated with them?

Mr Bransby—Yes, we heard that.

Senator CORMANN—Treasury have concluded that only 5,000 of those 1.4 million people will drop their cover.

Mr Bransby—I find that really surprising. We have 20 per cent of our fund members who have ancillary cover only. If there is no universal impact on ancillary then I have no doubt that that particular product will come under threat for that group of people.

Senator CORMANN—Is it fair to say that, given that Treasury did not assume a downgrading in cover and that they did not include 1.4 million people who have ancillary cover only, the modelling results underestimate the impact this will have on private health?

Mr Bransby—Absolutely. There is no doubt.

Senator CORMANN—Statements have been made by the industry that this will put additional pressure on public hospitals. Have you done any work to assess how much additional pressure it will put on public hospitals?

Mr Bransby—It is very hard to gauge. Without knowing people's incomes we can only use relatively old data on what income levels are. But we have absolutely no doubt that any downgrading and any exodus from the sector will put increased pressure back on the public system. There is no doubt about that.

Senator CORMANN—I have a final question. Last year we had the changes to the Medicare levy surcharge thresholds and this year we have Labor's broken promise on private health insurance rebates. Are you concerned about next year's budget?

Mr Bransby—We just need consistency from governments when setting budgets, yes. We have two changes in two budgets that have come as a surprise to us, on both fronts, and it does make it extremely challenging for us to plan ahead, particularly given that we have to lock in our revenues and premiums very early—probably well before the next budget. We do need consistency around policy when forecasting. So, do I remain concerned? Yes, I do.

Senator CORMANN—If the government were to tell you that this is it, would you trust that sort of assurance?

Mr Bransby—We look for consistency in policy.

Senator SIEWERT—I would like to go to this issue around ancillary cover. As I understand what you have just said, five per cent of your members only have ancillary cover.

Mr Bransby—No, I think it is about 20 per cent of our members who only have ancillary cover. Some 80 per cent have both and the remaining 20 per cent have ancillary cover only.

Senator SIEWERT—So what is the five per cent?

Mr Bransby—I am not sure that I mentioned five per cent.

Senator SIEWERT—Okay, I must have misheard. So 20 per cent have only ancillary cover. You do not have an understanding of the incomes of your particular policyholders, do you?

Mr Bransby—No, we just use access data so we just look at general population norms.

Senator SIEWERT—In your opinion is it more likely that those only holding ancillary cover will be people on lower incomes or people on higher incomes?

Mr Bransby—We actually find, and this is in my opinion, that ancillary cover is an entry point for the young into the private health system. We tend to find that they start there and then they move into full-blown hospital cover. Our job is to get people into the sector—to espouse a proposition. We have had a lot of growth in that space in the last couple of years. It is our entry point; it is what we specifically target to get people into the system. So I would suspect that a lot of those would be the young.

Senator SIEWERT—So there is a potential that they are on a lower income rather than a higher income and potentially are not going to be affected by the change in the rebates.

Mr Bransby—You are probably right; they would probably be at the lower end, I would suspect—but I am only suspecting.

Senator SIEWERT—We had a bit of a discussion in Melbourne yesterday around what is classed as younger. I was delighted to know that I was counted as young.

CHAIR—You were overjoyed by that!

Senator SIEWERT—Yes, I was overjoyed—my son does not believe it, mind you. It seems to vary between the different funds. What do you count as young? I will not be offended.

Mr Bransby—We actually push people through life stages as distinct from age. So there are young singles, there are middle families and then there is the retiree bracket. You can be a retiree at a relatively young age, I assume. But I would say that up to the age of 30 would probably be what we consider to be young.

CHAIR—The answer we heard yesterday was 40 something.

Senator SIEWERT—It was 48. I know because I just fit in there.

Mr Bransby—We would call those the young singles, and perhaps the middle phase would be the young family. So we use life stages as distinct from discriminating age wise. So we have young singles, young families et cetera.

Senator SIEWERT—Your growing family, your older family.

Mr Bransby—So you could still be a young family, but—

Senator SIEWERT—That, to me, makes much more sense. In terms of the million that are under 26,000, this is all based on the ABS data, isn't it?

Mr Bransby—Yes.

Senator SIEWERT—You will not have an idea of what type of policies those million people have.

Mr Bransby—No, not at all. I can only assume that it would be hospital cover, but I do not know. We have not got access to that data.

Senator SIEWERT—That is the assumption that I thought it would have been—basic hospital cover. Thank you.

Senator FURNER—You mention—I think it is correct—you have had 800,000 members over the last 60-odd years.

Mr Bransby—Yes.

Senator FURNER—What has been the growth in that over the 60 years? Can you give me some data with respect to what the inception was and how it has grown over those 60 years?

Mr Bransby—Can I take that on notice and provide that to you?

Senator FURNER—Yes, sure. Would it be fair to suggest that there certainly has been an increase in membership as a result of the booms in Western Australia?

Mr Bransby—There has certainly been an increase, there is no doubt.

Senator FURNER—None of the witnesses, unfortunately, have been able to ascertain or provide us with data on the income of their membership, but certainly out of that 800,000, there would no doubt be quite a few covered by the higher spectrum of income as a result of the mining sector and energy and resource industries?

Mr Bransby—Yes. A lot of them may have come via the corporate groups. There was a major push—particularly in Western Australia if you are talking about the mining sector as an employment differentiator as the market got so competitive—to offer private health insurance to that group of people. We actually see that as being a significant threat now with the reduction in rebate, because the costs to the business would increase and therefore we may see some decline in that part of the sector as well.

Senator FURNER—Are those contracts generally made by organisations of the mining sector or are they made up by individual arrangements between—

Mr Bransby—It is normally specific to the corporate, the employer, and it is quite a big industry in Western Australia.

Senator FURNER—What does the employer get out of those arrangements?

Mr Bransby—It is more an employment differentiation for them. As the market got competitive, it is just part of the proposition to attract people to their particular sector.

Senator FURNER—So a particular employer does not have any contractual arrangement with you to get some sort of percentage gain by putting their employees into a particular cover or—

Mr Bransby—Certainly the corporate gains are dissipating. A marginal discounted price for an employer group would come under threat—or the price would.

Senator FURNER—That is not what I am asking. I am asking whether particular employers get some sort of gain,—to use a raw term, a ‘kickback’—from your organisation as a result of putting their employees into a particular—

Mr Bransby—Not at all; not through HBF, no.

Senator FURNER—You indicated that around 302,000 would be affected by a reduction or a loss of the rebate. Where did you get that sort of data from? Was that using the industry modelling that you have been using?

Mr Bransby—We said 170,000 policies were directly affected.

Senator CORMANN—Is there any chance you might be able to table your opening statement, just so we can have a look through it?

Mr Bransby—Yes, sure. So 32,000 singles, 139,000 families, totalling 172,000 people affected.

Senator FURNER—How did you reach that conclusion? Was it once again using the industry modelling?

Mr Bransby—Absolutely. We do not have individual people’s incomes. We just use the normal access data modelling for Western Australia.

Senator FURNER—Given that Treasury has indicated that there will be an estimate of 25,000 dropping out, did you consider at any stage using that as opposed to the industry modelling?

Mr Bransby—We have done all sorts of modelling. We have used both lots of modelling, but when you actually slow the plan you start to think of what the worst-case scenario may be. You just do not know.

Senator FURNER—So you would rather use worst-case scenario as opposed to somewhere medium or in between?

Mr Bransby—I personally think we have to. We get one chance a year to have a look at our premium prices for the issuing year, so you have to go to the top end of it. There is no doubt about that.

Senator FURNER—Have you been making predictions already about what the premium increase will be based on your concerns of this particular effect?

Mr Bransby—It is far too early for that. We are starting to do that modelling now.

Senator FURNER—In response to Senator Cormann’s questioning on ancillary products you spoke about there being no penalty. Would you like to see a penalty on the arrangements for the reduction of ancillary matters?

Mr Bransby—Not particularly. We really want to see the preservation of both. We actually treat health cover as both areas, not just hospital but also allied services and so forth. Our job is to encourage people to take out both. I do not want to see any more change to the private health insurance system essentially that is going to create any disincentive for people to leave at all. Do we need encouragement? I think it is up to us as health funds to be sure we have got a proposition that works and that makes it reliable and ongoing as we go forward.

Senator FURNER—You have painted this picture—I would not say of doom and gloom, but certainly of a significant impact on your organisation. Have you done any forward estimates of what the impact will be on your staff at all?

Mr Bransby—Once again, we try to run our health fund on a very modest expense ratio. We are a not-for-profit organisation. Our job in life is to provide benefits to members in the health services area. Obviously, like any other business, if the business contracts in revenue our claims pool will stay the same. The only other place we can go to take cost out of our organisation would be through people. So as revenue comes off we do not see any reduction in our claims costs; there is an ageing population out there and so forth. The only other

area you have to drive efficiencies would be through the people. So I would suggest that if revenue came off our employment numbers would reduce.

Senator FURNER—And once again that is subject to if that happens.

Mr Bransby—Absolutely true.

Senator FURNER—Have you had an opportunity to have a look at other submissions that have been put into this inquiry at all?

Mr Bransby—Not at all, no. Sorry, I have read the industry association's submission.

Senator FURNER—That is the only one you have read?

Mr Bransby—Yes.

Senator FURNER—I would certainly encourage you to read a number of the others to get a balance on what has been suggested, particularly from Mr Wells, Dr McAuley and Dr Deeble, who has had, I would suggest, expert experience in this particular area. Certainly Dr McAuley indicates that the likelihood of people dropping out is very remote based on what he defines as the endowment factor. People tend to hang on to their health insurance because, unlike other insurance, once people have it, they wish to retain it for particular reasons: you do not want to put a price on or gamble with your health. What would your view be on that type of definition?

Mr Bransby—If you think about it, we needed a lot of incentives for people to join the sector, because it is in decline. So people were encouraged to join through the introduction of all these incentives—rebates and lifetime health cover and the Medicare levy surcharge. That is when the sector started to flourish. If you look at history, it has not been treated that way. So maybe the sentiment has changed. But my view would be, clearly, the sector was in decline pre all these incentives to join. And I accept that, as we take them away, people will leave. That is my view.

Senator FURNER—With respect to the notion of having an impost on the public sector, with a dramatic influx of additional people into the public hospital system, the department indicates that that will roughly be around 8,000, wherever that might be the case. However, people like you and other funds have indicated that that will certainly be greater. In the minister's second reading speech he indicated that, under the new arrangements of \$64 billion of COAG—which has been a negotiated agreement with the states and territories—hospitals will receive 50 per cent over and above the old Australian healthcare arrangements. That certainly puts a different picture to that painted by fund industries about what the impact will be on the public sector.

Mr Bransby—And what was their source of data?

Senator FURNER—Theirs is based on a calculated change in funding of \$64 billion over the next five years. So, naturally, that type of funding will certainly increase the benefits for the public sector and hospital admissions and no doubt have a bearing on the figure that they have proposed of 8,000 additional hospital admissions. I am not privy to how they came to that conclusion but it no doubt has a bearing on the 25,000 people they believe will drop out of private health insurance. So you do not dispute or refute that?

Mr Bransby—I really would not like to make a comment. I would have to do a bit more analysis on it.

Senator CORMANN—I just want to follow up on a few of the questions asked by Senator Furner, particularly in relation to the Treasury modelling and the sort of modelling you used to do your forecasting. Do you think it would be prudent if HBF based its forecasting on modelling that excluded 1.4 million Australians with private health insurance from their assessments and assumed that nobody would downgrade their cover as a result of the changes to the private health insurance rebate?

Mr Bransby—Absolutely not. I could not run the business that way.

Senator CORMANN—In relation to the changes last year, are you aware that Treasury and the health department both confirmed during Senate estimates that they still expect about half a million fewer Australians to be in private health as a result of the changes to the Medicare levy surcharge—that is, that last year's changes still are working their way through the system?

Mr Bransby—That is the assumption we have used there. So hopefully they have—

Senator CORMANN—You would report regularly to PHIAC on a range of statistics, including your health fund margins?

Mr Bransby—We do.

Senator CORMANN—You may not have the specifics at your fingertips but, by way of general trends, how has your health fund margin been tracking year on year over the last two years?

Mr Bransby—For the last couple of years the margin has been declining because we are paying more and more out in benefits.

Senator CORMANN—So you are paying more and more out and fewer people are coming on board compared to what you previously forecast, so your rate change will have to go up some time down the track, as it will have to for the rest of the industry, will it not?

Mr Bransby—As fewer and fewer people join it impacts on the premiums and the premium has to of course go up. Over the last couple of quarters, fewer people have been joining. Therefore, with fewer people in the revenue pool and claims costs continuing to rise, the only place you can source that back to hold a margin is through increased premiums.

Senator CORMANN—I am just asking—

CHAIR—Senator Cormann, I am letting you go ahead, but it has been our natural process here that a follow-up question comes through.

Senator CORMANN—I was in the line of questioning. As premiums increase by more, that in turn will have an effect on the members who remain—all of them, including those below the threshold?

Mr Bransby—Absolutely correct.

Senator CORMANN—So more will decide that it is getting too expensive and it is no longer good value and that will turn on itself, will it not?

Mr Bransby—It will just continue to slide. That is exactly correct.

Senator CORMANN—And those people will then turn to the public system and displace people who otherwise would have had access to a public hospital bed?

Mr Bransby—Exactly true. That is the only place they have got to go—to the public system.

Senator CORMANN—So, if I were to say that all Australians will be hurt by these sorts of policy changes—not only those in those income brackets, I would be right, would I not?

Mr Bransby—I would agree with you, yes.

Senator FURNER—When was your last premium increase?

Mr Bransby—It was implemented on 1 April this year.

Senator FURNER—What amount was that?

Mr Bransby—The average increase was 7.95 per cent.

Senator FURNER—And when was the last premium increase prior to that?

Mr Bransby—It was 1 April last year.

CHAIR—When was the last year that there was not an increase?

Mr Bransby—It was not in my time.

Senator CORMANN—How much were the previous two increases? You said 7.95 per cent this year. What was the one the year before and the year before that?

Mr Bransby—Much less. You are testing my memory. It was 3.95 per cent the year before and the year before that it was probably around four per cent.

Senator CORMANN—So it has already been trending up?

Mr Bransby—Absolutely. When you have got claims costs increasing and benefit payments going up, you have got to claw that back somewhere, and the only place you can get it is through increased premiums.

Senator SIEWERT—I want to go back to the percentage of your members who have ancillary cover, basics cover and combination cover. Eighty per cent had a combination of both.

Mr Bransby—Yes, or thereabouts.

Senator SIEWERT—What percentage has just hospitals cover?

Mr Bransby—I would have to take that on notice.

Senator SIEWERT—At the moment, I have got 100 per cent—

CHAIR—That is right; without hospitals cover.

Senator SIEWERT—I would have thought that more people would have just basic hospital cover than would have ancillary cover.

Mr Bransby—I would have to come back to you on that.

Senator SIEWERT—We have already discussed that we would expect those on a low income would just have hospital cover.

Mr Bransby—I can take that on notice and give you the full break-up, if you like.

Senator SIEWERT—That would be appreciated. Thank you.

CHAIR—Mr Bransby, we are out of time, but I have one question. Can you give me any data from your perspective about the dollar amount of the increases? We have a graph from the Australian Health Insurance Association, which is doing a general modelling of what it would be. People are throwing around their percentages, but I am really interested to know the dollar amount we are talking about. Have you done any consideration of this within your HBF products? When we talk about a 43 per cent and a 66 per cent increase, can you give me any information from your perspective as to how much that is?

Mr Bransby—As in what that means in dollars?

CHAIR—Yes.

Mr Bransby—Can I take that on notice as well?

CHAIR—That would be fine.

Mr Bransby—We have probably got it here. Did you want the pooled amount or just per policy?

CHAIR—You could take it on notice. For the family one, the AHIA figures show that around \$1,000 to \$1,500 is the highest increase per year and about \$500 or \$550 is the biggest increase for an individual per year. But we would like to see your modelling on that as well.

Mr Bransby—We are not far off those.

CHAIR—So, for a family on an income of \$250,000, the increase for the year is \$1,000 to \$1,500? Is that the kind of figure you have—at the top rate?

Mr Bransby—We are a little higher, but that number is not far off.

CHAIR—If you could take that on notice it would be appreciated. Thank you very much for appearing before us today.

[9.44 am]

BENSON, Mr Timothy Charles, Chairman, Health Consumers' Council of Western Australia

KOSKY, Ms Michelle, Executive Director, Health Consumers' Council of Western Australia

CHAIR—Welcome back, Ms Kosky, and congratulations on your Australia Day award; it is most deserved and I know that the people of Western Australia were very proud to have you nominated. You have information on parliamentary privilege and the protection of witnesses. Would you like to make opening statements?

Ms Kosky—In case senators do not know about the extremely famous Health Consumers' Council, I may give you some background about what we do and what we know. We have been established for 15 years and we have a role in advising government on policies and processes to do with consumers and patients. We are, in Western Australia, the patients' voice in the health system. We provide advocacy services directly to the public, training and support for patient representatives and review of policy and legislation for both the state government and, sometimes, the Commonwealth government.

We have not surveyed our members around the issue of private health insurance and the means testing suggestion. I would say that we have quite a divided community of members; we would have members with private health insurance and members who rely on the public system. What we do have as an organisation is a very strong commitment to equity and access based on clinical need and not on capacity to pay.

That concludes my opening statement. Tim may have some comments to make.

Mr Benson—First, I want to thank the committee for the opportunity to present to you this morning. As Michelle said, whilst we are here representing the council, we have not surveyed our members in detail, but many of the comments I want to make in my opening statement are based on anecdotal evidence from a number of members we have spoken to.

My concerns are fivefold. One is the obvious increase in pressure on the already stretched public hospital system. As more people move out of a situation where they have private health insurance, due to the increased costs, those people are going to have to go to the public system for treatment. Depending on whose surveys you look at, I think the number of people who will move out of the private health area could be up to a quarter of a million and there may be up to three-quarters of a million people who may downgrade the level of cover they have. Then there are other figures saying that it is only going to be 25,000. Like lots of estimates, you never really know until it happens. When one considers that something in excess of half of surgical admissions during the last 12 months were funded via the private health system, it does make you wonder where that money is going to come from and where the beds are going to come from in the public system.

Secondly, I think that the people who remain in the system are inevitably going to incur some increase in the costs of their health cover by staying in the system. I think the Treasury estimate was somewhere between 10 and 40 per cent. By definition, because seniors currently have access to a 40 per cent rebate, they are going to be the people most affected, so, in some ways those who are least able to afford it are going to be penalised the most. As a sort of rights based organisation, as Michelle said, I would see that as a concern.

Thirdly, there is obviously going to be a loss of funding into the health system. Again, the public purse is probably going to have to be opened to fill that gap. That is of major concern—probably.

Timing, I think, is another thing which concerns us, as a fourth point. We have a National Health and Hospitals Reform Commission with a report that I think is currently before the minister and shortly to be released. There is also the Productivity Commission inquiry that has been going on over recent times into the performance of public and private hospitals. This legislation has been put on the table before either of those reports, which could have a significant bearing on the legislation that has come before parliament. I find that interesting.

The final area that concerns me is some of the omissions from the proposed legislation around issues such as financial consent; the grading, rating or whatever you would like to call it of hospitals; the efficacy of prostheses and so forth which people receive as part of their treatment. There does not seem to be any section within the acts that is going to ensure that where the public dollar is being spent on those sorts of things they are perhaps using the most efficient prostheses in that procedure.

Senator CORMANN—I was very interested in your comments about how you focus on equity and need rather than capacity to pay. Of course it is a very important principle in our health system. How important do you think private health is as part of our overall mixed health system in Australia?

Ms Kosky—I think it is an inherited historical fact, and private health certainly plays an important role in looking after patients. I do not think anyone would deny that. It is just how much the taxpayer would subsidise it, really.

Senator CORMANN—Do you think it is just a historical fact? Let me go back a step. I would put the proposition that our health policy challenge is to ensure timely and affordable access to quality health care. I suggest you would agree with that.

Ms Kosky—Absolutely.

Senator CORMANN—Obviously in the public system it is affordable because it is free, but there is a question as to how timely it can be at times because there are waiting lists and waiting times which are a function of limited resources versus unlimited demand. The more people decide to take additional responsibility for their own health care needs by taking on private health insurance, the less pressure there is in terms of forcing people to wait who cannot afford private health who are not a high enough priority. I guess that is the theory behind the way the Australian system, quite uniquely, is structured. How important do you think it is for your members, both those who access services in the public system as well as those that access services through private system, that the Australian health system stays in balance with both a strong public and a strong private system?

Ms Kosky—I think that is what we have inherited. We could have had a completely different health system and modelled ourselves on other countries. The fact is that people are brought up with a mixed system. As I say, our members are both very responsive to the private system and very fond of the private system, but many of our members also rely only on the public system.

Senator CORMANN—If you could start from scratch and design—

Ms Kosky—Do not ask me. It would be too awful for you to hear. I just think that we need to have this idea of access, and I appreciate that the private hospitals do play an enormously important part. Other experts say they cherry pick the easy throughput, and the more complex cases are managed in public hospitals because public hospitals are teaching hospitals. I am not an expert on hospital flow, but that is certainly something that one reads often in the literature.

Senator CORMANN—We will have Dr Shane Kelly from St John of God a little bit later. We will ask him whether he cherry picks or whether he also performs some of the complex stuff.

Ms Kosky—When Dr Kelly was CEO at Fremantle Hospital, I was in the room when he made that observation. But now he works for a different hospital he will clearly have a different observation! And being a human being, I kind of support that.

Senator CORMANN—We will ask him the question and share that observation with him. If more people leave or downgrade their private health cover, it stands to reason that more people will have to present to public hospitals, doesn't it?

Ms Kosky—It depends what private health cover covers. If people are young and healthy and have private health cover, there is no reason that they would be going to hospital regardless of their cover. People with chronic conditions of course would drift across to the public system but many private hospitals do not even manage people's chronic conditions in an ongoing way.

Senator CORMANN—But if the people who leave are the young and healthy, as you say who do not use hospital services, then what you are really saying is that they are leaving a system that they are paying into but not using. So the people who stay behind are the ones who are using and you have just lost a whole heap of resources. Where are you going to get those resources from?

Mr Benson—Maybe if I could just comment on that to some extent. I think Michelle is absolutely correct that the private hospital system per se does not really look at long-term care of patients. That is something that is much more handled within the teaching hospital scenario. There are a number of young people who have babies and things like that who do take out private health insurance.

Senator CORMANN—So they do access private hospital services.

Mr Benson—Yes absolutely. In the maternity area particularly, possibly far more than, logically, the chronic disease area.

Senator CORMANN—Knee reconstructions, heart attacks.

Mr Benson—Yes, all sorts of things—there are sporting injuries, car accidents, mental health, as you say. There are a number of areas where the public do go to the private system. The other thing that we should not lose sight of is the fact that even within public hospitals there are people who choose to be admitted as private patients. There is an impact in that area as well.

Senator CORMANN—You mentioned informed financial consent and that is of course a very important issue. Mr McAuley appeared before us in Canberra—he is a supporter of this particular measure incidentally. He supports means testing the private health insurance rebate. Even he said that the most rational response from people in response to this measure is to go for the cheaper policy and to cancel their ancillary cover. Going for the cheaper policy means increasing your front-end deductibles or going for exclusions, such as excluding heart or orthopaedic surgery. This would then increase the incidence of patients facing gaps or not being covered at the time of accessing the service. Is this something that concerns the Health Consumers Council? Given that financial consent has not actually been addressed as part of this package, more people will be faced with higher out-of-pocket expenses or not being covered at the time of accessing the service and will be caught up in pretty unfortunate circumstances.

Mr Benson—I think you are right. I think that the informed financial consent issue is a huge one not only in relation to this particular set of bills but—

Senator CORMANN—It is already an issue now, but it could become worse.

Mr Benson—I think it can because at the moment people, particularly with private health insurance or people who are in the public system either way, have this somewhat naive expectation that their fund is going to look after them. The fact that we do not know really when we embark on a hospital experience just how much we are actually going to be out of pocket is a huge issue. If we now get people dropping out of cover or reducing their cover, the shock to them postoperatively could be quite significant more so then if they went into it with their eyes wide open.

Senator CORMANN—In the public system it is free universal access except that you have to wait until you are a high enough priority to fit into the number of available services.

Mr Benson—Correct.

Senator CORMANN—But in the private system—and it is already a problem now, potentially, to get access when you think you need it rather than when the system says you are a high enough priority, paying extra is both a combination of the premium and whatever out-of-pocket expenses there are, depending on your level of cover. If more and more people will downgrade their level of cover, is that not a hidden problem that is going to become worse?

You are either in the public or in the private system, that is very clear-cut. But if you stay in private health and, as you say, you have this naive perception that you are covered for things that perhaps you are not, isn't this going to lead to more complications for more people who think they are covered, who think that they will not have any out-of-pocket expenses, but then have to pay \$500 out of pocket or find that they are not covered for knee or heart surgery? Surely, as a health consumers organisation it would be of concern to you that that is an increasing problem.

Ms Kosky—It is an increasing problem, but I am glad that you go to a doctor who when you say that you think you should go somewhere says, 'Right'. First of all the patient does not decide when they need the surgery or the intervention, your specialist does and, oddly enough, if you have private health insurance, somehow you fast track. That strikes me as deeply inequitable because it is not on the basis of your clinical condition but on the basis of your capacity to pay.

I agree with you, but also there is an obligation amongst the private health insurance industry to better inform their members of the products that those members have paid for. We have had many concerns over the years that people are not clear about what it is they are insured for and what it is that they are not insured for. I have to say that in this state the largest health insurer has taken on board that view of getting a much better quality of health information and insurance information out to their members. So it is a problem but—

Senator CORMANN—I can hear that you are of the view that perhaps we should have a public system across the board. Are you nodding? Hansard cannot pick up your nod, so I am reading into the *Hansard* the fact that you nodded.

Ms Kosky—If Senator Cormann says I nodded, I nodded! Sure.

Senator CORMANN—I go back to the point that, because of government action, because of government going back on the promise they made before the last election of not changing the private health insurance rebate, one of the most likely things to happen, according even to people who support this measure, is that people will downgrade their cover. So a problem that already exists and that you think is a bad problem—that is, people not being sufficiently aware as to the additional out-of-pocket expenses they face and the things that they may not be covered for—will actually get worse. Is it something that is of concern to you that, as a result of this measure, more people will get caught up with out-of-pocket expenses they would potentially be unaware of and that more people will be not covered for things they thought they would have been covered for?

Mr Benson—Yes I think that is true, but with or without these amendments the issue is still the issue of people not being aware of their liabilities. Because there are going to be more people who do not have the cover or who have chosen to reduce the cover then the potential damage, the gap, is going to be a lot greater, yes.

Senator CORMANN—Going back to your original statement, and I will leave it there, do you think it is inequitable that some people choose to pay extra through private health insurance to get immediate access at a time when their specialist tells them that they need access rather than to have to wait in the queue until there is enough available space in the public system to let them in? Do you think that is an inequitable thing.?

Mr Benson—The inequity comes about because of the fact that people cannot get into the public system when they need to get into the public system.

Senator CORMANN—Okay. But if fewer people pay extra in the private system then they will displace further people from the public system who otherwise would be able to get access. You are nodding.

Mr Benson—Yes, I am. I totally agree with you. We already have the inequity that we cannot treat all people through the public system when they need to be treated and if we are going to put more people into the public system without resourcing it adequately, we are only going to compound the problem.

Senator CORMANN—So it is a good thing that people take additional responsibility and pay extra to get access to the private system because that means more people that need it and cannot afford to pay extra can get access to the public system?

Ms Kosky—I have no problem at all with taking the view that people who can afford it should have private health insurance to enable people who cannot afford it to access the public hospital system. But I still think it should be one equitable health system, not a two-tiered system—one for the wealthy and one for the poor. I think that there is a major problem when the capacity to pay moves you along a clinical list. So there is something about medicine and surgery that we need to address, because if we have a health system that is looking after everyone then we should really be treating sick people. I also think that means-testing a private health insurance rebate for wealthy people is not an unreasonable attitude for government to take at this time. By wealthy, I suppose I mean people on over \$100,000 a year.

Senator CORMANN—Thank you. I take note of that. Just going back to the beginning of your comments, do you think that if we had a completely universal public system it would be able to handle all of the demands for public hospital services out there in the absence of a private system?

Ms Kosky—We have never experienced that, so I cannot prophesy what it would be—

Senator CORMANN—There are experiences around the world that do it. I put it to you—

Ms Kosky—Yes, and there are varying views, Senator Cormann, about how well the national health service in the United Kingdom works. There are varying views so—

Senator CORMANN—Having experienced it I can tell you that people have to wait for a very long time for services that would otherwise be quite necessary.

Ms Kosky—Right, and one hears a different view: that other people—

Senator CORMANN—Mr Benson was nodding when I was saying that.

Ms Kosky—have experienced that they have not had to wait. So it is difficult to know.

Senator CORMANN—All right, I will leave it at that.

Ms Kosky—Thank you very much for your questions. We appreciate it.

Senator SIEWERT—I am just wondering. Where have you got the information from regarding your comments around the number of people who are going to drop out of private health insurance or be affected?

Mr Benson—Thank you for the question. The information comes from three sources, I guess. One is from polls that have been conducted by independent research organisations such as the Roy Morgan group and others. There has also been some information that has been provided out of Treasury estimates and there is other information that has come from within the industry. So there is a sort of independent-government-industry mix.

Senator SIEWERT—One of the underlying problems with this is in being able to access data. For example, one of the things I am finding extremely frustrating is that none of the funds has access to—or they cannot compare, or do not know—what people's income is. So when they are looking at how this is going to affect people, they cannot do that because they do not know how many people are over the threshold and will fit into the various tiers.

Mr Benson—That is right.

Senator SIEWERT—Catholic Health Australia has commissioned an Access Economics review and basically they agree with Treasury's analysis which indicates the number of people who are likely to be affected. They do then comment on the ancillary issue, and I want to come back to that. I also want to touch on the fact that what Treasury are also saying is that there are about 130,000 extra people who will get caught up with the increase in the surcharge. There will be increased pressure on them to take out private health insurance. I am wondering whether you have a view on that. And I wonder what your view is on the use of ancillary cover, which the industry in the hearing in Melbourne admitted that a lot of people do not use. The industry uses the funds generated from that to cross-subsidise some of their other policies. So I wonder whether you have looked at that and whether you have views on those issues.

Mr Benson—I guess I have a view, particularly about the use or lack of use of ancillary services. I think as people get older perhaps they use the ancillary part more than they do when they are young as they get more problems with their oral health and their eyes and they have a need for physio and things in that sort of arena. But in real terms of how much cross subsidy there is, I would not be privy to that information and would not even hazard a guess. I think there will be an impact on people who do have ancillary benefits, because I think that that will probably be one of the first things, as a percentage of the total premium, that will be dropped—particularly by the younger section of the community, unless they have a known need for retaining it.

Senator SIEWERT—What sparked my question yesterday was the comment that people would be dropping it. I said, 'Well, there are a lot of people actually maybe looking at it and thinking they do not get value for money so they will in fact drop it.' Have you had experience with that? Have any of your members talked about whether they use it or get value for money?

Mr Benson—I have certainly heard the comment from people that if they are going to do something as a result of this legislation that will be the sort of thing that will go first. One of the other interesting comments which I did not mention in the opening address but which I find quite fascinating is that a number of elderly people or people at the older end of the spectrum are saying that because they have such a large need to use the system—with hips, knees and some of the other conditions that become more prevalent as we get older—they are really looking at how they can make savings in other parts of their life rather than drop that particular cover. They recognise the need to maintain that ability to receive treatment when they need it and not necessarily have to wait for 12 months or something within the public system.

Senator SIEWERT—I suppose my question is—it is more a philosophical question—should older Australians in particular be required to pay out of their fairly meagre savings for private health insurance or should we have a system that is robust enough to actually be able to pay for those services so they do not feel like they have to have insurance to enable them to access effective and efficient hospital care?

Mr Benson—I think the short answer is yes, we should have a system that is equitable in the sense that those people who have a need should be able to get access as and when they need it.

Senator SIEWERT—And the \$3 billion that we are currently investing in private health insurance, some argue—and I must declare, including me—would be better invested in helping those people.

Mr Benson—I think \$3 million—

Senator SIEWERT—Billion.

Mr Benson—Sorry, \$3 billion. I was going to say that \$3 million is not going to make much of a difference. Obviously \$3 billion will be far more significant. Maybe that is true, but I think if we do that we really have to have a look at it. Providing the money is one thing. Providing the rest of the infrastructure, whether it be people, beds or whatever, is another thing. Money does not buy everything.

Senator SIEWERT—Mr Ian McAuley argues that if you reallocate those financial resources then the other resources will go. So, if you prioritise the public health system and put more funding into that, you will get a shift in emphasis from the medical profession. That is his argument now. I have not heard that from the medical profession. We can ask the AMA. His argument is that you will find that there is a shift in the system when the resources are there. My other question is around the NSL and the increase in the number of people that may go into the system. Have you had a look at the arguments there, from Treasury?

Mr Benson—Not really, no.

Ms Kosky—I could not make any comment.

Senator SIEWERT—Obviously they are going to be the higher income earners. The argument is that they are higher income earners and there will be extreme pressure on them to take out private health insurance through the increase.

Mr Benson—I think that is probably true but from our organisation's perspective we have not looked at so much of that because the majority of our membership are not in that sort of bracket.

Senator SIEWERT—I appreciate that. I have one other question. Part of this inquiry is looking at the extended Medicare safety net provisions. This is the legislation that allows the minister to impose a cap on certain procedures. At the moment there is the IVF procedure and potentially fixing cataracts. This bill basically allows the minister in the future to put a cap on other services. Have you had a look at that? I am not actually referring to the specific issues at the moment. We heard about IVF access and the doctors working on fertility yesterday. At this stage, are more interested in the concept of applying the cap to the safety net.

Mr Benson—I have concerns not only directly related to your question but that it is not in the interests of the public or patients generally to have politicians or even bureaucrats sitting down and saying to a medical practitioner that they cannot provide the best treatment because the funding is not going to be available from the government to pay it out of Medicare. If the patients are not in a position to pay the shortfall then that puts a huge impost on their health and wellbeing.

Senator SIEWERT—The PBS has an independent expert mob that does the advising, complaints and things like that. I forget the exact name off the top of my head. But if you had an independent expert body looking into that, would you be more comfortable with it?

Mr Benson—I would certainly be more comfortable.

Ms Kosky—To say you can have 15 cycles of IVF but we cannot give water to some Aboriginal communities in Western Australia is preposterous. I find that it is that kind of inequity where the government completely lets the people down, I am sorry. I think there does need to be sensible resource allocation. I think it is entirely appropriate for parliamentarians elected by the people to make some decisions around how taxpayers' dollars are going to be spent and invested in health over the next 20 to 30 years. Otherwise, we are not going to have a sustainable health and hospital system.

Senator SIEWERT—That partly goes to my next question. The issue that has come up a number of times is runaway medical expenses, the increasing cost, for some procedures in particular because they have an emotional context. Are you saying an increase in those fees is not proportional to other medical procedures? Other than the cap, so far no-one has really come up with a sensible suggestion, as far as I can see, about how you deal with those excessive fees that do seem to be out of proportion with inflation and the increases for other medical procedures. What is your opinion on that and have you got any suggestions on how it could be dealt with?

Ms Kosky—No. That is why we pay you so much! I have not got any brilliant suggestions. I do think that there needs to be some community discussion around what it is we can and cannot afford in this country in terms of investment in health technology and medical procedures. Moving away from consumers to citizens, and to the public good away from self-interest, I think most citizens may well say that there needs to be an independent body set up and authorised by government to give government some advice about capping certain procedures. I think it is a really good initiative.

Senator SIEWERT—The obstetrics measures that have been brought in have been discussed. Whilst some of the other changes have not been discussed with the medical profession, I understand that one has been. As I understand it, there has been a lot of cooperation with the profession. It is not quite going to an independent body, it is working it out with the profession, but it seems to me that we do need some expert advice on what is appropriate expenditure.

Ms Kosky—Yes.

Mr Benson—I think that is true and I think the other thing that goes with it is that some procedures are obviously life enhancing and life saving; other procedures perhaps could be classified as not so crucial to the patient's wellbeing. If we are going to introduce a capping system—and I think a capping system is probably the best that we have available on the table at the moment—Michelle has pointed out we have to look again at this equity word. How much do you spend on a particular procedure for a particular patient when you have communities that are suffering?

Senator SIEWERT—I do understand that is the point that you employ to make some of those tough decisions. It is more the expertise around what is appropriate for a specific procedure that I think we probably do need some independent advice on. Thank you.

Senator FURNER—Firstly, can I just get a quick understanding of what your membership is in terms of age demographics. I think you pointed out that you do not have research or data on their earnings or income.

Ms Kosky—We currently have 800 individual members. We have 260 non-government not-for-profit organisations in Western Australia as members. Our individual members, by and large, would be over 50. Many of them are on pensions, many also are still in the workforce and some of them have had very considerable difficulties with the health system. Because we have provided them with a service, they have come and joined and wish to make a contribution in some small or big way to make the health system operate more effectively. We do not have millionaires, Senator, as our members. We would like to, and we are always looking for extra funding. But we do not have people with large incomes as our members. I could assert that truthfully.

Senator FURNER—So it could very well be the case that those out of that 800 that are over 50 may not be affected by these changes whatsoever given the introduction of the new tier arrangement for the changes.

Mr Benson—They may not be directly affected, but if we put more people back into the public system, which significantly they rely on, then they will be indirectly affected because the weight of this will get bigger and the quality of care potentially will decrease as more pressure is put upon commissions to increase their throughput or whatever else to try to meet that need.

Ms Kosky—If the community could be assured that the savings are going to be reinvested back into the public hospital system in a new and glorious future for Australian health then I think people would feel less anxious about this whole proposition.

Senator FURNER—Ms Kosky, I think you made a philosophical statement about the view of your organisation being based on equity and I think you started to answer this question earlier about the proposals. Do you think they go towards fulfilling that philosophical statement that those that can afford to fund private health insurance will be more greatly captured to assist those that necessarily cannot?

Ms Kosky—As I have already said, we have not asked our members about the means testing of the private health insurance tax rebate. I personally strongly support it, I have to say. I will show my bias now. I think it is a reasonable way for a government—I appreciate that the election promise was to maintain it but I do not think it is sustainable for the Australian health system over the next 10 to 20 years.

Senator CORMANN—Was that your view before the last election?

CHAIR—Ms Kosky, you can choose whether or not to answer that question about whether you had a longstanding view about public hospitals.

Senator CORMANN—That the rebate should be means tested.

Ms Kosky—No. I have had it ever since it was introduced. It is not something that—

CHAIR—It is a longstanding view.

Ms Kosky—Yes.

Senator FURNER—You used the definition of young people for some of the people that you represent. How do you define young people? This started yesterday in Melbourne, where we had some debate about what you determine as young.

Ms Kosky—We would probably not have many members under 40. We do not have many adolescents or young married people as member of the Health Consumers Council of Western Australia—that is mostly probably because they have not had much to do with the health system. They have not run into problems. Once you hit 40 and over you can run into problems with the health system—you might get sick or something may happen.

Senator FURNER—So in your experience most of those people you would consider as young have had little or no exposure to the health system at this stage?

Ms Kosky—Of course we welcome the involvement of young people—occasionally there are young people with cancer, young people with chronic conditions, young people with diabetes and young people with asthma or chronic respiratory conditions. We assist those people but they do not tend to join the council. That is the observation I would make.

Senator FURNER—You made the point about insurance industries, and I think it is quite relevant, however you qualified it in terms of WA, about the information to their membership being shared. Certainly something that was shared yesterday in Melbourne with the majority of industry bodies was that there is a lack of understanding about what a policyholder has access to. Is that your experience?

Ms Kosky—Yes, absolutely. I think it is a challenge for the health insurance industry. How do you make the information sexy and interesting? People say, ‘Oh, insurance. I’m not going to read the fine print.’ And they do not actually understand the nature of their cover. So we have to think of more imaginative communication strategies to get the information to the consumers—the members.

Senator FURNER—It is a bit like most insurance though, isn’t it? You only go to the fine print or have a look at your policy when you need to make a claim.

Mr Benson—And there certainly seems to be a lack of communication between the treating physicians, the patient and the health insurance industry. It is sort of a triangle which does not seem to be closed on any side.

Ms Kosky—The other thing that strikes me around private health insurance generally is that the press are very interested every time there is an increase in the premium. They seem to think that premiums are quarantined from market forces in this country. They are mostly pretty bright, intelligent people. I have been responding to the rises in premiums for 10 years publicly now and I always say, ‘But, don’t you understand that we live in a market economy and premiums are not quarantined from being raised.’ It goes back to informing the public. There is this misunderstanding by the public that somehow the premiums are quarantined and that is reinforced by the press. It is slightly misleading I think and I do not know how the industry should and could sensibly address it.

Senator FURNER—I do not know where that comes from. Certainly the previous witness indicated that there have been premium increases over the last three consecutive years ranging from a bit over seven per cent and on average four per cent in the previous two years. Have you had an opportunity to look at the other submissions that are on the website at all for this inquiry?

Ms Kosky—I have had a look at the one from Dr McAuley, but I would because I kind of agree with him so that is where my prejudice naturally lies. That is the only one.

Senator FURNER—I encourage you to look at the others. We will had the opportunity to hear from Dr McAuley the other day in Canberra. There are also submissions from Dr Deeble and Mr Wells which, in summary, seemed to come from the one page. For example, Dr McAuley indicated that there would be little or no reduction in membership in the private health insurance sector due to what he terms as the endowment phenomenon—where people tend to hold on to health insurance as opposed to maybe car insurance or household insurance. If things get tight, they might consider dropping one of those. People tend to decide not to drop their health insurance because of the fact that you are gambling with your own health. Do you agree with those sorts of analogies that have been put forward?

Mr Benson—I think it is true that it is something that may not be dropped at the rate that some of the surveys have indicated. But what concerns me about that is, as I have mentioned before, that people will retain their health insurance for all the very valid reasons you have just mentioned but what that will do is impact upon other aspects of their life like maybe the quality of their food, their clothing or their other environmental

conditions which will consequentially impact upon their health. They have to make a decision about the dollar, if they are going to use it to pay for their health insurance or for their heating. This is particularly so for those people in the older age group or those people who are on limited incomes. So I think that, whilst the numbers may not drop off at the rate that some of the pundits are quoting, there will be a consequential effect on people's health.

Senator FURNER—I think however that will always be the case regarding human nature. You would not defer an illness as a result of not deciding to deal with it as opposed to purchasing something that you do not necessarily need or would rather afford to put your life and your health before any other household accessories.

Mr Benson—I totally accept that. But for people with limited incomes some of the things that they have to defer are things that perhaps you and I would consider to be actually very important to our wellbeing, like food, clothing, heating and other stuff.

CHAIR—I know that there have been a lot of submissions on this issue but I am still not convinced that a lot of people out in the community have got across it yet. That is what happens with all these things. In evidence we have heard there has been a lot of talk about percentage increases and tables as to people. Do either of you have any idea of what is exactly the dollar figure of how much we are talking about? Percentages have been thrown around but I do not think there has been a lot of awareness of this. If you have an income of \$80,000 and you are single how much vaguely is it going to cost you? It all depends on whichever fund you belong to of course. Do you have any idea whether your members or the people who are interested in this issue have got any concept of exactly what the dollar figure is?

Mr Benson—My guess—and it truly is a guess because, as we have said a few times, we have not surveyed our members—is that most people do not really understand what that dollar impact would be. We as an organisation certainly have not done any financial modelling, nor are we really in a position to because we do not have access to the information that the funds have available to them.

CHAIR—There has been some general work done but of course it has been general because each individual fund is talking about its own packages, of which there are so very many. But I think it is very important for people who are looking at this to understand what it is going to mean as to their own pocket, rather than to have generalities. So that is why I was wondering if you did. Mr Benson and Ms Kosky, you will get a copy of *Hansard*, as you always do. If there is anything that you want to change or add or if you think of things we should know over the next period, please let us know by contacting the secretariat. We have deeply appreciated, as always, having your input.

Proceedings suspended from 10.34 am to 10.52 am

JENNINGS, Mr Peter, Deputy Executive Director, Australian Medical Association (Western Australian Branch)

CHAIR—Welcome. You have information on the protection of witnesses and privilege. Would you like to make an opening statement.

Mr Jennings—I would like to deal with the safety net legislation first and then lead on to the various interconnections between the two. Obviously, the legislation is seeking to empower the minister to determine the maximum benefit payable under the extended Medicare safety net for specified Medicare benefits items. The legislation has its genesis in the issue of gaps fees versus rebates and I think it is important to reflect on why gaps have arisen.

The CMBS itself has a particular history and I would like to quote Dr Blewett back from the inception of Medicare and then a few years after that, in 1987, when he stated that payments for doctors in public hospitals et cetera were never designed for the CMBS to apply. In other words there was an acceptance by the government of the day that rebates are different from fees. That was then corroborated further at that point in time in the 1980s when there were a series of inquiries into scheduled fees for rebate purpose. A member of the federal industrial commission presided over that inquiry. Again, it was stated in those inquiries that the inquiries concerned with fixing fees for medical benefits purposes were not the fees to be charged by, let alone the incomes of, medical practitioners.

There has always been a healthy debate, at best, as to adjustments to Medicare rebates and what that has meant in terms of gaps, which this seeks to deal with. The Commonwealth Auditor-General, in audit report No. 32 of 1990-91 commented:

Developments in recent years—

this is going back—

would suggest that the scheduled fee simply represents the amount the government, having regard to budgetary and economic considerations, is willing to pay for the provision of particular medical services.

In other words, there is no logical mechanism, post the inquiries, for adjusting Medicare rebates. It is simply adjusted on report of pay basis so it did not necessarily reflect movements in practice costs and the costs of delivering quality care.

Subsequent to that there was a lot of debate in the 1990s leading to a relative-value study into medical rebates and fees. That was commissioned, if I recall correctly, by Dr Carmen Lawrence at the time. That was a work-value analysis of Medicare rebates and doctors' fees. It came up with a number of recommendations which would have been very expensive for government to implement so they did not address the deficiencies that were in the schedule at that time. I do note that at this point in time the average gap in the safety net report of 2007 was \$72.

What I would like to table is a series of indices in recent years that put it into perspective as to where they are. What this does is simply track CPI, average ordinary time earnings—so it proposes an indexation methodology—and the movement in the CMBS. This will give you an insight into why there is an imbalance and why this might in fact deteriorate even further. Essentially, from 1999 to 2008 the compound CPI was 36.3 per cent. The average weekly earnings compound effect, from Australian Bureau of Statistics figures, was 49.19 per cent. The CMBS had actually increased by 25 per cent. In a graphical sense, and I have copies of this, what I have here illustrates that the CMBS has been adjusted by that amount, the CPI has gone up by that amount and average weekly earnings has increased by that amount, so there is a gap because rebates have not kept pace with inflation.

If you want to look at that in another way and adjust for inflation so that you have inflation as zeros, it shows that weekly earnings have actually gone up by about 13 or 14 per cent and Medicare rebates have decreased on average by 11 or 12 per cent. The costs of employing staff and nurses and of running practices have of course gone up and the rebate has gone down. So, against that backdrop and the Auditor-General's acknowledgement that rebates have been purely adjusted for economic reasons and for what the government wants to pay, it is little wonder that there are gaps. They are not the fault of doctors per se, so I make that point. So we have gaps and in particular areas we have got large gaps as to the safety net in fact designed to deal with that situation.

The bill itself seeks to enable the minister to determine by legislative instrument the particular items for which a safety net will be capped and the maximum benefit that will be applied in that particular instance. The notes to the bill suggest that the powers have been separated to clarify that the minister may make changes to the instrument or to the caps only and that the index will be the CPI, not average weekly ordinary time earnings as is proposed in the other piece of legislation that we will be discussing shortly. So there is actually an inconsistency in methodology between the two pieces of legislation.

The interesting thing is the report justifying this approach, and I believe that will be commented on in a lot more detail by federal AMA members, who will be making a separate submission and appearing in separate capacity from me as the WA representative. It has been used to justify this, but there are a number of flaws within that report that I think they will go into on another occasion before this committee. One of the issues is that the whole report and concept is predicated on averages. Medical services do not necessarily fall into an average category nor do the circumstances under which they are provided fall into an average category. The very concept of a safety net recognises that fact and hence deals with situations where people are out of pocket beyond the thresholds that are described in the legislation that exceed a certain amount and provide them with an 80 per cent cover.

Obviously, there are particular examples where, logically, costs will be different. These include rural services where viability issues and costs can be problematic compared to the metropolitan context. This is also so in relation to small services. I will use IVF, for example, where there might be only one service within a state and the costs of providing that may well be substantial and there is not opportunity for people to go elsewhere given the nature of the beast and so on, so there are the particular problems there. In the context of specialist services in the bush, in the Western Australian situation the vast majority of specialist services are in fact visiting services. A very high proportion are visiting services including ophthalmology. There are some resident obstetric services principally at Bunbury, Geraldton and Kalgoorlie, with not much beyond that other than by non-specialist service, for example, up in the north-west. The remainder are largely dealt with by visiting specialists who incur substantial costs in going to the bush. The alternative is for patients to come to Perth under the PAT Scheme, which presumably you are familiar with, at a greater cost. So there is an economy in a specialist going to a country setting and seeing a number of patients rather than a number of patients coming to a metropolitan setting and all claiming under the PAT Scheme and the like. So the concept underpinning the legislation does not really take into account that the safety net is predicated on dealing with issues that do not comply with averages. If an average is applied it could have detrimental effects as to the provision of services in certain circumstances; for example, rural costs are going to be different.

Another facet of the legislation is that there is there does not seem to be a process within the legislation itself as to how the minister comes to a conclusion. Generally speaking, advice to ministers in relation to the Medicare Benefits Schedule is through the Medical Benefits Advisory Committee, which is constituted under sections 66 and 67 of the Health Insurance Act and would advise the minister on the inclusion of new items and on, for example, the descriptors that would apply and on the schedule fee for rebate purposes level. This particular legislation does not seek to do that. The association does not support it in its current form. We would argue that clearly it should be varied to be consistent with the overall legislation in generality, that the minister should take into account the advice of the Medical Benefits Advisory Committee on matters and that, where the minister feels a matter should be explored, that matter should be referred to the MBAC to provide advice. Another facet is that the scope of that advice might be also to provide flexibility to take into account rural and access to service issues and whether a cap should apply and whether a cap should apply differently in different circumstances such as rural areas or in states where there is only a single service. Another facet is indexation, which I have mentioned. If a cap is to be applied, then clearly it should be indexed in line with average weekly ordinary time earnings. That is all I want to say in relation to that particular bill. I am happy to answer any questions. Thank you very much, Chair.

CHAIR—Does anyone have questions on that part of the particular bill?

Senator CORMANN—Yes, Madam Chair. Mr Jennings, you pointed out how at the beginning when the CMBS was conceived it was never the intention that the rebate would equal the fees, so there was always a view that there would be some gap. That is what you said, isn't it?

Mr Jennings—Yes. In fact if you go back further between 1953 and 1969 the then medical benefits were adjusted, I think, about twice with creeping 1½ per cent inflation. That led to the new inquiry. That led to the Hayden healthcare plan. That led to Medicare et cetera.

Senator CORMANN—So when were those statements made? By that I mean the ones that you referred to in your opening statement.

Mr Jennings—The opening statement in relation to Dr Blewett was in 1987. The Auditor-General's statement was in 1990. The other statement in relation to the inquiry before Mr Justice McKenzie I have not noted. That would have been around the 1985 to 1986 period.

Senator CORMANN—I do not want to waste too much time, but when it was introduced it was envisaged that there would be a gap?

Mr Jennings—Yes.

Senator CORMANN—And your profession—the AMA—would support the concept that there would be a gap? Is that a fair statement?

Mr Jennings—We support doctors charging reasonable fees pertaining to the particularities of the patient and the circumstances in which the service is delivered, and of course they discount their services in many instances.

Senator CORMANN—So your key argument, if I were to sum up what you have been saying, is that the Medicare safety net has really been a Band-Aid for a problem caused by not keeping up with increasing the CMBS rebates.

Mr Jennings—Yes.

Senator CORMANN—So if the government were to go down the path of limiting the Medicare safety net, they really have to have another look at what happens to the CMBS rebates. Is that your submission?

Mr Jennings—Logically, they should. You will see from the figures that I have tabled that the CMBS, essentially, in every year for the last 10 years has been two per cent to 2.3 per cent maximum. All of you would recall that CPI has been well in excess of that and average weekly earnings, and hence the costs for practitioners who employ staff et cetera, have increased by greater than that. You would also be aware that the cost of the health system in general—for example, the public hospital system—is a reflection that those sorts of underlying practice costs on a mega scale have increased by six, seven or eight per cent a year. For example, the state government's budget in this state has gone up in gross terms in the last four or five years by an average of 11 per cent a year. Those are the cost pressures.

Senator SIEWERT—I want to go to the point you were talking about concerning advice to the minister. The Health Consumers' Council raised concerns about the ability of the minister to make the decision and needing expert advice. They, for example, said that they potentially would support an experts panel. But what you are suggesting is that the Medical Benefits Advisory Committee would have to provide advice to the minister before any legislative instrument with any cap was tabled.

Mr Jennings—That has been the normal process in relation to, say, new items, benefits levels and the like—division 2, Medicare Benefits Advisory Committee, section 65 onwards, under the Health Insurance Act.

Senator SIEWERT—This is a question that we will probably have to ask the government: there is legislation now for the cap but under that we already know that the government has got a number of proposals—IVF, the other obstetrics measures, ophthalmology—

Mr Jennings—Cataracts.

Senator SIEWERT—and I think there is another one as well.

Mr Jennings—It would probably be otolaryngology, which is very hard to pronounce!

Senator SIEWERT—Yes, I am not even going to try! Are you aware of whether that committee was consulted about those issues?

Mr Jennings—I am not aware. The problem with those areas, as I said before, is that it is predicated on averages but the patients and the circumstances in which you deliver services do not conform to an average. So, for patients in the bush who require cataract surgery or obstetrics, the costs of delivering those services are fairly problematic in a lot of instances and they are cross-subsidised to some degree by clinicians who do the outreach services—going out into the bush for professional reasons, not economic reasons. If a cap were to be introduced, the viability of that is going to be teetering in a number of areas. Patients could suffer not just in terms of reduced benefits but also in terms of access to services, and then the state could end up picking up the tab because the patients use the PAT scheme to come in to the public system. So I do not believe it has been very well thought out.

The other facet is that if you take the legislation to its theoretical extreme, which obviously is an extreme, then under this proposal the minister could unilaterally determine that there will be a zero safety net. There is no proper process underpinning it.

Senator SIEWERT—The minister may, but the minister is unlikely to get something like that through the Senate because these are disallowable instruments.

Mr Jennings—I understand that but I said it was a theoretical extreme. But if they are reducing patients' access by several hundred dollars today on one item then it could be another \$100 more next year. And when we come to the next bill—I rest my case. That is exactly what they are doing.

Senator SIEWERT—I am not actually arguing against the issue about an independent panel or about getting advice—it seems to be to be quite a sensible idea—but the ultimate check on that is that it is a disallowable instrument and will have to go through parliament.

My other question is about the regional and rural issues, because it comes up time and time again, and the issue particularly about access to specialty services, such as obstetrics. I understand that some of those have been discussed with the obstetrics changes but, with the ophthalmology changes, there is a great deal of concern about the impact it is going to have on the bush. Have you got any suggestions about how it could be dealt with? If this legislation were to go ahead, what changes would you suggest we put in place to actually address these issues, particularly around rural and remote access?

Mr Jennings—I think that is partly why I have suggested that the MBAC have that role and its role not be in relation to establishing necessarily an average cap. If a cap is going to be accepted, which obviously we do not support, it should be a cap for the situation. If you take, for example, rural cataract services it might have a different approach to metropolitan services, similarly obstetrics. We are having grave difficulty in this state, for example, in getting specialists to go out to rural areas and we have an ageing specialist workforce, where they do exist, in the bush. I instance Bunbury which is obviously a major centre in WA. The obstetricians there are all around my vintage onwards—55 plus. For five or 10 years now they have had great difficulty in attracting people. This is not going to help. The nature of the beast in the country is obviously vastly different also to Perth. If you take obstetrics, they are not just servicing their patients but they are the backup for the GPs who deliver as well. So the lifestyle is even more extreme in the bush whether it is as a solo practitioner or as a small number of specialists servicing a community and indeed a region. It is a very tough life and this sort of thing will not help in terms of recruitment.

CHAIR—In terms of the legislation around the Medicare safety net, my understanding is that the process came out of the review that was made public in early 2009. Have you seen that review?

Mr Jennings—Yes, I have.

CHAIR—The figures in that I found quite confounding in some areas in terms of the growth of expenditure. Did you find some of those figures difficult to understand?

Mr Jennings—I found the report itself quite confounding. I think if it were subject to the normal peer review study, it would not stand up to scrutiny.

CHAIR—Your organisation has in principle opposition to the report.

Mr Jennings—What we are saying is that the assumptions, the extrapolations and, for example, the assertions about the movements in fees are inaccurate and there are some substantial flaws in the report. It needs to be recognised for example—

CHAIR—I am sorry Mr Jennings, I totally take your point. It is difficult for me to question when the committee has not seen a submission either from your organisation or the AMA yet on this issue. But because you are raising it here, your point is that your organisation has particular issues with the 2009 CHERE review, I heard it called yesterday—the centre for health economics report. Your opposition would be based on a disagreement with that. I did not know that.

Mr Jennings—My comments are in relation to your question as to whether we accepted the report as being a sound document. The answer to that is no. That I believe will be evidenced by the federal AMA.

CHAIR—Somewhere we are going to get a submission that allows us to have a look at that.

Mr Jennings—Yes, I understand that is the case. I would make the point though just to expand on that that the percentage movements claimed in there are based upon inadequate data. For example, the assertions about the increases in obstetric rates do not reflect the reality because they did not capture the base data correctly at

all and they excluded costs and fees being charged in doctors' rooms in terms of antenatals as part of the overall process. They did not capture those to determine what the percentage increase was. They overestimated the percentage increase very substantially indeed. I understand there will be evidence to that effect.

CHAIR—I am looking forward to reading that. It makes it very difficult to question when I do not know what the situation is. I can go no further because I do not know what the basis of the argument is.

Mr Jennings—But I think that is, again, one reason why we would suggest that a professional process under the act, rather than commissioning a particular organisation with a process to engage or consider various aspects, is a more appropriate approach. It would put it on a proper footing.

CHAIR—On that basis we will move to the next piece of legislation.

Mr Jennings—Again, thank you for the opportunity to speak on it, and I am really speaking from a WA perspective. The AMA in WA is probably a little bit different to some of the other AMAs, in that we represent all the doctors across the whole spectrum, both public sector and private sector. In states like New South Wales, for example, there are three organisations. We are a one-stop shop in WA, so we cover doctors both in public and private. The interesting aspect of this, of course, is that this could have a very profound effect indeed on private health insurance—the private sector and the state situation itself. The general outline accompanying the bill seeks to introduce three new private health insurance incentive tiers. The bill is headed up as 'Fairer Private Health Insurance Incentives'. The outline goes on to state:

These changes will ensure that those with a greater capacity to pay make a larger contribution towards the cost of their private health insurance—

and that—

... Government support ... remains fair and sustainable ...

That is the logic of it. It then goes on to illustrate the financial impact. It will have significant revenue implications in 2010-11 of some \$695 million in savings to Treasury, \$650 million the following year and \$680 million the year after that. In other words, \$2 billion is being taken out of private health insurance support in three years, which is clearly a very substantial amount indeed.

Interestingly, a year ago almost to the week I appeared before the Senate economics committee considering the other threshold legislation. I am just wondering where I will be this time next year. We would assert that the delicate balance is at risk, a balance that the government stated it supports. I would suggest—and please do not take this wrongly—that commentary about supporting it seems to be spin rather than substance.

CHAIR—We will try not to take that in any negative way.

Mr Jennings—Two billion dollars cannot be spun. Withdrawing \$2 billion is hardly supportive. Last year before the Senate economics committee the issue was the government proposal to raise the threshold at which people without private health insurance pay a surcharge. Treasury estimated at that point in time that the effect of that legislation would lead to some 485,000 policies not being renewed, a very substantial effect indeed, and that is still working through the system. That legislation is what I would describe as a bottom-up squeeze on the private sector and private health insurance. It undermines what I refer to as intergenerational transfers, a community rating principle which is fundamental to private health insurance, and potentially encourages what is also called adverse selection, putting pressure on premiums and setting in train an effect over time which could lead to a significant reduction in private health insurance levels and increased pressure on the public system. The implications could be quite profound and, in terms of the effect of this on top of last year's and so on, in my view it is not a wise policy mix at all.

This year, of course, the legislation seeks to reduce the private health insurance rebate for those on modest incomes of \$75,000 by 33 per cent, from 30 to 20 per cent, and by greater amounts for higher income earners and, indeed, to abolish it in its entirety above a certain level. I describe that as a middle- and top-down squeeze, on top of last year. Again, the potential adverse effects on the public sector, with increasing demand and reduced access for patients on waiting lists, have to be taken into account. As you will probably be well aware from the PHIAC figures, 50 per cent of people within Western Australia are privately insured; hence those 50 per cent will be affected in one way or another. The other 50 per cent, those that are uninsured, are seeking to access the public sector and they will also potentially be affected.

The public sector in this state is constantly stressed. It is going through a major recapitalisation program, but its capacity to deal with demand, on present projections, is problematic. We are a huge state geographically and demographically, and the cost of providing services within this state is arguably higher than in more

concentrated states. Again, I come back to the incentive for rural patients to be privately insured and that being undermined by this legislation. The other interesting facet is that income may also vary from year to year. If I am a farm worker, a crayfisherman or a miner, the income that I enjoyed last year might well have been a lot more than I will get this year. In fact I am being penalised for having a good year, in terms of the rebate going down.

Within the public system, occupancy is often 100 per cent currently. It is not 85 per cent, which is the recognised efficient standard and indeed the safe standard. We have constant arguments about inadequate capacity in beds. We have access problems—ramping and other issues. We have research that has demonstrated unequivocally—and been accepted across the board—that these problems affect very directly the quality of care and outcomes in hospitals and lead to avoidable deaths. We cannot afford to put excess pressure on the public system to the detriment of public patients, which is what this initiative may well do.

The private sector currently provides a very significant level of services. Forty per cent of separations are undertaken in the private sector and 50 per cent of surgery. It takes a huge load off the public system. That level has been achieved because of the private health insurance incentives introduced from the late 1990s onwards. They have taken huge pressure off the public system, to the benefit of both public patients and private patients.

The state health budget this year is \$5 billion on the recurrent side, separate from capitalisation. The Commonwealth contribution to state health is still well less than half. The Commonwealth's proposals will clearly increase demand on the state, for which it arguably will not fully compensate. We would argue with senators representing your states that, if this legislation were to proceed, you should demand that the Commonwealth fully compensate the state. Of course, we are arguing that the legislation should not proceed.

The Commonwealth has talked about the blame game, but in reality, whilst it has increased some funding—and some of that is one-off, not recurrent, and this is a recurrent problem—again, when you look at the substance, this will put additional pressure on both the private system and the public system. Pre Medicare, interestingly enough, private health insurance premiums were tax deductible, which in today's terms would mean that somebody in the \$80,000 to \$180,000 range would effectively have a 38 per cent rebate. That is the current marginal tax rate between \$80,000 and \$180,000. If the old regime of tax deductibility occurred, they would get a 38 per cent rebate. Above \$180,000, it would be a 45 per cent rebate. The current 30 per cent rebate compares to that. When Medicare was introduced, tax deductibility did not continue and, as a consequence, private health insurance plummeted down to about 31 per cent, from, I think, 68 per cent immediately pre Medicare.

Senator CORMANN—That is in Western Australia?

Mr Jennings—Yes. Progressively it went down. The 30 per cent rebate was introduced, along with other initiatives, to reverse this trend, and it has been a key element in absorbing surgical demand and reducing growth in the public sector. It has also been fundamental to providing an environment of relative certainty conducive to private and public sector planning and investment based on projected demand figures. In other words, the rebate is part of what I have referred to previously as an integrated trilogy—the three pillars sustaining the balance—of lifetime community rating, the rebate and the surcharge. This legislation underpins the pillars. It sends the wrong signals and is indeed a second breach of an election commitment to retain the rebate—on top of last year's threshold legislation. It penalises those who are taking responsibility for their health care and puts added pressure on premiums as income earners either drop out or downgrade their policy. And it creates further uncertainty and concerns in both the public and the private systems.

The bill characterises itself as fairer. Fairer? Hardly, if those with private health insurance will be disadvantaged directly if the rebate is reduced. Is it fairer on those who are not directly affected by loss of the rebate because they have maintained private health insurance and still retain the 30 per cent but as a consequence their private health insurance premiums increase because of effects on community rating and adverse selection? Again, hardly. Is it fairer on those in the public system, where demand will increase, queues will lengthen and access will diminish? Again, hardly. I note again that Treasury is estimating that it is going to pull out some \$2 billion over three years, and that is a great concern.

The bill, of course, seeks to reduce the amount of private health insurance rebate an eligible taxpayer receives, according to various thresholds. It effectively removes carrots. If you are single person earning between \$75,000 and \$90,000 the rebate will drop by 10 per cent, from 30 per cent to 20 per cent. What is the effect of that? I confess a conflict of interest. Like many people, I am privately insured—I have family insurance. I think everybody actually has a conflict of interest in this argument. If I am a public patient and I

am not privately insured, I have a conflict of interest because I have an interest in making sure the queues do not get longer, so I think that probably nullifies the conflict. But, if a person is paying \$4,000 for top family hospital and family essentials as standard, which is the current HBF rate in this state, they cannot really receive a rebate of \$1,185—for simplicity's sake, let's call it \$1,200. If they are earning above \$75,000, then the rebate drops to \$800, a \$400 drop. That constitutes a 14.3 per cent increase in their net premium. So the effect of this legislation is to disadvantage anybody earning above \$75,000 who has family cover of that nature and impose a 14.3 per cent increase on their premium. If they fall into the next category, above \$90,000, and the rebate drops from 30 to 20 per cent, the effect of that is a 28.5 per cent increase in their premium. If they fall into the next category, above \$120,000, it is a 42.8 per cent increase in the premium. It is obviously higher again for other groups, who will lose it in its entirety.

The net effect of that is that people are not going to go into private insurance. People are going to downgrade according to the affordability et cetera. That will then lead to what I have talked about before in terms of adverse selection, which means that you end up with a pool of people remaining in health funds who do so because they have a high need. The whole principle of community rating is that you spread the risk and people pay an equal premium and that there is an intergenerational fund transfer by attracting younger people in, who pay premiums et cetera and then achieve the benefit later in life—they contribute a bit like superannuation. If we do not attract those people in and we are left with an ageing group of fundholders, then the premiums will not go up by 14 per cent, 28 per cent or 43 per cent; they will go up by even more. We will see, again, a very significant reduction in private health insurance levels and a significant increase in demand in the struggling public sector. That is a real problem.

Obviously, the other facet of the bill is to increase the surcharge, which is the stick side of the carrot and stick argument. The proposal there is to index it according to average weekly ordinary time earnings. So, interestingly, the threshold will increase well above the current methodology for adjusting the CMBS I referred to in my previous evidence on the bill—and I would like those comments to also be taken into account in this inquiry.

Another facet of this of course—and I referred to the blame game earlier—is that it is interesting that the Australian healthcare agreement is a cooperative agreement between the Commonwealth and states which seeks to prescribe the basis upon which they would complement each other in meeting the needs of the health system. The healthcare agreement states:

Governments acknowledge that private providers and community organisations play a significant role in delivering health services to the community and will continue to be partners with government in meeting the objectives of this Agreement.

Partners. I am not sure they were consulted about this. I am not sure they agreed. It also goes on to state at section 26 of the healthcare agreement that the government in addition to its joint funding responsibilities with the state will fund access to private medical care and access to the private health insurance sector and will regulate it et cetera. The agreement suggests that there is a partnership. It suggests matters should be dealt with through consultation and changes ideally should be agreed. This legislation completely contradicts the election commitments and the ideology expressed within the healthcare agreement.

It can hardly be said that it is fairer either to private patients or indeed fairer to the states because on my understanding there has been no consultation with the states which will have to absorb the consequences of this. In essence there has been, as I understand it, little consultation with the states, the insurers, the private hospitals and the profession. It is a great shame. It was not an election policy. It is the second breach in this area. In our view there has not been any credible short- or long-term analysis of the implications but clearly history points to the problems.

Again if one goes back to the PHIAC data one can track—and this is an extract from their report—that back in the seventies private health insurance was up in the very high 70s at about 78 per cent and it plummeted down to about 31 or 32 per cent and then with the measures it came up again. During the period of it plummeting I think all of you can recall the problems for state governments and waiting lists and so on. This is what we are facing again—

CHAIR—Are you wishing to table that, Mr Jennings?

Mr Jennings—I am very happy to. It is entitled 'Insured persons covered by hospital treatment insurance June 1971 to June 2007.' It is an extract from the Private Health Insurance Advisory Committee report. We have the potential to go backwards again. I cannot overemphasise the importance of the concept of community rating, the risk of adverse selection and the fundamental importance of intergenerational transfers and the risk-sharing principle within private health insurance which this directly attacks. Essentially, it is introducing

means testing. It is interesting, the logic of that means that they should actually introduce means testing for Medicare, but I will leave you to ponder on that.

I say again it is definitely not good for private, it is definitely not good for public, it is definitely not good for the states and it is definitely not good for private health insurance policyholders. It creates further uncertainty of last year's initiatives and begs the question as to where we will be sitting this time next year. Public sector planning is extremely complex and private sector investment at this time is obviously extraordinarily difficult to attract. The fundamental question is: what is the commitment of the government to state public hospitals and the private hospital health sector. It states it supports private health. Indeed the Health and Hospitals Reform Commission interim report stated that and affirmed the need for the balance but its actions without consultation or consideration of the implications for all privately insured and indeed public patients generally really does beg the question.

I draw a parallel here with what transpired again in the eighties and early nineties. In that era there were a series of measures that were assessed by Access Economics as constituting raising premiums by 40 per cent—a series of measures taken by government post the introduction of Medicare. Removing Commonwealth bed subsidies, undermining the reinsurance pool and shifting onto health funds Medicare rebate costs for inpatient care were done through the 80s. That led to an aggregate effect of increasing premiums by 40 per cent.

This measure in one fell swoop increases premiums for people working above \$75,000 which is a modest income when you look at the occupations who earn that. It is only a middle level income. This measure achieves, in one fell swoop, a 14 per cent, 28 per cent, 43 per cent or even larger increase in premiums overnight. That can have a catastrophic effect. It is a very large slice. It is what I refer to as 'salami politics', where you do things a slice at a time and the aggregate effect is that the poloney is gone. We will therefore run the potential for a repeat of what that graph shows.

The Commonwealth government has also raised the issue of seeking to take over state public hospitals. This obviously puts pressure on the states and makes it harder for them to perform. Perhaps it even fuels that debate. We would argue, in closing, that the Commonwealth needs to unequivocally state what mix it is committed to. Obviously you gather that we do not support the legislation. I think it is wrong in principle. It is terrible in its timing, in terms of the recession, when we need to have people retain insurance. It is awful in its magnitude. I do not think its implications can be underestimated.

If the legislation were to proceed, there should be a consistent approach in terms of indexation, as I referred to earlier. The thresholds are clearly wrong. But we would argue that neither of those should occur and the legislation should in fact be rejected and very firmly rejected indeed. We need to maintain the balance. The legislation should not be passed. If the government want to proceed with this, contrary to their election commitment, they should take it to the next election. Thank you.

CHAIR—Senator Cormann, you have time for two questions.

Senator CORMANN—I want to start off with your final statements, Mr Jennings, pointing to the takeover of public hospitals that has been mooted. Do you think that measures like this put additional pressure on the states and territories and that, it being the second time in two years that this has happened, the Commonwealth is setting the states and territories up for failure?

Mr Jennings—Absolutely. I think the issue here is that this will have an effect over time. It cannot be judged within a year. These things take time to feed through, but, inevitably, yes.

Senator CORMANN—You have mentioned how premiums will go up, membership will go down, out-of-pocket expenses will increase and there will be additional pressure on public hospitals. Is it fair then to say that not only those with private health insurance but all Western Australians, like all Australians, will be hurt by this, inasmuch as there will be some that will not get access to a public hospital service they need because they have to compete with somebody who used to be in private health insurance? There will be resources lost. Is it fair to say that all Western Australians will be hurt by measures like this?

Mr Jennings—Yes. Again, the problems of the eighties and nineties, before the rebate was introduced, evidence that categorically. The most disadvantaged in society, who most need public hospitals—bearing in mind that the Medicare agreement is predicated on the basis that you cannot discriminate based on circumstances; people have to be treated in accordance with clinical need—and who are on longer queues, suffer the greatest. That is the problem.

Senator FURNER—You indicated there would be increases in premiums. What sort of modelling have you done to indicate that is going to be the case?

Mr Jennings—What I said was that the net increases in the premium in the first instance would be 14, 28, 43. That is self-evident because the rebate is reduced and, generally speaking, depending on your arrangements, the rebate is taken out upfront by the employer health fund. That is the immediate effect. The secondary effect is—

Senator FURNER—Excuse me. I asked you what sort of modelling you have done, as the AMA, to determine there will be an increase in premiums.

Mr Jennings—I have not done modelling per se. What I can tell you is that adverse selection and price elasticity issues would lead to people—those who do not perceive they have an urgent need for health care—dropping their premiums. That will leave people in the fund who have a higher need, leading to adverse selections. That has been identified consistently as giving rise to increases in premiums. People will also downgrade their policies, so there will be less cross-subsidisation.

Senator FURNER—Have you done modelling to determine that?

Mr Jennings—No. As I have indicated, I have not.

Senator FURNER—So you are not relying on any data or any research to give you that assumption.

Mr Jennings—I referred earlier to the Access Economics studies about the 40 per cent increases during the eighties and nineties as evidence. There is a lot of evidence supporting that.

Senator CORMANN—Did you see this measure coming?

Mr Jennings—No.

Senator CORMANN—Why is that?

Mr Jennings—The government said it supported the rebate.

Senator CORMANN—That was a pretty emphatic commitment, wasn't it?

Mr Jennings—Yes.

Senator CORMANN—What are your thoughts about the opposition proposal to increase the excise on tobacco by 5½ per cent as an alternative to means-testing the rebate to avoid the fiscal impact?

Mr Jennings—We would clearly support that. I think that our position on antismoking is very well known. I think smoking is one of the great burdens on the health system.

Senator CORMANN—I would like to spend a little bit of time considering the impact of people downgrading to cheaper policies. What is the effect from your members' point of view if there are more and more people going for cheaper private health insurance policies?

Mr Jennings—It probably means the safety net will increase.

Senator CORMANN—We are talking about privately insured people, of course.

Mr Jennings—The implication is that people downgrading will put pressure on premiums generally. There is a pooled arrangement and a degree of cross-subsidisation, so the premiums will rise. That is point 1.

Senator CORMANN—When we say people will go for cheaper policies, we mean they are taking exclusions and large out-of-pockets through the form of increased front-end deductions.

Mr Jennings—That is correct.

Senator CORMANN—What does that mean in practice? When privately insured people present at private hospitals, your members treat them and—

Mr Jennings—In practice it will mean two things. In some circumstances, because of the exclusions, they will go into the public system and increase demand on the public system. In other circumstances they will have greater gaps.

Senator CORMANN—The government have said that they expect 8,000 additional public hospital admissions, but that is based on their assumption that only 25,000 people will leave. Treasury assumes that nobody will downgrade their cover as a result of this, which I would argue is the most rational response for people to take. My question is this: the impact on public hospitals will be much more significant than what the government are telling us, won't it? Even people downgrading cover can result in more pressure on public hospitals.

Mr Jennings—Absolutely, because the cover would exclude certain services or put a gap on them, so people would choose to go into the public system.

Senator CORMANN—What were the circumstances in private hospitals and public hospitals towards the end of the eighties and in the early nineties in terms of utilisation, and what are the circumstances today? Some people have argued before this inquiry that increasing membership in private health has not resulted in less pressure on public hospitals. I just want you to give us a bit of a perspective as to what the circumstances in private and public hospitals were at the end of the eighties and in the early nineties and what the circumstances are now and to comment on whether or not increased private health membership has contributed to less pressure on public hospitals.

Mr Jennings—Firstly, the circumstances in the eighties and nineties before the rebate was introduced could be described only as dire. Private health insurance had slumped to around about 31 per cent and the projections were it would drop below 20. In other words, it would collapse. There were a number of authoritative people who stated that at the time. The effect of the rebate on community rating et cetera was to provide carrots to go back into private health insurance. What that saw was the escalation in demand on public hospitals for elective surgery basically stabilise. There has been very little growth in elective surgery demand on the public system in recent years. Elective surgery surged within the private sector and went back to levels that had not been seen for quite some time. That meant there was better access to the public system as well, which reduced the pressure on waiting lists.

If you look at the data—and, again, I think that the PHIA data shows this—you will see that the growth in the last five years plus of elective surgery has been principally in the private sector. The problems with emergencies in the public sector have had a lot to do with medical cases not surgical cases and so on. So there has been a balance and that has allowed the public system to cope to a greater degree, although it is still struggling, principally because of capacity issues. It is still operating in the metropolitan context at 93 to 102 per cent levels day in, day out.

Senator CORMANN—If it had not been for the private hospital sector absorbing a large part of the growing demand, what would have happened to the public system?

Mr Jennings—I think you would have again seen nurses deserting the system, doctors deserting the system, patients in longer and longer queues. I think the burnout and stress cannot be underestimated. That has been one of the big problems with recruitment and retention of nurses in the public system. The effect for patients would be increasing waiting lists and, as I indicated earlier, in terms of the research, further problems with access, leading to a reduction in quality and actually leading to deaths. That is well evidenced, well published and well peer reviewed.

Senator CORMANN—Do you think that the effect of measures like this and the measure last year will be a one-off effect or do you think there will be a series of second-, third-, fourth-round effects, where we will potentially go back into a downward spiral like the one that you have demonstrated in that graph occurred during the eighties and early nineties?

Mr Jennings—It is undoubtedly the latter. I should say that, in another life, I was offered a job by the Productivity Commission—I have economics qualifications as well. I look at it from that standpoint, not just from a straight medical point of view. You can go to the Access Economics analyses, going back to the initiatives. I talked about a salami slice at a time. When you aggregate the slices and you look at the multiplier effects and how they work through over time, it is undoubted that, as that graph indicates, the cumulative effect will be drops and slides, and the only issue is the magnitude and extent. If you get into an adverse selection scenario, where funds are left supporting sicker and sicker patients who are not supported under community rating by well patients at this point in time, and their costs per episode increase or the episodes per policyholder increase and their costs increase, then premiums are just going to escalate inexorably. That is what happened in the past when government cost-shifted onto funds when it removed the reinsurance pool and the other initiatives in the eighties and nineties. That graph can easily be replicated, and the only arguments are going to be about the magnitudes of the drops and the slides, not about whether there will be any.

Senator CORMANN—Just as a closing point: you mentioned that you thought there was little consultation with the states and territories. The evidence that we have had from Treasury and the health department federally is that there has been no consultation with the states and territories. Is that something that concerns you in the context of the commitment before the election to cooperative federalism on health and ending the blame game et cetera? This is the second time now that an initiative like this has been introduced that has a potential for significant impact on state and territory budgets and there has been no prior consultation with the states and territories. What is your view on that?

Mr Jennings—I think it is a tragedy. It is wrong. It is unfair to the states. It is unfair to patients, whether they are public or private. Everybody is disadvantaged by this move. It does not make any sense at all. I said last year, before the economics inquiry, that we hoped there would be consultation in the future. If the Commonwealth is committed to this, then logically it should commit to fully fund the states, both in a recurrent sense and a capital sense, to build the capacity necessary to deal with the fallout from this initiative. It did not last year. There were some one-off payments but not recurrent payments. This year, of course, the money it set aside for the education and hospitals funds was largely dispensed through the \$900 stimulus. So that has been withdrawn as well, and yet it has done this on top. It is sad.

Senator CORMANN—Thank you.

CHAIR—Thank you, Mr Jennings.

Mr Jennings—Thank you very much.

[11.49 am]

KELLY, Dr Shane Patrick, Chief Executive Officer, St John of God Hospital Subiaco, St John of God Health Care

CHAIR—Welcome, Dr Kelly. I let the last session go over time by 10 minutes, so I thank you for waiting and appreciate your patience.

Dr Kelly—It is my pleasure.

CHAIR—You have information on the protection of witnesses and parliamentary privilege. I invite you to make an opening statement and then we will go to questions.

Dr Kelly—Thank you for the opportunity. By way of background, St John of God Health Care employs some 8,000 working across 14 hospitals, with over 2,000 beds in WA, Victoria, New South Wales and New Zealand. We also operate a community hospice, pathology services, a major disability support service in Victoria and a wide range of social outreach and advocacy services in Australia, New Zealand and the wider Asia-Pacific region. Last year we admitted approximately 175,000 people into our hospitals. As a Catholic not-for-profit group, St John of God Health Care returns all profits to the communities it serves by updating and expanding technology and facilities, expanding existing services, developing and operating new services and providing social outreach and advocacy services to the marginalised—people who are oppressed, materially poor, powerless and disadvantaged.

Through Catholic Health Australia, of which St John of God Health Care is a member, we have assessed the likely impact of the proposed changes to the private health insurance rebate, and I must say our assessment differs significantly from that undertaken by Treasury. Clearly, the budget changes will result in substantial increases in the cost of private health insurance premiums, as we have already heard, for those who will lose access to the current 30 per cent, 35 per cent or 40 per cent rebate. In concluding that coverage of private health insurance will be around 25,000 fewer than it otherwise would have been, Treasury modelling on the impact of the changes makes a questionable assumption that the elasticity of demand for private health insurance is the same—that is, negative 0.2—for an individual on \$75,000 as it is for an individual on \$250,000. In other words, Treasury is suggesting that an individual on \$75,000 who faces a 10 per cent increase in their health insurance premium at an average cost of \$2,000, which represents 3.4 per cent of their take-home income, will react in the same way as an individual on \$250,000 whose premium also cost \$2,000, which represents only 1.2 per cent of take-home income.

In addition, Treasury modelling has not taken into account the likely very large downgrading in policies held by the privately insured in response to the large increases in premiums, as we have already heard this morning. Privately insured members subject to the Medicare levy surcharge can still avoid the surcharge by downgrading their membership from a comprehensive full cover style of product to one subject to high excesses and exclusions from a number of conditions. The impact of many members downgrading, especially by younger, healthier members, will be a reduction in the moneys available in the total insurance pool, resulting in higher premiums down the track, leading to a further negative impact on membership levels. This will particularly adversely impact on the one million privately insured members who earn less than \$26,000 per annum.

Analysis of the changes undertaken for Catholic Health Australia by Access Economics suggests that the budget changes could result in a reduction of up to 100,000 members nationally, leading to an additional 37,000 admissions to public hospitals. The measures in this year's budget build on the changes to the Medicare levy surcharge in last year's budget. Those changes are still forecast to result in a reduction of 492,000 privately insured members, as I understand has been confirmed in recent Senate estimates hearings. Taken together, the changes in the last two budgets are modelled to result in a reduction of close to 600,000 members and an additional 220,000 public hospital admissions.

The Australian Institute of Health and Welfare's latest *Australian hospital statistics* report shows the contribution of the private sector in Australia's health system, and the data supports the view that the private sector plays an extremely significant role in reducing the burden on the already overstretched public sector. Forty per cent of hospital separations—that is, 3.1 million out of 7.9 million in total—occurred in the private sector. In the last year, public patient separations increased by 1.9 per cent and separations for private patients funded by private health insurance increased by 6.7 per cent. Between 1998-99 and 2007-08, total separations increased by 37.3 per cent. Separations per 1,000 persons increased by 5.2 per cent for public acute hospitals

and by 39.6 per cent for private hospitals. The data indicates that private hospitals have substantially reduced the workload on the public hospitals.

Whilst any reduction in private health insurance membership will have a detrimental impact on our private not-for-profit hospitals and our ability to provide high-level care with quality equipment in facilities of a contemporary standard, it is the negative impact on public hospitals and Australians generally that is of concern. Logically, the decline in patient admissions and procedures in private hospitals will correlate with an increase in admissions to public hospitals. Waiting times for public elective surgery will therefore increase. Public hospitals are already struggling to meet their current workloads. The recently released *Australian hospital statistics 2007-08* report shows public hospital elective surgery waiting times have increased from a mean of 32 to 34 days. Additional demand from patients that were previously privately insured will only exacerbate this trend.

We also note that waiting times for elective surgery have increased, notwithstanding the additional resources provided by the Commonwealth for the last half of the year. Longer waiting times will impact on those with low incomes and impact most on those with low incomes, as it is low-income earners who face the longest waits for public elective surgery. These waiting times will particularly occur in specialties where the private sector plays a very large role, areas such as orthopaedics, involving hip and knee replacements, and ophthalmology, involving cataract removals and lens insertions, to name but a couple.

It is well recognised that the public hospital sector has insufficient staffed beds to cope with existing demand, and, at least in WA, population growth will continue to outstrip any growth in staffed beds for the foreseeable future, with the hospital reform program having a very long lead time, particularly in relation to constructing hospitals. Public elective surgery waiting list trends are clear evidence of the fact that there is no capacity to deal with the transfer of admissions from private hospitals to public hospitals that will occur if the private health insurance rebate changes are implemented.

I conclude and summarise by saying to the committee that the proposed changes should not be implemented. The existing private health insurance rebate should remain in place to maintain private health insurance coverage and the critical balance between private and public healthcare provision in Australia. Whilst acknowledging the difficulty in predicting human behaviour and factoring in all of the other variables that can influence private health insurance coverage and therefore being precise about the quantitative impacts of the proposed changes with respect to drop-out rates for private health insurance and the consequent changes in public and private hospital admission rates, it is clear that application of the rebate changes will have a detrimental impact on both the private hospital industry and the public hospital sector and ultimately therefore on the people in our communities who are served by one or other of these. The changes proposed in this legislation, as we have heard several times already this morning, breach the government's pre-election commitment to retaining the rebate in its current form. Thank you.

Senator CORMANN—Dr Kelly, did you believe the Prime Minister when in opposition he made an emphatic commitment that a Labor government would retain the existing private health insurance rebates? Did your organisation take the Prime Minister at his word?

Dr Kelly—Yes, of course we did.

Senator CORMANN—You would have heard that commitment repeated many times since the change of government.

Dr Kelly—Yes, we did.

Senator CORMANN—So did you see this measure coming?

Dr Kelly—No, because a number of parties sought reassurance on a number of occasions that that pre-election commitment was solid, and they received that reassurance.

Senator CORMANN—Policy changes like this at the federal level have the potential to have significant impact on your very sizeable operation and a flow-on effect on the people that you serve, don't they?

Dr Kelly—Absolutely, and it leaves us with a lack of confidence going forward for capital investment in private facilities.

Senator CORMANN—Can you just talk us through the impact that it potentially has on capital investment across your hospitals.

Dr Kelly—Clearly our ability to invest in capital to continue to provide the services in contemporary facilities and to expand those services to meet demand is reliant on how well our business is tracking. If we get to the point where we do not have sufficient capital to invest in capital, then obviously we cannot do that.

Senator CORMANN—In that context, perhaps you can talk us through the experiences, as far as you are aware of them, of the private hospital sector in Western Australia in the eighties and early nineties in terms of utilisation and viability as compared to what they are now. And perhaps you could look forward—what the impact is likely to be if changes like this continue to be introduced.

Dr Kelly—The private hospital sector was in dire straits in the mid- to late eighties and, really, capital investment was unheard of. There was not really the possibility or opportunity to invest or reinvest, and it was only the trilogy of changes to private health insurance that reinvigorated the industry and enabled it to once again invest in contemporary facilities. There has been considerable investment. For example, St John of God Health Care, even at my campuses, made a very substantial investment in upgrading the hospital and providing services to Western Australians, something that is now in doubt for the future.

Senator CORMANN—I just want to focus on utilisation. In the late eighties and early nineties, what was utilisation in private hospitals in Western Australia on average compared to now? What was the circumstance in terms of utilisation in public hospitals and waiting lists in public hospitals then compared to now?

Dr Kelly—I do not know the exact figures about the late eighties because I was in the public sector then, but I was certainly aware that the public sector was overflowing and the waiting lists were very long. But the private sector was underutilised.

Senator CORMANN—If it is too hard, tell us, but how difficult would it be for you to give us on notice the average utilisation in, say, the years 1991, 1992 and 1993 and compare that to utilisation in your hospital in 2007, 2008 and 2009? Would that be difficult?

Dr Kelly—I expect those figures are available. You have to take into account the utilisation measures of percentage occupancy and, of course, you have to factor in how many beds were available at the time. It is quite likely that there has been a significant increase in the number of beds in the private sector over that time.

Senator CORMANN—Let's get to that. Essentially, we have received evidence that increasing private health insurance membership has not contributed at all to taking pressure off the public hospital system. Would you comment on that from your point of view.

Dr Kelly—I think I already have by quoting those figures from the Australian hospitals report and the Australian Institute of Health and Welfare report. It has been a very significant impact. As you well know, up to 50 per cent of surgery is undertaken in private hospitals.

Senator CORMANN—Earlier Ms Kosky quoted a conversation she had with you when you were the head of the Fremantle hospital and I promised to relate the details. Essentially, she made the point that private hospitals cherry-pick and take the easy cases whereas public hospitals take all of the complex stuff and that that is the view that you might have held in the past when you are running a public hospital. Would you care to tell us about the circumstances from your point of view.

Dr Kelly—I am humbled that Ms Kosky would take notice of something I said to her many years ago. I think it would be true to say that, once upon a time in the dark past, private hospitals did the less complex work in the community. That has certainly changed over the last decade and, compared to 10 years ago, we certainly provide high complex surgery and high complex medical care at a par with the state public hospitals. It would be fair to say that the state hospitals do some things that are not done in the private sector, for obvious reasons such as logistical reasons and low-volume reasons such as transplant work, but they are the exception to the rule these days.

Senator CORMANN—Did you mention in your opening statement—I might have missed it—the cumulative effect in terms of additional public hospital admissions of the two measures, last year's measure and this year's measure?

Dr Kelly—Yes.

Senator CORMANN—What was that figure?

Dr Kelly—The cumulative effect is anticipated to be about 600,000 fewer members than would otherwise have been, with about 220,000 additional admissions to public hospitals.

Senator CORMANN—Have you done any work locally as to what that means for Western Australia?

Dr Kelly—No, but as a rule of thumb Western Australia is normally impacted about 10 per cent of the national figure—so we would expect about 22,000.

Senator CORMANN—There seems to be general agreement, including from those that support this measure, that the most rational response for people with private insurance who will be affected by this directly because their premiums will go up—and they are also faced with the Medicare levy surcharge stick—will be to downgrade to a cheaper policy, which of course means additional exclusions, higher out-of-pocket expenses. Can you talk us through what that will mean practically, on the coalface, in your private hospitals.

Dr Kelly—Practically it means that, with the exclusions, they will not be able to be admitted to our hospitals, so they will go to public hospitals and add to the waiting lists there. There will be greater out-of-pockets, which drives further disincentive for maintaining private health insurance. Their total contribution to the insurance costs will be less, meaning that premiums will inevitably increase. These things have been assessed as well by the Access Economics review that was undertaken.

Senator CORMANN—Did the Access Economics review include an assumption on how many people would downgrade their cover?

Dr Kelly—Yes.

Senator CORMANN—There is a big discrepancy between the figures. The federal government says 8,000 additional as a result of this measure, so that is not taking into account the Medicare levy surcharge change. You say 220,000 as a result of both, but that includes an assumption that people will downgrade their cover and the effect of that.

Dr Kelly—That is right.

Senator CORMANN—Do you think there will be only a one-off effect or do you think there will be a series of effects over a period of time as a result of measures like these?

Dr Kelly—I think it is likely to be the latter. You can look at the history, in the graph that was given to you by Mr Jennings from the AMA. Typically what happens with these sorts of changes is that there are progressive changes over time.

Senator CORMANN—There will be additional increases in premiums that will build on each other; there will be additional drops in membership.

Dr Kelly—Yes.

Senator CORMANN—And there will be additional pressure then on public hospitals as a result.

Dr Kelly—Yes.

Senator CORMANN—And you will be impacted in terms of your investment in your private hospital infrastructure. Have you been asked by the department to participate in any implementation processes in relation to this?

Dr Kelly—No.

Senator CORMANN—Do you know whether your peak body has been asked to participate in any implementation processes?

Dr Kelly—No, I am not aware of that.

Senator CORMANN—Since the measure was announced, have you been consulted in any way by the federal Department of Health and Ageing about practical implementation?

Dr Kelly—No, there has been no consultation.

Senator CORMANN—I might leave it at that and perhaps come back after others have asked some questions.

Senator SIEWERT—Dr Kelly, is the Access Economics report that you are referring to the recent one that Catholic Health Australia has done?

Dr Kelly—That is right.

Senator SIEWERT—My reading of it—and maybe I am misinterpreting it—is that they are broadly supportive of the Treasury modelling, other than the issues that we have been talking about, around possible downgrade, and the ancillary cover issue. The final conclusion in their executive summary says:

The broadening definition of MLS income will have a minor positive (thus offsetting) impact on PHI coverage as well as lifting MLS revenue.

I suppose the interpretation of that is in the eye of the reader, because you said you do not agree with Treasury modelling, whereas this report has found that they broadly agree with it, and, secondly, they are saying it looks like it will be a relatively minor impact.

Dr Kelly—Perhaps it is in the eye of the reader. I did not read it as them saying they broadly agreed with it. I think they said it was within the realms of possibility. Yes, I agree that they said the changes to the MLS will have a slightly positive effect, but they did not quantify it. They still came to the conclusion that up to 100,000 people would be adversely affected—people who would otherwise have private health insurance would drop that cover.

Senator SIEWERT—They say:

... we reached broadly the same conclusions regarding coverage as the Treasury based on our conceptually quite different scenario analysis.

So they have come from a different angle but have come to the same conclusions.

Dr Kelly—Except they have come to different figures in terms of the impact.

Senator SIEWERT—My interpretation of their final sentence is that they are interpreting that to say that there is a relatively minor impact because one will offset the other. Now, that is the position that Treasury are putting as well because the increase in the MLS will force more higher-income earners into private health insurance, which is a carrot-and-stick approach.

Dr Kelly—The Access Economics report did indicate that there would be a small increase as a consequence of the increase to the MLS.

Senator SIEWERT—Treasury are saying that that will be around 130,000 people.

Senator FURNER—Not increased; they will be impacted.

Senator SIEWERT—I beg your pardon, they will be impacted and could be encouraged into private health insurance. The other proposition that is pointed out by people who are supporting this measure—such as Ian McAuley and Dr Deeble—is that the maximum increase is the difference of three cups of coffee per week. In other words, it is not going to have such a significant impact that it would force people. Because the response to price is fairly inelastic people will not be jumping out of private health insurance—because of the value they place on it.

Dr Kelly—That was one of the issues that the Access Economics report raised: the assumption that the price inelasticity was as low as it was.

Senator SIEWERT—But I think they largely agree with that.

Dr Kelly—That was not my interpretation.

Senator SIEWERT—Well, I thought that they broadly agreed with the inelasticity to price. I also found it interesting that the private health insurance industry—I think it was the association—was quoting figures about response to insurance that were based on general insurance. I must admit I was quite surprised about that, given that I thought they would have a pretty good understanding of consumers' response to private health insurance, which I think is fairly well known to be much more inelastic than general insurance. Are you basing your assumptions on the Australian Health Insurance Association's assumption of a broader elasticity to price or on inelasticity to price?

Dr Kelly—Well, I was basing them on the Access Economics report.

Senator FURNER—With respect to the Access Economics report, on page 9—

CHAIR—Do you have a copy, Dr Kelly? As Senator Furner is quoting it might be useful if you had your comments as well. Read it into *Hansard*, Senator Furner.

Senator FURNER—On page 9, half way down, under the heading, 'Price inelasticity assumption' it says that 'Treasury's assumption does not appear unreasonable'. It is referring to that upper bracket of higher-income earners and the effect on their capacity.

Dr Kelly—It then goes on to say that it is a reflection of a judgment as opposed to being based on strong empirical evidence.

Senator FURNER—That is right. So I guess it comes down to how you model something. That is the basis of some of the arguments in the modelling of Access Economics as opposed to Treasury's processes. It also indicates, on page 5, in terms of the downgrading effects, that it reduces rebate expenditure. I guess that is a plausible argument, because if people do downgrade that is naturally going to be a reduction in the access to ancillary matters as a result of a policy holder. And in turn it will not have such an impact on the overall fund and in general have bearings on reductions all around. I would be interested in your comment on that.

Dr Kelly—I think that is a reasonable conclusion.

Senator FURNER—Have you had an opportunity to have a look at some of the other submissions to this inquiry—like those from Mr Wells, Mr McAuley and Dr Deeble?

Dr Kelly—No, I have not.

Senator FURNER—They draw conclusions on a variety of things. In particular, Mr Wells refers to the Roy Morgan research data indicating that you get the answer to the question you asked based on how you ask that question. He goes on further to indicate that it certainly does prejudice the overall findings in that research data.

Mr Wells also indicates that there is no real evidence on premiums going up or down. If you refer to the likes of what you have just concurred with the downgrades, it is plausible—it has not been determined—that there will be no reduction or increase in premiums as a result of that occurring. Over the last couple of days, we have also heard—and I think Senator Siewert touched on this—that about 130,000 people will be affected by the changes to the Medicare levy surcharge and that there is a likelihood that some of those people will move to private health insurance as opposed to continuing to pay the surcharge.

Dr Kelly—You would expect that there would be some. They also have the option of taking up the lower products.

Senator FURNER—Of course. Naturally, they will take up some form of health insurance as a result of getting out of paying the surcharge.

Dr Kelly—The Access Economics report indicated that there would be a small impact as a consequence of that. But I do not recall it quantifying it to the extent that it would offset entirely or to any great degree the impact of the rebate changes.

Senator FURNER—You indicated in your introduction that you have 8,000 employees throughout your 14 hospitals?

Dr Kelly—That is right.

Senator FURNER—Are the 8,000 in Australia or does that figure also include New Zealand?

Dr Kelly—It includes New Zealand, but that is a very small service.

Senator FURNER—How many people would be employed in New Zealand?

Dr Kelly—Probably only a couple of hundred.

Senator FURNER—In general, would those employees in Australia be on enterprise agreements? What sort of employment instrument would they be on?

Dr Kelly—It varies from professional to professional.

Senator FURNER—Are you able to give me some indication of what they might be employed on?

Dr Kelly—I am curious as to the reason why this question is being asked in this context?

CHAIR—Dr Kelly, the questions flow. If you choose not to answer it that is your prerogative, but there is no problem with the senator asking the question.

Dr Kelly—We use a variety of instruments. Some are on AWAs, some are on EBAs and some are under awards.

Senator FURNER—We would no longer employ anyone on AWAs. Certainly there is a time lag there.

Dr Kelly—Historically, there are a small number of people on AWAs.

Senator FURNER—But, in general, if you had to give an answer, would the majority be employed on enterprise agreements?

Dr Kelly—Yes.

Senator FURNER—I am just looking at your submission with regard to your capacity as an organisation to remain sustainable into the future. You put up as an argument that, should these things be implemented, there might be circumstances whereby your capacity could be limited.

The minister, in summing up her second reading speech on the legislation to parliament, indicated that last year COAG had undertaken to put \$64 billion into the public hospital system. That is an increase of 50 per cent over and above the old Australian Health Care Agreements negotiated by the previous government. There was a further historical \$872 million investment in preventative health. If we are going to argue that there will be an impost on the public health system as a result of these proposals, surely those types of initiatives will to some extent go towards addressing the issues that you and other people have raised before this committee.

Dr Kelly—As a taxpayer, I would certainly hope that they are going to have some positive impact. I would expect, though, that a number of them and particularly things like the preventative health measures have a very long lead time and, in the meantime, we need to have a critical balance between the private and the public health industries to ensure that people have access to services.

Senator FURNER—Earlier today, we heard from the Health Consumers Council of Western Australia. Their philosophy is that the proposal for this bill restores equity in the system. What is your point of view on that sort of statement?

Dr Kelly—I think I have made our position fairly clear: we do not believe this is in the interests of the Australian public. It is going to have an adverse impact on both the private health industry and on the public health industry. So we do not think that is an equitable outcome at all.

Senator CORMANN—Just going back to the Treasury modelling, Senator Siewert mentioned how access Economics broadly agreed, but of course, that was conditioned by the reference to the number of people downgrading cover. That is a pretty significant condition on the assessment of it, isn't it?

Dr Kelly—I think it was one of the key observations that the Access Economics folk gave to Treasury's assumptions: they did not take into account the downgrading of policies.

Senator CORMANN—Treasury told us that 2.3 million people will be impacted by this directly, because they will have a reduced rebate or the rebate abolished altogether. So to think that none of them would downgrade their cover is a very heroic assumption, isn't it?

Dr Kelly—The effective increase in the premiums as a consequence of losing the rebate in its entirety, or partially losing the rebate that they currently get, is clearly going to result in people looking to find cheaper measures—the obvious way is to downgrade your policy.

Senator CORMANN—Treasury also excluded 1.4 million people with private health insurance from the modelling because they did not have income data on it. That is more than 10 per cent of the privately insured population. That is a significant number of people who were not taken into account.

Dr Kelly—Yes, they are big numbers.

Senator CORMANN—Over the last 10 years, St John of God has invested quite significantly in additional capacity, certainly in Western Australia—I am not so aware of what has happened in other states. Can you just talk us through how many additional beds and what sorts of sums of money we are talking about in terms of your investment in private hospital infrastructure in Western Australia?

Dr Kelly—In Western Australia in recent times there has been about \$120 million of investment at St John of God Hospital in Subiaco, which has created additional infrastructure in terms of beds, theatre capacity and endoscopy room capacity. There have also been expansions and investments at the next largest of our hospitals—at St John of God, Murdoch—again resulting in increased capacity in beds and theatres. There have also been significant investments in some of our eastern states hospitals—such as St John of God Ballarat, with a \$65 million investment in recent times. There has been investment in a number of other hospitals as well.

Senator CORMANN—And that was to cater for growing demand in what you anticipated to be the growth trends into the future.

Dr Kelly—Correct.

Senator CORMANN—The changes in federal government policy will now have an impact on those utilisation trends, moving forward

Dr Kelly—Yes, and when we made our capital investments we had to make an assumption that the trilogy of measures in place to maintain private health insurance would continue as they were. So it is disappointing that, having made those investments to serve the people of Western Australia and Australia, these changes are now looking to come in.

Senator CORMANN—Across your two major private hospitals in Western Australia—at Subiaco and Murdoch—what is your utilisation at present?

Dr Kelly—Our mean occupancy at Subiaco is about 75 per cent and our mean occupancy at Murdoch, which has an emergency department, is about 85 per cent.

Senator CORMANN—I know we have gone on about this before, and I will leave it at that after this, but it is fair to say that this is higher, even though you have additional capacity now, than what it would have been in the late eighties and early nineties?

Dr Kelly—Certainly; yes.

CHAIR—Dr Kelly, could we have your annual reports for the last four or five years, just to have a look at the financial process in your organisation?

Dr Kelly—Sure.

CHAIR—Is that something that you could provide to us, so that we could see the growth and also the profit in terms of investment?

Dr Kelly—Yes.

CHAIR—That would be very useful. One of the difficulties I have in this process is in trying to come down to the actual amount that people are going to have to pay. The Australian Health Insurance Association has done some modelling on this. It is very difficult because every private health insurance package is different.

Dr Kelly—Yes.

CHAIR—It surprises me that they claim that it is not complex. In terms of process I am looking at their figure for an average premium—and I take that basis. If you are earning between \$75,000 and \$250,000 as a single person, their perspective is that the increase ranges from \$181 a year to \$544 over a year. The maximum possible impact is \$544 for the year, which, over a 12 month period on an income of \$250,000 does not seem to be such a major impact.

When you go into families, it ranges from \$150,000 up to \$500,000 and the change in the premium is from \$363 to \$1,088. The absolute maximum increase under this proposal, for an income of over \$500,000, is \$1,088. Allowing that we are talking averages, I am interested to know, from your perspective, with the cost of medical processes and gap costs, why those figures are seen as so high, from a perspective of arguing why people would drop out.

Dr Kelly—I think it comes back to the issue of the community rating we have in place in our industry and the fact that it relies very heavily on the relatively young and well to be insured. If you are hit with another \$1,000 why wouldn't you question whether or not you need that product?

CHAIR—When, as a single person, you earn more than \$120,000 per year.

Dr Kelly—Potentially.

CHAIR—Actually, there is no way a single person would be hit with another \$1,000 because on this impact the highest is \$544. If you have a combined income and you are a young, healthy person, it would go to an extra \$1,000 per year at an income of \$244,000.

Dr Kelly—And they are the ones who are likely, if they hang on to their insurance, to go to a lower product. I hope you are right; I hope the impact is minimal.

CHAIR—I am not making a statement; I am just trying to understand the process.

Dr Kelly—The information we have, having looked at the Access Economics report, is that it will have an impact.

CHAIR—I have no doubt that there will be people who will make different choices. That is the whole basis of our system—that people have information on which basis they can make a choice. It is just that the discussion around the introduction of a means test for people earning over \$75,000—that is, the lowest income that this can impact is \$75,000—seems almost to be on the basis that the whole of the rebate is gone and that

this is not a removal of the rebate; it is actually an imposition of a means test on a segment of people who are impacted.

Dr Kelly—I understand that.

CHAIR—The arguments we have heard seem to be premised on the fact that it is going to end the whole involvement. I am fascinated by the discussion around the impact on private hospitals. Do you, as a private hospital administrative organisation, know the income basis of the people who come into the hospital?

Dr Kelly—No. We do not collect income information from our patients.

CHAIR—In terms of the interaction between the hospital and the people using the service, you would know when people have private health insurance because the first question you are asked, almost as you come in the door, is, ‘Do you have private health insurance?’ The fact that people do not does not stop them having the service; is that right? It is just that they have to pay for it.

Dr Kelly—That is correct.

CHAIR—From your records, do you have any indication of how many people who do not have private health insurance actually use your system?

Dr Kelly—About five per cent of our admissions.

CHAIR—And that is across the board?

Dr Kelly—That is right; yes.

CHAIR—These are certainly some of the questions I am putting on notice for the private hospitals group as well. We ran out of time with them. In the study you have done of the whole issue—I know it is deeply important to you—have you had any discussion about or do you have any understanding of the personal impact in terms of dollars?

Dr Kelly—Personal impact?

CHAIR—For people. In our discussion, percentages have been thrown around: 43 per cent, 60 per cent and those types of figures. Have you or your organisation been able to bring that back to a dollar amount? I know you are part of the Catholic health network as well. Has the individual aspect of it—by how many dollars a week it is going to impact on people—been something you have looked at?

Dr Kelly—I think it is fairly easy to translate the percentages into dollar terms, knowing what an average premium costs.

CHAIR—And allowing for the variation in premiums, because there is a great variation.

Dr Kelly—There is a great variation.

CHAIR—Okay. Thank you very much for your patience. I have also been asked by Senator Adams to let you know that she would have been here if she had not been elsewhere with the medical system.

Senator CORMANN—I think she may have been in your establishment, actually, Dr Kelly.

Committee adjourned at 12.30 pm