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Reference: Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

WEDNESDAY, 6 AUGUST 2008

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SENATE STANDING COMMITTEE ON

ECONOMICS

Wednesday, 6 August 2008

Members: Senator Hurley (*Chair*), Senator Eggleston (*Deputy Chair*), Senators Bishop, Bushby, Joyce, McEwen and Webber

Participating members: Senators Abetz, Adams, Allison, Barnett, Bartlett, Bernardi, Birmingham, Boswell, Boyce, Brandis, Bob Brown, Campbell, Carol Brown, Chapman, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Ellison, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Heffernan, Hogg, Humphries, Hutchins, Johnston, Kemp, Kirk, Lightfoot, Lundy, Ian Macdonald, Sandy Macdonald, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Moore, Murray, Nash, Nettle, O'Brien, Parry, Patterson, Payne, Polley, Ronaldson, Scullion, Siewert, Stephens, Sterle, Stott Despoja, Troeth, Trood, Watson and Wortley

Senators in attendance: Senators Bushby, Cameron, Cormann, Eggleston, Furner and Hurley

Terms of reference for the inquiry:

To inquire into and report on: Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

WITNESSES

Committee met at 2.00 pm

BOWDEN, Mr Richard, Deputy Managing Director, BUPA Australia

CHAIR (Senator Hurley)—I declare open this meeting of the Senate Standing Committee on Economics inquiry into Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008.On 18 June 2008, the Senate referred the bill to this committee for report not before 26 August 2008. This bill increases the Medicare levy surcharge threshold for individuals from $50,000 to $100,000 and for couples from $100,000 to $150,000. The increased thresholds will apply from the 2008-09 year of income and later years of income. This is the fifth public hearing for this inquiry, the committee having taken evidence in Perth, Brisbane, Adelaide and Sydney. These are public proceedings, although the committee may agree to a request to have evidence heard in Canberra or may determine that certain evidence should be heard in Canberra. I remind all witnesses that, in giving evidence to the committee, they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as contempt. It is also contempt to give false or misleading evidence to a committee. If a witness objects to answering the question, the witness should state the ground upon which the objection is taken, and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to exist on an answer, the witness may request that the answer be given in camera. Such a request may, of course, also be made at any other time.

I welcome Mr Bowden from BUPA Australia. Would you like to make an opening statement?

Mr Bowden—Thank you. I will just spend five minutes, if I could, to put into context BUPA Australia for you. BUPA Australia supports the healthcare needs now of just over three million Australians through brands that you would know as HBA, MBF and Mutual Community. BUPA also acquired the aged care businesses of Amity Aged Care last year. Our brands have been in this country for over 70 years, whilst BUPA has been owners of this business since 2002. BUPA is one of the world's leading health and care companies.

If I could, I will spend just one minute to give you a snapshot of BUPA. We insure about 10 million people around the world, in about 200 countries. We also provide wellness, hospital and aged care services to thousands of people every day. BUPA is in fact a provident. It has no financial shareholders, so any surpluses of profits made in the group are reinvested for the benefits of our customers. Put simply, BUPA Australia at a local level is a for-profit registered health insurer.

In terms of our corporate structure we pay tax in Australia but, as we say, we are part of the BUPA Group, so we have a mission driven social enterprise. The BUPA Group has invested over $4 billion in the Australian market since 2002 by building a private health insurance and aged care business. BUPA Australia has an enviable performance in the market by being focused on its customers. We have had premium increases below the industry average for each of the last seven years and management expenses below the industry average for each of the last seven years. In June this year, we combined with MBF to create the largest health and care organisation in Australia and are now rivalling Medibank Private in terms of coverage.

From my context within BUPA, Australia has a health system that really is the envy of the world in terms of mix of public and private, and the key tenant of this is actually keeping this system balanced so that people in private health insurance can have access to affordable private health care. Importantly, that access has a direct relationship through to the public facility, and it really unclogs the straining public system. Over the last decade, the federal government has demonstrated its commitment to the private health insurance industry through initiatives that you would know well as the private health insurance rebate, lifetime health cover and the Medicare levy surcharge. We see that these three initiatives work in an inter-related way and each of them is an important cog in that balance of private and public.

I am sure you have heard in previous submissions as well that another underpinning feature of the Australian private health insurance market is the community rating principle, which means irrespective of age, gender or status, you cannot claims risk or you cannot set a price for risk. Therefore, the average risk of the insured population is borne by all customers in the sector, an important element for this change. Age is the major factor in determining premiums that we need to cover, and the higher the average age of the book of customers, if you like, the greater average utilisation. So, as a rule of thumb, if an average age moves by one year, you need about a five per cent increase in risk to cover that average increase. The MLS is likely to have both a one-off impact and, we believe, an impact in terms of ongoing coverage of customers, and therefore future average age. This is especially important in a community rated environment, and I am happy to take questions on that.

The policies that support private health insurance in this country have improved the age mix. It has allowed a whole number of people to participate in the sector that would not have been able to participate if it had not been in place. Importantly, it makes it possible for low and middle income earners to afford private health cover. As you know, the wealthiest of Australians will always be able to afford access to private care or private insurance, so any additional pressure on premiums or risks will be hardest hit on low to middle income earners. Of course, this includes some of the greatest consumers of health care services in this country who are likely to do virtually anything to maintain their cover.

Something I know that has been discussed at great length has been the impact of the exodus or the focus on the numbers, and whilst there is a range of estimates around about how many might leave, it will impact the public sector, regardless of which estimate you might think to believe. We are talking about hundreds of thousands of lives falling onto the public system. Whilst the government subsidy of 30 per cent of cost of hospital cover might be a cost saving for the government, the 70 per cent that is funded by the private insurers basically represents a very large number of dollars that will essentially go out of the sector, because if you accept the principle of community rating, the contributions those individuals are making, whether it is for a claims risk for them or the rest of the customers or policy holders in the system, that money will disappear from the system. We estimate that close to $3.8 billion will disappear as a contribution to the health sector generally as a result of this change, based on the forecasts. So BUPA is committed to ensuring a sustainable and affordable track record for premiums for our customers. As I said before, we have a strong track record in delivering that. We have had below industry average premium increases for every year of the last seven years, and certainly the recent merger with MBF puts us in a better position to be able to respond to whatever challenges are happening in the market. We are increasingly focusing, however, on improving the health of our customers, so we are getting actively involved in wellness programs, chronic disease management programs, prevention and wellness more generally.

In conclusion, the fundamentals that make PHI attractive are still very strong in our product. So, choice and access to care when you need it, at the time you need it and in a facility when you need it, are really important valuable contributions to our product. Australians recognise the value of this product and the argument about how much is being influenced by the government incentives, but they are voting with their feet with close to 60 per cent of elective surgery now happening in the private sector. Millions of middle to low income earners and families who are not currently subject to a Medicare levy surcharge already and will continue to contribute to private health insurance. We believe that the choice of whether you are covered for private health care should not just be something for the wealthy. As one of Australia's leading providers of insurance, we warmly welcome the government's continued support of the lifetime rebates and the 30 per cent lifetime cover. We are concerned that the MLS threshold will have the potential to put choice out of the reach of some Australians, particularly those low to middle income earners, and at the same time, it will put additional pressure on the costs of an already straining public system. All of this, in our view, will be a net financial impact; it will likely be a cost to government, not a saving to government, and from where we sit, that equation just simply does not add up. Thank you very much for that.

Senator CORMANN—Mr Bowden, BUPA operates both in the British and the Australian markets. In Britain, they have a very different policy approach, I guess, to hospital service delivery. Can you describe for us how that impacts on you and how that is reflected in the demographic profile of your membership and the services you are able to provide in Australia, as opposed to Britain? You say we have a health system that is the envy of the world. Can you put that into context for us in light of the unique perspective you have as an organisation that operates in both markets?

Mr Bowden—Sure. BUPA operates in a number of overseas markets, and I am happy to use the UK example. First of all, the principle of the fundamental difference at the very start between the two systems is that the UK system is a risk based insurance system. Australia is a community rated open enrolment system, so in the Australian environment, even if you wanted to avoid taking on board a customer for some reason, or you wanted a price for it, you cannot do it by law, whereas the UK system, by law, is a risk rated system and you can charge premium based on the risk of the customer or you can exclude or decline coverage, so it is a totally different marketplace. That has driven some different things in the system. First of all, the percentage of population—and I take note of the accuracy—I think the percentage of population insured in the UK system is about 11 per cent. It might be 12 or it might be 10, but I think it is about 11 per cent, so you have a low proportion of people participating in the sector. Therefore, you have a big focus on employers who sponsor private health, because it is seen as a valuable thing to be not necessarily just relying on the public system. What that means for services provided in the private sector, you would have to say a lot of high end services

are covered more in the public sector than the private sector in the UK. That is starting to change, but it is only starting to change because the UK government is starting to outsource public beds to private facilities.

Senator CORMANN—To put my question into context, I think the policy challenge for any government is to ensure that its population has access to timely and affordable quality hospital care, and I guess the UK has gone down a particular path which is nearly exclusively public with private health insurance for the very rich or for people who are employer sponsored, whereas in Australia, we have a more balanced and more mixed health system, where you have a free and universal public hospital system that is available to everybody, but complemented by the private health system for those who are able to make an additional contribution. I guess I am just trying to understand, from your perspective, where you see the advantages in the Australian system compared to the British system?

Mr Bowden—I think, overwhelmingly, it is certainty for customers. You know you can get insurance when you want it. You can buy it and be covered, and the range of services is much broader, as an example.

Senator CORMANN—And is it fair to say that, in Australia, there are more people of low and middle incomes that take out health insurance?

Mr Bowden—Absolutely. We do not have income levels on our customers, but if you see the research in the AHA paper from ABS or someone from 2005, a high proportion of people who are low income earners are still able to afford the product.

Senator CORMANN—You mentioned community rating. There is commentary around that all that health funds need to do, in terms of managing the impact of this measure, is provide more attractive products for young people, for the young and healthy. Can you just explain to us how community rating impacts your capacity to offer very attractive products to the young and healthy?

Mr Bowden—I would say products are reasonably attractive to young and healthy now, but there is a price for it. Young people believe they are infallible and bullet-proof, but the large majority of young people are buying products that exclude some of the more high end services, so I would say the pricing so far on youth products is probably about as low as it can get. They are still making a contribution to the community rated principle, but less of a contribution than perhaps some people might—

Senator CORMANN—Is there much more capacity for you to be more attractive on price with young people?

Mr Bowden—I think it is at the margin, Senator.

Senator CORMANN—All right. You mentioned the system would lose $3.8 billion. Have you done your own modelling, and can you maybe explain to us how you came to that figure?

Mr Bowden—We have done our own modelling for our customer base. What we have done on that $3.8 billion is just take the projections in the AHA industry proposal, which came from Treasury estimates. You might say that is worst case example, but we have taken those numbers, and we have done our own estimate of what we think would happen if it is implemented in our customer base, but that is how we came up with the $3.8 billion.

Senator CORMANN—Have you done any modelling on how this measure will impact on your membership base and how many members would you expect to lose, and what would be the impact on premiums? What is your expected reduction in revenue from private hospital insurance?

Mr Bowden—Sure. We have, and it is a very difficult thing to project, but we have a range of what we think can happen, based on the existing proposal. We sort of call it the shock lapse, that if implemented, we will see almost an immediate impact of people dropping their cover. We think the range for us is somewhere between losing 4.5 per cent of our customer base to 7.5 per cent of our customer base, and we think that the impact on pricing, for 4.5, we think incrementally the price would go up by 2.5 per cent, so above whatever is sort of an underlying claims inflation, and for 7.5, it would be 4.5.

Senator CORMANN—In that context, federal Treasury has made its costings based on the assumption that there will only be a one-off reduction in membership. Do you think it is a realistic assumption there will only be a one-off reduction in membership, or do you think that this could be the start of a new downward spiral, I guess like we experienced in the eighties and early nineties? You touched on this in your opening statement, and I am wondering if you could give us a bit more detail on your views on this?

Mr Bowden—Yes. We do think there will be impact. There are two things in running a health insurance customer base—the level of new sales coming in and the lapse rate from the existing book, and we think both

will be impacted. We will get a one-off impact, but over 60 per cent of our new customer sales is in the age range between 20 years and 34 years of age, every day or in every year. We think that is the area that is likely to be impacted in a major way, so we think it will impact new business levels and increase lapse. I think we certainly will see a period of flattening out or minor losses to the book going forward.

Senator CORMANN—Looking at the three pillar policy and accepting that they are all important, is it fair to say that in recent years, the Medicare levy surcharge with the thresholds of $50,000 and $100,000 respectively has become increasingly effective in light of CPI and rate increases?

Mr Bowden—You would expect me, as a managing director of a health fund, to say we want to maintain the thresholds as they are, because we really believe in our product and we really believe that we are giving value to our customers. There is no doubt it has had an impact, as people go and make their tax return, and say, 'You could save this much of your tax if you were privately insured,' and if you can privately insure and buy it for the same value as a tax loss, of course it has had an impact.

Senator CORMANN—Do you think that people who earn between $50,000 and $100,000, who also take out health insurance, are equally deserving of a tax cut as those who do not take out health insurance, if the government takes the view that those people in those income ranges do it tough?

Mr Bowden—I do not think it is my job, Senator, to advise the government on tax policy.

Senator CORMANN—I guess the context is this: the government says the reason it wants to increase the threshold is because people between $50,000 and $100,000 are doing it tough, and essentially this measure is a 1 per cent tax cut for people in those income ranges. The reality is that there is a whole range of second round effects, which Treasury, the health department and others have told us, that they have not assessed because it is not relevant to what they have to do. My contention is that if there is a significant impact on the privately insured in terms of increased premiums, if there is a significant impact on public hospitals, should not the government, in your view, be exploring alternative tax measures to address what it is seeking to address without having these sorts of secondary effects?

Mr Bowden—I understand the argument. From my perspective of a private insurer, you have to stand back and say what is the contribution people are making across the whole health system, and I would argue that people with private health insurance are making a higher dollar contribution. Yes, they are getting value from that in terms of insurance as well. Do I think the government is getting a good deal for its 30 per cent? I think it is, and I think it is making a very strong contribution, but I do not think it is my job to comment on tax policy.

Senator CORMANN—Were you consulted about this measure before the election or were you given any indication before it was announced?

Mr Bowden—No, I was not.

CHAIR—Mr Bowden, those people that do take out private health insurance in Australia get a 30 per cent tax rebate as well, and you mentioned the United Kingdom system where employers might assist employees out of their wages agreement to take out private health insurance, but the government there does not have a similar system of assistance?

Mr Bowden—No, it does not. As far as I am aware, the employer does not get any tax advantage. However, the employer does not pay any fringe benefits tax, to my knowledge, whereas in the Australian system, if you are an employer and pay for someone's insurance, you pay fringe benefits tax.

CHAIR—The private health system in Australia gets quite a degree of government benefit, and this is one of those pillars of the tax surcharge. It was originally intended for high income earners, rather than the bulk of the population, and the government has said this is redressing that situation. Why is that unfair? Is it unfair? I know it may impact you badly, but it is not necessarily unfair to the people who then are given greater choices to whether they take out private health insurance or not?

Mr Bowden—As I said, I am the managing director of a private health fund. I am presenting the value. I think every one of those customers who comes on board gets good value, and will continue to get good value. I hear the argument about fairness. We have a tax system where the higher the income level goes up, the higher you pay and that applies across the board.

Senator CAMERON—Mr Bowden, in some of the submissions we have heard, there is a bit of a Chicken Little approach: the sky is falling in on the private health funds because of this change, but when the Treasurer, Wayne Swan, introduced the bill, he indicated that this was about bringing back the position when the levy

was originally introduced, and that is about 8 per cent of single people above a threshold would be caught with the tax impost. This will bring it to 8.5, so if the health funds could grow in the period when the initial impost was put in place, what is the difference now if we are bringing it back to that level that the sky is falling in, with some of the submissions we have heard?

Mr Bowden—I had not heard that number of 8.5 per cent. I think the issue here is one of the cycle gets broken on insurance. One of the reasons why private insurance in this sector has been growing is that the fundamental principles have been in place to support it, those three things that we have already spoken about. But what we are seeing, year on year in the sector, is actually growth in more new customers coming on board than those that are leaving essentially. Once that cycle starts to go the other way, and it could just be as a result of the shock lapse, whether you accept our numbers somewhere between 4.5 and 7 percent or the top end at 10 per cent, I think the growth rate for the last 12 months was about 4 per cent net, so what you are going to see, if you have the 10 per cent, is a 6 per cent loss in customers, and you would see higher prices as a result of that move. So, for a number of years, you might actually see prices actually drive more people out of the sector. I think it is the impact of the one-off shock. That would be my view.

Senator CAMERON—One of the arguments we have heard on the committee also is that the competition within the industry really relies on the government support. You do not really have a true market in the normal sense of a market in the private health industry. We have had evidence here that some managing directors have had bonuses over $1 million to privatise. Does this not affect the premiums that people pay and is there not a responsibility on the private health funds to operate in a very conservative way in the context of how they operate and provide salaries rather than if they are relying on the public purse to such an extent?

Mr Bowden—I understand the argument. I always go back to customer value. As I said before, the BUPA Group is a provident or a limited by guarantee company, so it is not dissimilar to the structures of HCF in New South Wales or the like. Having said that, we have been a for-profit player in this market for some time, paying tax and doing all those sorts of things. Whilst we have been doing that, we have been delivering lower price increases and better benefits for our customers. In my view, whether an organisation has changed in the structure is almost immaterial. The important part is if it is continuing to provide value to its customers.

Senator CAMERON—How does an individual customer determine whether you are a market leader or you are providing value for money? Why is it that we have this weird situation in the private health industry that people need to go and get separate external advice to manage their way through the confused and confusing private health fund industry? Is that not part of your problem as well?

Mr Bowden—There is no doubt if you look the research, customers find the product complexity confusing. We have tried, and I know that a number of other insurers have tried, and we continue to try to make things as simple as possible and have customers communicate with us at the appropriate time. I actually think it goes one step further. I think the whole health care experience sometimes can be quite confusing, and what we are trying to do is actually provide advice to our customers about that. The government has set up a comparative site of its own under the ombudsman's office. Product complexity is probably being driven by competition. You said there was no competition in the market, but I would argue there is.

Senator CAMERON—No, I said it is different.

Senator EGGLESTON—BUPA, of course, is the British United Patients Association, is it not?

Mr Bowden—Provident.

Senator EGGLESTON—And that operated as a health insurer in the UK where I presume the premiums were risk based, were they?

Mr Bowden—That is right; they still are.

Senator EGGLESTON—They still are? Could you just explain that to the committee, what that means?

Mr Bowden—Sure. I think I covered this off just before.

Senator EGGLESTON—Sorry, I was out of the room.

Mr Bowden—Largely what it means is the whole insurance system is risk rated, so you price the risk, you can decline a risk as well; the larger of the two differences.

Senator EGGLESTON—So here in Australia, we have this community rating system which is quite unique, except I believe Ireland is copying it, but that system depends very much on a broad range of ages being part of the contributing pool, if you like. What we are concerned about is the possibility that, with the

removal of the surcharge, private health insurance rates may drop back to what they were when the surcharge was introduced, and we are concerned that that might impose some threat to the community rating system. Do you have a view about that?

Mr Bowden—First of all, I am a strong believer in the community rated system. It probably suits Australia's egalitarian society really well, but if you look at all the other systems around the world, I think the risk based system, whilst it might be pretty good for an insurer to be more certain of outcomes in terms of claims, I think it is a much better and fairer system. With respect to the community rating, I think the name gives it away, does it not?

If you do not have a large percentage of the population involved, it starts to break down, so what happens is that, if prices go up too high, more people drop out and the risk pool gets higher and higher, and then you just get into the cycle again. So, as I answered Senator Cameron's question, I think the one off change has this impact to shock lapse to get us back in a cycle, and I do not know how long the cycle is likely to be.

Senator EGGLESTON—When you say it is better and fairer, by that I presume you include the idea that people currently declined health insurance on the basis of risk, so that in the UK under BUPA, somebody might be declined because they had, for example, a bad cardiac history or something like that?

Mr Bowden—Absolutely, and making sure this does not become a beat up BUPA risk rate, we are talking about the system—

Senator EGGLESTON—Yes, we are talking about the system.

Mr Bowden—It is exactly the same in the US in terms of risks, but you are right. If you have some form of chronic ailment or something wrong with you, you just probably cannot buy insurance for that in lots of the risk markets around the world.

CHAIR—Thank you, Mr Bowden, for your evidence today.

[2.32 pm]

BARNES, Mr Terence John, Private capacity

CHAIR—Welcome, Mr Barnes. You have circulated a statement. Do you want to give an additional statement?

Mr Barnes—Yes, Madam Chair. I circulated a statement because I thought we originally had more time, so I decided I would try not to waste your time by talking too much. My comments in this area will therefore be brief, in contrast to my written submissions, for which I also apologise. My expertise is as a former public servant and ministerial advisor in this area, and my aim today is to draw on my experience. I will say, however, that I made my submission from a position unapologetically favouring the current public-private balance in health funding and provision.

My overall conclusion is that this is a short-sighted and not fully thought through measure, which has the hallmarks of a bottom drawer option from the Department of Finance, accepted by the government to achieve budget savings, targets consistent with its broad policy outlook. The surcharge measure, if passed, will not in itself kill the private health industry and the health services that it funds, but it would severely undermine their long-term viability and their ability to offer cover in the newly opened up areas of prevention, risk management and chronic condition management.

Briefly, I would just like to stress three things to you now. First, in 2005-06, the previous government, of which I was a part, weighed up the cost and benefits of doing something very similar to this and revisited the issue again when the then opposition raised it in early 2007, but we decided that the negative wider consequences of going ahead outweighed any short term benefits. Secondly, the likely sharp additional hikes in premiums from the measure will probably wipe out the estimated budget savings from the private health insurance rebate outlay and the states' and territories' frankly rent seeking behaviour in respect of extra public hospital funding from the Commonwealth will make the measure a big net loser for the government. Thirdly, there is a less damaging way to achieve the savings outcome that the government's advisors sought, and that is the abolition of all loadings on the private health insurance rebate for over 65-year-olds. This is on the basis that it is much the lesser of two evils compared to the likely consequences of the current measure. I am also prepared to admit in saying this that the Howard Government made a policy error in bringing that measure forward.

A compromise around the level of the single Medicare levy surcharge threshold to genuinely align with average weekly earnings in movement since 1997 is a possible way forward but, given the swings and roundabouts of tax and family assistance reforms since 1997, the real disposable income of middle Australian households has also significantly increased since then. In short, the delicate balances in our public-private health care mix are better served by leaving things as they are.

Senator CORMANN—Mr Barnes, do you think a government that decides to introduce a measure like this, having gone to the election with a promise to end the blame game in health and introduce a new era of cooperative federalism, should be making their modelling of the impact of this measure available to the states and territories so that they can properly assess the impact on public hospitals in light of the fact that Treasury and Health do not appear to have costed or assessed that impact themselves?

Mr Barnes—This Treasury has said to this committee, I think, that they have only modelled the fist line effects of this measure, but given that there have been questions about the reliability of their modelling and the assumptions made in it, it seems sensible and prudent to allow the states to see frankly, in the spirit of fair disclosure, what the Treasury has put forward to the government in terms of setting out a position, so at least that can be talked through. The other thing is that, since the announcement was made, state premiers and ministers have made it clear that they want to seek adjusting compensation to public hospital funding from the Commonwealth in relation to any flow-on from the measures. As I recall, Minister Roxon agreed to that at the health ministers' meeting on 22 July. I think it is actually in the public interest that all assumptions are laid fair and square on the table, but I think that it should also be a case that the states put on the table their assumptions in terms of the flow-on they expect.

Senator CORMANN—My concern as a member of this committee—and we are inquiring among other things into the impact of this measure on public hospitals—is that everybody seems to agree that there will be an impact on premiums, and there will be an impact on membership levels, and there will be an impact on public hospitals, but nobody has done the homework or the necessary work to properly assess, model, forecast,

cost—call it whatever you like, to actually quantify those impacts. Health funds have quantified the impact as best they can on the membership levels and premiums; Treasury has told us what it expects to happen with membership levels, but nobody across Australia, as far as I am aware, has actually done the homework and properly assessed the impact on public hospitals. How do you think this should happen?

Mr Barnes—I think basically it is an interrogative process, but I think it would also help if we had a full sense of what Treasury's assumptions were. Certainly my reading of what has been available has made it very hard to get into unpacking some of the detail, if you like, particularly around the assumptions about year-on-year premium increases as a result of change in participation in private health insurance. As Mr Bowden was pointing out in his submission, there should be an effect on premiums over and above what is already in the system as a result of utilisation and aid, so it is very hard to get a hard picture on that. I think just as fairly, from the other side, it is a question of who leaves their cover as well, and we are talking about so-called young and healthy people leaving in large numbers. It may well be that the actual demand on public hospital services is not as great as the numbers of people suggest, but even so, those people are still going to use those services.

Senator CORMANN—Let us just focus on that for a minute. I guess my starting proposition is, even if it is less than what the worst case scenarios might suggest, you still should properly cost and model it so that you know what you are dealing with. Even Treasury told us in Melbourne last week that it is now 644,000 people rather than 485,000 that the Treasurer told us the day after the budget. But is it not as relevant how much money goes out of the health system overall? The government tell us that it expects to save $960 million—that is in the budget papers—as a result of not having to pay the 30 per cent rebate. If we go along with the government's argument that the people that will leave are the young and healthy, they attract a 30 per cent rebate, so that $960 million is 30 per cent of the contribution income that is lost to the health system. That means that the total amount is actually $ 3.2 billion. Health funds tell us that 85 to 90 per cent of their hospital insurance income goes into funding hospital treatment. The point I am making is this: the suggestion is that if young people leave, they might not have accessed hospital services, but they might not have. Every single person that leaves and does not access it contributes funding for the treatment of others. So, if $3.2 billion leaves the system, of which $2.7 billion and more would have funded hospital treatment, where is that funding going to come from, assuming that demand will not go down?

Mr Barnes—I understand what you are saying, Senator. I think there are two sides to this, and one is as Mr Bowden eluded earlier. There is the question of community rating in terms of those who remain privately insured.

If those young and healthy members leave in large numbers, that is going to affect the depth of the risk pool of the insured population that remains. Therefore that will have a premium effect which those people will have to pay, in one way or another, which will in turn be supported by the 30 per cent rebate. On the other side, those people who do leave will not be immune from illness and injury. As I pointed out in my written submission, just using a rule of thumb based on utilisation and member numbers suggests that one in seven members will use their private health insurance in any one year, young or healthy or not, so that money has to be found, if it is a hospital episode, from the public budget. So it is a double whammy.

Senator CORMANN—Just going back a step, what was the strategic reason for introducing it? Was it a tax measure or was it a health policy measure? Would you describe introducing the Medicare levy surcharge as a tax measure or as a health policy measure?

Mr Barnes—A tax measure that was a health policy measure. I am sorry for sort of having the best of both worlds. But not anymore, Senator, it is clearly a tax measure. I mean, the Medicare levy is a collection in the form of a tax, but it also provides an incentive, some would say a negative incentive, to people who are in a position to afford to do so, to choose to take out private health insurance.

Senator CORMANN—As a tax measure, it is also a health policy measure. Do you not think if you make a change to it that you need to assess both the tax and the health policy implications of it, and do you believe that, in this instance, both the tax and the health policy implications have been properly assessed?

Mr Barnes—Maybe I can go back a step too. It is important not to see the surcharge in isolation of 30 per cent rebate and lifetime health cover, in terms of the three pillars of support, if you like, of the private health choice. By taking steps or measures, looking at one of those pillars potentially undermines all three, because the three of them work together to underpin the private sector. It is very hard to unpack them in terms of their effect and say, well, Medicare levy surcharge generates so many members and lifetime health cover so many and so on. By looking at one without the other two means that you are actually potentially undermining the whole structure.

Senator CORMANN—This is my question: if the government is saying to us that it wants to provide tax relief, particularly to singles with an income between $50,000 and $100,000, who do not take out private health insurance, if they want to pursue a tax measure, and it is introduced as a tax measure which is also a health policy measure, do you think that sufficiently assesses the impact on the health policy side of the equation or do you think there is more work to be done?

Senator CORMANN—I think there is considerably more work to be done. As I say, you cannot look at it in isolation of those other measures and of the operation of the private health sector side by side with the public sector, particularly the public hospital system.

CHAIR—Mr Barnes, you state in your submission that you are qualified to talk about this matter because it was your back of the envelope calculations which were responsible for the original initiative?

Mr Barnes—That was the aged loadings on the rebate.

CHAIR—But with respect to these and other measures introduced by the Howard Government, was there a release to the state governments of their costing and modelling?

Mr Barnes—That is a fair question. I think once the decisions were taken and implemented, there was a sharing of information with the states. I think the issue here, Senator, is that there is supposed to be a spirit of no surprises in the relations between federal and state governments—

CHAIR—No, you said, in fairness, that in a budget measure the states should have been released all the costs and modelling, and I ask you if this was done in the Howard Government?

Mr Barnes—In that case, I think basically it was an election commitment and it was basically costed and released once it was done. The states did not get a copy of my envelope, Senator, if that is what you are getting at.

CHAIR—No. You were saying that full Treasury costing and modelling should be released to the states. Also, in your submission, regarding the $50,000 limit, you say that tax increases and family tax benefits have assisted that group in that income range, but have not tax measures also assisted people in the $100,000 plus range?

Mr Barnes—Of course they have, and there is nothing wrong with that, Senator.

CHAIR—So given that they are equal, why should that group in the $50,000 to $100,000 still continue to bear a disproportionate amount of the private health system?

Mr Barnes—As I point out in my detailed submission, I am suggesting that in 1997, when the surcharge was introduced, the world was different, particularly in terms of the taxation system. Since then, we have all benefited from major tax reform that your government is continuing. I am suggesting that, when you look at things together, there is a more real disposable income in the hands of Australian families.

CHAIR—But it is not particularly in the $50,000 to $100,000 range. Indeed, there was great criticism that it was not in that range. Given that everyone has benefited, why should we continue to disadvantage those people in that range whose threshold has not continued to keep pace?

Mr Barnes—I am saying that I do not think we are. I think there have been swings and roundabouts, very significant swings and roundabouts, in terms of tax and family benefits available since this surcharge was introduced in 1997, so to simply say that in 1997 $50,000 was average and $78,000 is average now is only part of the story. When you look at that broader picture, there is the change to GST, the change in personal tax scales, the changes to family tax benefit A and B, and you could also include the Medicare safety net as part of the equation on the health side. The world is different. All I am suggesting is that, just as you have to look at the pillars of private health holistically, you have to look at the family tax situation or the family income situation holistically.

CHAIR—But you are not saying that that has preferentially affected those on the $50,000 to $100,000 mark?

Mr Barnes—No, I am not, but I am also saying, if you like, the wider public interest of ensuring that there is a strong and viable private health system complementing the public justifies leaving the thresholds as they are, given that families have benefited financially in other ways from government support.

Senator CAMERON—Mr Barnes, can you just briefly tell me what 1805 Consulting does?

Mr Barnes—I advise on strategic and public policy issues. I am largely from a health background, but not entirely. I have a long experience in government in various positions, and since the change of government, I have been drawing on that.

Senator CAMERON—Who do you advise?

Mr Barnes—I advise a number of clients. It is a new business and business is growing, but largely in and around the health sector so far.

Senator CAMERON—The private health sector?

Mr Barnes—Private health insurance, do you mean? No, I have no private health insurance clients.

Senator CAMERON—Do you consult in the public health sector?

Mr Barnes—I would be happy to consult in public health sector if clients came my way.

Senator CAMERON—Would that be rent seeking, if you did that?

Mr Barnes—You could say it is a form of rent seeking, if you wish, Senator.

Senator CAMERON—When you gave your submission here, you spoke about rent seeking public hospitals.

Mr Barnes—No, I talked about state and territory governments rent seeking, I believe. Again, this is drawing from my experience, I guess, the Commonwealth announces a significant policy change, and it is not necessarily a partisan thing. The state and territory governments are on the door asking for more money. This has been no different.

Senator CAMERON—Were you an advisor to Minister Abbott during the last election campaign?

Mr Barnes—I was.

Senator CAMERON—Were you part of the advice as a senior advisor on the Mercy Hospital debacle?

Mr Barnes—I was involved in that, yes.

Senator CAMERON—You were involved in that?

Senator CORMANN—Is that relevant to this inquiry?

Senator CAMERON—Yes, I am just trying to get an idea where the witness is coming from, actually. If you go back to 1997 and assume you were doing back of the envelope calculations in 1997 that resulted in eight per cent of single taxpayers exceeding the Medicare levy surcharge, and that gave the base for the private hospital insurance industry, and given that, after this change, that base will be 8.5 per cent, why is this such doom and gloom for the private health industry if you are only reinstating the same structure for the industry?

Mr Barnes—As I said in my opening statement, I do not think it is going to kill the industry, but it is going to make it harder for them to do what they had been doing, but more particularly innovative and grow, particularly in providing new services under what is called broader health cover, out-of-hospital services like chronic care management, for instance. As I pointed out earlier as well, this is part of a group of measures that underpins the system. The big question with this is the extent to which it will actually undermine the overall operation of private health insurance, but also the private sector as a whole, and that includes private hospitals and private service providers who are basically funded by insurers as well as the insurers themselves.

Senator CAMERON—Do you not think one of the biggest problems the private health industry has is the confused and confusing product it is selling? This is the only industry I know that has an industry hanging off it advising consumers how that industry works. Surely that is a problem?

Mr Barnes—I would not quite go that far. I think also the industry itself has to continue to adapt or die. It has to keep up with the times in terms of the products and services it offers, particularly in that out-of-hospital area. Prevention and chronic disease management is very important, and to her great credit, Minister Roxon has picked up on that. The private sector needs to work just as much as the public sector to do that. The reforms last year gave the means for them to do this, and the last thing I think we all want is for them to go back into their shells and stick to their core business, which is traditional hospital insurance. We all lose that way.

Senator CAMERON—Senator Abetz this morning said in another hearing that, in his ideal world, nobody would pay any tax, yet we have Senator Abetz' colleagues here today on this issue arguing that workers on $50,000 should pay what is quite a punitive tax. Can you see some problems in these two approaches? Why should these workers continue to pay a punitive tax under this system of private health insurance?

Mr Barnes—They do not have to pay the tax if they take out private health insurance, Senator. I would still say to you that you just cannot look at the threshold in isolation of other changes in the taxation and family assistance system around it.

Senator EGGLESTON—You were quite critical of the states for rent seeking, as you put it, and I have to say that I think that was a rather harsh criticism you made of the states. Surely by seeking extra funding from the Commonwealth for the anticipated increase in numbers of patients who might come into the public hospital system as a result of this measure's being implemented, can you not really say the states have made a rational assessment that the assessment of the numbers of people who will come into the public hospital system is under estimated by Treasury and they are quite rightly and wisely assuming that the numbers will be much greater than the government has so far said would be the case? Therefore, you are being rather harsh on the states, because they will need compensation for those extra numbers?

Mr Barnes—At the moment, Senator, I think it is a guessing game without full detailed assumptions on the table. It is up to the states to do their own modelling, and I think the Treasurer of New South Wales, Mr Costa, has indicated that is exactly what they are going to do, and I think that is good. It would be very interesting to see what the states actually say about the effects of this measure, but it is very hard to test all the assumptions on the table if basically they are not.

Senator EGGLESTON—One of the dimensions of Treasury modelling that seems fairly clear is that they counted members of private health insurance as numbers of people, when in fact quite often there are families involved, so there is more than one person—it is a husband, a wife and children—so the probable number of people shifting away from private health insurance might be 700,000 or 800,000 rather than the 480,000 anticipated, and I think you would agree that that will impose a huge burden on the public hospital system?

Mr Barnes—Yes, I think that is right.

Senator EGGLESTON—The Commonwealth is surely obliged to compensate the states or provide them with extra funding to provide the services?

Mr Barnes—I have never suggested that that should not be done. What I was suggesting, though, as soon as the measure was announced, was that the states are out there with their cap in hand. I think the issue here is who leaves and what numbers. I think in a sense, as you point out, Treasury understated the numbers affected because of their assumptions in the first place, but we are talking between, say, $800,000 and $1 million, and possibly more depending on how this measure is received in the community. If people sort of say, 'Well, look, if it is okay for me to drop my private health insurance, I will, off I go', that that could actually inflate the effect. So it is trying to get a handle on all of that. As I said before, even if the majority of those people are good risks in an insurance sense, they will still to need to be treated if they have an accident or if they fall ill, and there is no guarantee that you will go through life totally free of illness. The public system needs to be prepared for that contingency.

Senator BUSHBY—I was interested in Senator Cameron's comments about Senator Abetz in a different reference, particularly in the context of his eight per cent, 8.5 per cent comparison, but I did not hear him ask this morning for LCT to be taken back to the 2.5 per cent. I heard you earlier refer to the wider public interest of the role of private health as part of our overall health system. I would appreciate the opportunity to hear what you think those benefits are?

Mr Barnes—I think basically we have a very efficient and effective private health system, as I am sure other submissions have pointed out. It carries that very big proportion of the overall load, particularly in hospital admissions. I think 56 per cent of surgical procedures are done in the private sector. I think the other side of it is the actual investment behind that—the infrastructure, the service providers, the doctors, the nurses, the other health professionals. If the full range of what is offered was funded by the public sector, it would be a much more onerous and perhaps crippling burden for any government, state or federal. I remember several years ago a study was commissioned by Medibank Private, involving Professor Ian Harper, who is now the Fair Pay Commissioner, and he found that every dollar of private health insurance rebate spent attracting people into the private system saved two dollars of government spending, both state and federal. So it drives our overall health dollars a lot further, and it means that we share the burden more fairly, particularly of those who have the ability to contribute something themselves and are doing so through their private health insurance.

CHAIR—Thank you, Mr Barnes, for your evidence today.

[3.00 pm]

WOODRUFF, Dr Tim, President, Doctors Reform Society

CHAIR—Welcome, Dr Woodruff. Do you have an opening statement you would like to make?

Dr Woodruff—I do, if I could, thank you. Determining how many people drop out of PHI and what effect this will have on premiums and public hospitals is impossible. It depends on predicting human behaviour. Modelling may be grossly inaccurate. We do know, however, that price does not seem to be a major determinate of take-up of PHI or of dropping PHI. Coverage kept on going down after the surcharge was introduced in 1997, and the 30 per cent rebate in 1999 also failed to have any impact on the declining coverage. It rose dramatically following changes to lifetime health cover and an advertising campaign which emphasised security. This campaign direction fitted with research named the largest single reason for PHI coverage was security, protection and peace of mind, with 47 per cent of people. Another 20 per cent were talking waiting lists. Price, as a reason for having PHI coverage, was hardly rated—at one per cent. That is uptake.

What about dropping insurance? Despite premiums rising several percentage points above inflation over every year for the last seven years or so, percentage cover has been stable since 2000, currently at 44.6 per cent, once again suggesting that cost is not a major factor in people dropping PHI. But a more important issue than guesstimating answers to these questions is what will happen to patients dependent on public hospitals and what should be done about it? When the various measures supporting PHI were introduced, other policies were already working to help uptake of PHI. For some years, patients had been faced with delays getting access to public hospitals for elective surgery. One of the claims of the government in introducing such extensive support for PHI was to reduce the load on public hospitals. This was never intended to happen and it has not.

There are at least four reasons for this. First, the federal government has failed to fund public hospitals adequately through the Australian health care agreements, and I will take that up a bit further. Secondly, the federal government failed to adequately address aged care so that up to 10 per cent of public hospital beds have been taken up by patients waiting for placement in aged care places. Thirdly, the federal government has failed to fund and resource primary care adequately, and we have nine per cent of patients in hospital who, with adequate care in the community, would not need admission. Fourthly, the huge expansion of the private hospital industry requires doctors. The only place from which such specialists can come is from the public hospitals. They cannot be in two places at once, so doing more in private cannot happen without having less time for the public.

Let me expand on the first point regarding funding under the AHCAs. As I noted from the records, one of the committee was under the impression that the states have under funded public hospitals. The page one at I have given you lists the AIHW figures showing that since 2003, states and territories have increased public hospital funding by $2.3 billion, whilst the federal government has only increased by $1.1 billion, leaving the states contributing 50.9 per cent of public hospital funding compared with 41.5 per cent from the federal government. Thus, the previously reasonably even split of contributions from federal and state governments, shown in the graph on page two, has fallen by the wayside to the tune of a $2.2 billion shortfall. We already have problems with public hospitals, mainly relating to waiting times for elective surgery. This needs to be addressed, whatever the effect of changing that threshold. Essentially, all of the four issues which have led to a decline in capacity in the public hospitals must be addressed. The current federal government has not committed to making up the $2.2 billion shortfall, but it has moved towards it, committing $1 billion in direct funding and other sums including $150 million for an elective surgery blitz. It has addressed primary health care, but that is a long term project, and even if done perfectly, it will not help public hospitals in the short term. Both the previous and the current federal government have expanded aged care, but not enough, and so called access block, due to aged patients waiting for aged care patients, continues to be a problem.

It might help to focus federal government efforts if patients awaiting aged care placements became the financial responsibility of the federal government if they are still in a public hospital two weeks after applying for such a place. Importantly, however, there has been no willingness to address the issue of PHI support, dragging crucial medical staff from the under resourced, low morale, public hospital system to the convenient and comfortable taxpayer funded private system. For the economically minded, an important question should be whether treating patients in public hospitals will cost taxpayers more than if they are treated in private hospitals. As you know, 30 to 40 per cent of PHIs from taxes through the rebate and, in addition, drugs,

prostheses and other devices used in private hospitals are subsidised through taxes. In a landmark study in the Medical Journal of Australia, at page three in my submission, these costs were added up and compared to costs in a collocated public hospital. The study looked at coronary angiography and stenting following a heart attack. The study found that it costs taxpayers just as much for the private patient as for the public patient. There are no savings whatsoever. The second finding of the study was that the private hospital charged twice as much as public hospital costs. Thus, if all patients who leave PHI end up being treated in a public hospital, it would not cost the government anything in terms of the actual treatment costs. Many would argue that paying the extra cost gets you a better service. Unfortunately the opposite is probably true. A root and branch analysis of our health system as promised by the Prime Minister would reveal we do not know about the quality of either private or public systems. We have not bothered to measure it.

We can look overseas, however, to North America where, over the last couple of decades, there have been multiple studies of case adjusted mortality comparing public and for-profit private institutions and outpatient dialysis services. The bad news is there is a consistent picture emerging of higher mortality in for-profit private hospitals than in public hospitals. Given that 50 per cent of private beds in Australia are for-profit, these are very concerning statistics. Efficiency should be measured as cost per health outcome. Private care is more expensive, with worse outcomes. It is not efficient. Those of you interested in equity know our system is not equitable. Change is needed. Our public system needs the support and inefficient private industry does not.

To immediately abolish the PHI would break an election promise of maintaining the rebate as is. We are not naive enough to suggest PHI should be abolished overnight. The tariffs for inefficient manufacturing industries were not removed overnight either. In the interests of sound evidence based economically rational public policy, which is also equitable and socially inclusive rather than exclusive, we believe that taxpayer support for the inefficient private health insurance industry, under whatever guise, and for the potentially dangerous and very expensive private hospital industry, does need to be transferred back to the public system. Thank you.

Senator CORMANN—Dr Woodruff, Wayne Swan and the Treasury tell us that they expect 644,000 people to leave private health insurance as a result of this measure. John Deeble, the father of Medicare, tells us that he expects up to 750,000 to leave as a result of this measure, yet you say that we cannot possibly forecast the impact of this measure on the number of people leaving private health insurance. On what basis have you come to that conclusion?

Dr Woodruff—What we are trying to do is predict human nature. Presumably, there was the same assessment of what might happen when the Medicare levy surcharge was introduced in 1997. I hope that that was only done to increase private health insurance uptake. It failed to work. So the assessment there was completely wrong, if it was done. The PHI rebate was introduced, with no effect. If we have modelling, it seems to be either falling down or grossly inaccurate—sorry, that is the same.

Senator CORMANN—I guess as you put budgets together and as you put policy changes together, obviously some forecasting, some modelling and some assessment of the expectations is done and you are able to test that as the actual events eventuate, and you can adjust your forecast as you go along. We have had evidence from the Institute of Actuaries, and they actually make it their business to be as accurate as possible, so are you saying there is no capacity at all to estimate the impact of a measure like this on the number of people who are likely to leave private health insurance?

Dr Woodruff—Not at all. I am not suggesting there is no capacity at all. What I would suggest is that the results may well be completely wrong or they may be mildly wrong, and I suppose the other thing to say is that there are different estimates from different people, obviously partly based on what assumptions they make in their modelling. That is understandable. But to say that this is what was going to happen is obviously a furphy.

Senator CORMANN—To be fair to the government, I think they say that this is what they estimate will happen, and I guess if the estimate of the government eventuates, there are those of us who would say that that will not be a good thing for the system. Leaving that aside, do you think that Australia needs a strong private health system as part of our overall health system?

Dr Woodruff—Not at all. I think Australia should have a private health system; that is fine. We can have a private health system, but it should be private. We do not have a private health system. We have a private system that is actually hugely subsidised. It is hardly private. It is pseudo private.

Senator CORMANN—You see this measure as the first step in a series of measures which would also down the track involve abolition of the 30 per cent rebate, lifetime health cover and other such measures that currently underpin private health insurance?

Dr Woodruff—If I were in government, that is what I would be doing, but I do not know what the Labor Party is planning; you would have to ask them.

Senator CORMANN—You mentioned that the federal government is not paying its fair share in support of public hospitals and that state governments are. Do you have an estimate on how much additional funding you believe the federal government should be investing in public hospitals across Australia?

Dr Woodruff—Not an accurate estimate. I am not an economist, but I am saying that there is a yearly $2.2 billion shortfall at the moment, and there has only been a commitment to $1 billion, so we need that as a minimum. I suppose the fifth factor that has led to the problem with capacity in public hospitals is that there has been a huge increase in demand everywhere, across the Western world. We do a lot more than we used to do, so we have an increased demand to cope with. The state governments have kicked on and attempted to do that. They have not won the war, but they are doing it by themselves at the moment, or have been, but they are still behind the eight ball.

Senator CORMANN—Your assessment is there is a need for $2.2 billion in additional funding which you think should be coming from the Commonwealth?

Dr Woodruff—Absolutely.

Senator FURNER—Doctor, the previous witness's submission made the statement that these changes may in fact bring on a benign effect by minimising costs and maximising efficiencies. I would have thought that the insurers these days have been able to achieve that. What is your point of view on that?

Dr Woodruff—The insurers currently run at 10 per cent administration costs compared to the public health insurance, which runs at three per cent, so there might be some room for some efficiencies there, but I do not know.

Senator FURNER—What is your view on minimising costs?

Dr Woodruff—The problem is that they are in a fee for service model that is so uncontrolled. This is one of the basic problems here. How do you control use of services? The Yanks tried to do it and they went into managed care and they had accountants deciding on medical care. It was a total disaster. If you have fee-for-service, then there is a potential always for over servicing, and the second study that I have given you, on page 4, is a study showing that there is a significant disparity in the rate of angiography following an infarct in private versus public hospitals, even collocated ones using the same facilities. We have either under servicing of public patients, which is a sad reflection on what is going on, or over servicing of private patients or a mixture of both, and I think most doctors who are in the field would say that it is probably a bit of a mixture of both. Once you have a fee-for-service mechanism, then you have the potential for over servicing. For the insurance company to try to limit that is extremely difficult.

CHAIR—Dr Woodruff, we have been discussing community rating a bit, and on that fee-for-service issue, community rating means, of course, that private health insurers cannot refuse to insure people on the basis of their chronic illness and so on. But, there are instances, are there not, where private hospitals will transfer a patient to a public hospital if they have significant chronic ongoing conditions or complex conditions that they cannot treat?

Dr Woodruff—It is more than complex conditions. In a situation where there is complexity, most private hospitals are not capable of safely dealing with the very complex, so they will be transferred to a public hospital in everybody's interests. That is entirely appropriate. It has been happening forever, and it will continue to do so. It is a very small number of very large private hospitals in the major metropolitan cities who do not have the capacity to deal with moderate complexity, but even then, where did the Bali bombing victims go? They all went to a public hospital. You do not go to a private hospital with that kind of disaster. Where does everybody go if it is an acute disaster? We go to public hospitals. We must fund our public hospitals properly, otherwise we will suffer. It is not just the poor that will suffer. The people at the top of the line—Kerry Packer's life was saved in a public hospital. We need our public hospitals as strong as possible. Out in the country, there are usually no private hospital facilities. We need the money in the public system to make sure that out in the rural and remote areas, the public system is working really well.

Senator BUSHBY—Thank you, Dr Woodruff. Do you think that the public system could meet fully the demand for hospital services if the private system was a fully private system, as you suggest it should be?

Dr Woodruff—Yes.

Senator BUSHBY—How?

Dr Woodruff—Not immediately, not like that; just gradually. We can build the public system again, having let it fall behind the eight ball, and do the job. Why should it not?

Senator BUSHBY—How much additional funding is needed to be able to do that? You talk about $2.2 billion that is currently needed, but if you were actually going to transfer a larger proportion of services currently provided by the private system to the public system, what would that mean on the need for funding?

Dr Woodruff—I cannot give you a figure, but I could say it would be less than what is currently paid in the private system to maintain the private system, because the private system is much more expensive.

Senator BUSHBY—So, it would be less than the 30 per cent that the government is currently putting in towards it? Are you including the money that the individuals are also putting in as well?

Dr Woodruff—No. I am just saying the costs in the private system are huge compared to public systems, so to gradually move towards a strong public system doing everything that is necessary, it would certainly not cost as much as the current situation.

Senator BUSHBY—So the bottom line would be not as much, but the cost to government—currently, for every dollar that the government puts in, they get two dollars of private contribution towards private hospital care, so the cost to government is only one in every three dollars effectively. Are you saying it would be cheaper for government as well?

Dr Woodruff—It would be the same cost to government. Government is currently paying as much for a private patient to have a procedure as it is for a public patient to have a procedure. That is what the paper at page three talks about.

Senator BUSHBY—I see that, but also you have a large number of privately insured Australians who are putting money into the hospital system as well, admittedly to the private hospital system, which would not be there if they were not taking out private health cover. Are you saying that that is irrelevant?

Dr Woodruff—No, it is not irrelevant; of course it is not, but what we have to realise is that that huge price differential between private and public goes to fund the private industry. A private industry requires profits, and 50 per cent of our beds are for-profit. The insurance companies are increasingly looking for profits, becoming de-neutralising and are profit driven. There is a huge slab of it that is profit, and if more money is needed to cover the risk because you are talking about covering people who are not requiring operations, adding to the pool, what we are saying is the fair way of doing that is for them to contribute through a tax system rather than through private health insurance premiums.

Senator BUSHBY—Which then comes to the Medicare levy surcharge?

Dr Woodruff—No, the Medicare levy constitutes 18 per cent of health care expenditure. It is only a small component.

Senator BUSHBY—But the way to actually get the money from those who are not putting it in as private health insurance is through tax, but what we are actually talking about doing here is taking tax off which will actually then take money out as well. It is counter intuitive to what you are trying to achieve.

Dr Woodruff—What I am trying to achieve is a much bigger thing than what you are talking about. This is just a minor kind of blip on the horizon, really, of what is needed.

Senator CAMERON—Dr Woodruff, we have received evidence to this inquiry that many privately insured people still continue to freeload on the public system. They are privately insured, but they do not use their private insurance—

Senator CORMANN—They pay taxes. They are not freeloaders.

CHAIR—Senator Cormann! Go ahead, Senator Cameron.

Senator CORMANN—Point of order. Senator Cameron should not use this language—

CHAIR—Senator Cormann!

Senator CORMANN—It is a point of order, madam chair.

Senator CAMERON—I do not interrupt you and I will use the language I want to use, and if you—

CHAIR—Senator Cameron, Senator Cormann has a point of order.

Senator CORMANN—The point of order, Madam Chair, is that I think you should draw the attention of the senator to his language. Freeloading is a very loaded term—

CHAIR—I am sorry. Senator Cormann, I think you have used a number of loaded terms during this discussion. Dr Woodruff.

Senator CAMERON—Freeloading was the term that one of the witnesses used, and it was used to describe private health insured people using the public system. Do you have any comment or have you any experience of that?

Dr Woodruff—Well, we know that it happens. A lot of people who have bought private health insurance have no intention of using it. A lot of people go into hospital with acute illnesses and I would often recommend my patients, whether they have private health insurance or not, to go in for an acute illness as a public patient because that will work better for them. As well as that, I think that, having paid their taxes, as has been said, I think they are absolutely entitled to not declare their insurance status and I think it is inappropriate that that has been demanded of them.

Senator CAMERON—For the record, so do I believe that they are entitled to use the public health system, but the point that the witness was making was that you cannot look at the percentage of private health coverage at the moment and say, if there is a decline in that, it automatically means a pro rata increase in the services done in the public system?

Dr Woodruff—Absolutely. I mean, that goes back to what I was saying before. It is quite true what Senator Cormann said, that you have to be able to do some modelling, but there are so many questions, so many steps through this, with so many assumptions about people's behaviour that the chances of getting it right are not extremely high.

Senator EGGLESTON—Dr Woodruff, you talked about a completely public health system—

Dr Woodruff—I do not think I did, but go on.

Senator EGGLESTON—Well, you mentioned that it would be possible. There is a system like that in Canada where there is a very extensive public system that which covers everything in medicine, from not just hospitalisation but things outside it. There is also an adjacent private system, but it is not used a great deal. In the United States, they have a very largely private system with a somewhat meagrely funded public system adjacent to it. In Australia, it is said that we have the best worst system because we have a balance of public and private medicine. This measure that is being proposed by the government, we have heard a lot of evidence that a lot of people will give up private health insurance and it will tip people into the public health arena, and cause a lot of people to seek treatment in public hospitals. Would you not agree that it is quite justified for the states to seek extra funding to cope with that extra load of patients who will be coming into their public hospital system?

Dr Woodruff—Absolutely. That was easy.

Senator EGGLESTON—It was an easy one. It is very important to have it on the record, though.

Dr Woodruff—If there are changes, and presumably there will be some changes, I just do not know the magnitude, but if there are changes and an increased demand on the public system from these people who may leave private health and are users, then it is incumbent upon the federal government to play its part in funding the alternative. What I am saying is that funding the alternative will ultimately be cheaper and fairer than trying to go through the private system.

Senator EGGLESTON—Going back to this situation as it is now, you are agreeing that it is quite reasonable that the states are anticipating an extra lot of patients coming into their system, and it is quite reasonable of the state governments to be seeking extra funding from the federal government in anticipation of the problems this measure will cause them in terms of increased patient numbers in public hospitals? Is that what you are saying?

Dr Woodruff—If it happens.

Senator CORMANN—But should they plan for that?

Dr Woodruff—How do you predict that?

Senator CORMANN—Are you going to predict it? That is the problem.

Senator EGGLESTON—Yes, I know, but like I said before—

Senator CORMANN—Do you just sit back and see people are coming?

CHAIR—Senator Cormann!

Dr Woodruff—Well, I suppose what we need to do is see how many people do actually drop out. You can use modelling to give you a guide, but it could well be completely wrong.

Senator CORMANN—We should at least have some modelling as a guide?

CHAIR—Senator Eggleston, please finish your questions.

Senator EGGLESTON—I just think that from the answers that we have been given, it is reasonable to conclude that the states should prudently prepare for what may be modelling notwithstanding a greatly increased number of patients coming into the public system, and the consensus here seems to be that that will be occurring in some degree.

Dr Woodruff—In some degree. I think you used the term 'a great' something or other, a great number. I do not see there is any evidence to conclude that.

Senator EGGLESTON—Well, to a greater or lesser degree?

CHAIR—I think, Dr Woodruff, there are currently discussions between the states and the Commonwealth about the health agreement, are there not, and the mix in funding, so I presume that that is one of the factors coming into consideration? You have alluded to the fact that the public health system needs more funding in any case. You referred to part of the problem being the number of specialists, the number of medical people around. Would you see that as a critical issue as well?

Dr Woodruff—There is no problem getting a specialist to do your hip operation in the private hospital or an anaesthetist. Try going next door to the public hospital and they seem to have vaporised. We have a problem, not necessarily an overall shortage, although there are some shortages, and I am not going to go into detail on the medical workforce, but in the speciality sphere, it is a terrible mal-distribution of specialists.

CHAIR—We have heard evidence from the private hospital system that the number of procedures in areas like cataract surgery, hip surgery and knee replacement have increased dramatically in the private health system and that they are doing the majority of those cases, so you are saying the general attractiveness of the private health system is because the specialists choose to work in that system because they are getting more money?

Dr Woodruff—No, I would not go quite that far. I would just say that, because the system is being led down the private hospital route, some specialists may be doing exactly that and doing it for money, but I think they are the minority. Many are disillusioned with the public system, frustrated with the public system that has been under funded for the last 11 years, and therefore are looking for an alternative, and the alternative is there. It is there because it has grown. It has expanded. People are privately insured, so they can do the operation in a private hospital.

CHAIR—Do you not see that as reason to maintain the private hospital system as such? Evidence that we have had suggests that they do that kind of day surgery quickly and efficiency?

Dr Woodruff—This is where I come back to the evidence that I am talking about here about efficiency. Efficiency is not throughput. Efficiency is not doing 20 arthroscopes in an afternoon or something like that. Efficiency is comparing the health outcomes, risk adjusted and the amount that it costs to get to that result, with what happens in the public system. This is where there is a terrible misconception that private health care is actually better, when in fact the evidence does not exist for that, and it is suggestive that it may not be, especially if there is a profit motive involved.

CHAIR—Thank you, Dr Woodruff, for your evidence this afternoon.

Proceedings suspended from 3.30 pm to 3.46 pm

CARTON, Mr Gerard Patrick, CEO, Private Health Insurance Intermediaries Association Inc.

SASSON, Mr Peter, President, Private Health Insurance Intermediaries Association Inc.

CHAIR—I welcome to the table representatives from the Private Health Insurance Intermediaries Association. Do you have an opening statement to make?

Mr Carton—Yes; it is fairly brief. The Private Health Insurance Intermediaries Association, PHIIA, is an incorporated body. It has been registered and operating since 2002 in Victoria and it operates nationally. I was part of the setting up of the association but I am not an intermediary myself.

If you have any specific questions regarding broking which I am unable to answer I will defer to Peter who is president of the association and has been in the health insurance business for over 35 years, some of that time as the CEO of a health fund.

We are open to membership to anyone who sells a registered health fund product in Australia and who is not employed by a health fund. We believe we represent about 50 per cent of the businesses engaged in that activity but our members are responsible for the bulk of enrolments and memberships managed by intermediaries in Australia. We have worked to establish standards in our industry. One of our early aims was to bring brokers within the auspices of the Private Health Insurance Ombudsman which we achieved through appropriate lobbying several years ago. We have our own code of conduct but are in the process of making that a more contemporary and living document. Our members are at the coalface in dealing with consumers, generally operating a consistent level of reimbursement from health funds and as such will recommend the most appropriate product within those funds' portfolios.

As to my own background, I work as a consultant in the health insurance industry and have done so for several years. I have been variously employed by the Commonwealth Department of Health as the Regulator, by Medibank (marks, I, II and III) and by the HBA. I was a board member and vice president of a public hospital and I am currently on the Hobsons Bay City Council Disability Advisory Committee. For the last 40 years I have intently observed the private health industry from a public, private, personal user and freeloader perspective. PHIIA's concern with the MLS changes are that they appear to have been poorly researched and outcomes not clearly perceived. We believe that young, good risks will leave the industry, but that will not generate any savings for the government. We believe indexation would have been a more appropriate response to the government's apparent objectives, and we believe that this initiative will adversely impact on many working families. The minister has said that if insurers deliver attractive, effective policies then people will want to buy them. Well, I believe that funds do deliver such products within the regulatory framework which binds them.

Community rating is what makes the Australian system one of the world's best. People have choice, admittedly when they can afford it, and Medicare is a great system. The price now for a government to sustain community rating is some form of subsidy or support, the proverbial sticks and carrots currently in place. Governments of all colours want to maintain community rating for political and social reasons. Some people are invariably incensed about the two-tiered system but fail to acknowledge the money which people voluntarily put into our health system. Private health insurance contributions last year amounted to some $10.5 billion with about $7 billion contributed by consumers. For every $1 the government saves through its Medicare levy surcharge changes, $2 will disappear from Australia's health system. But we do not believe those savings will materialise. We believe a simple transfer of wealth will occur. Singles earning between $50,000 and $100,000 a year and couples earning up to $200,000 a year will have the opportunity to be better off, whilst in a direct attack, families earning up to $50,000 less will be penalised. That is all I have to say as far as the introductory statement is concerned, thank you.

Senator CORMANN—Mr Carton, we have been travelling around Australia for some time now taking evidence. You have brought a new argument to the table that I do not believe we have come across before, and that is that the removal of the relativity between the threshold for singles and the threshold for couples or families actually provides an incentive for people to, I think as you put in your submission, 'be dishonest about the status of their relationship.' I had not actually thought about that. So what you are saying is that people could actually benefit from a threshold of $200,000 by declaring themselves to be two singles rather than one couple? Can you just expand on that a bit?

Mr Carton—A young couple living together may choose not to deem themselves to be living in a bona fide domestic relationship, which are the words the legislation uses. I suspect with the arrival of a child they might

have some difficulty in acknowledging that, so all of a sudden they are living in a bona fide domestic relationship. If their combined income was $199,000, they were previously exempt. Once they are living in a family relationship they are no longer exempt.

Senator CORMANN—What you are saying is that really that relativity between the threshold as it applies to singles and as it applies to couples is quite important? That is a two to one—

Mr Carton—Absolutely critical. It is the backbone of the whole thing.

Senator CORMANN—You are essentially like a peak body for brokers selling private health insurance, is that correct?

Mr Carton—That is right, yes.

Senator CORMANN—And in a similar—

Mr Carton—Not just brokers; 'intermediaries' embraces agents too.

Senator CORMANN—But, brokers who advise potential members with private health insurance on products and choices are similar to what exists in the general insurance system as well, is it not?

Mr Carton—Yes.

Senator CORMANN—What value do you think, from your experience, private health insurance has for those members that your members relate products to?

Mr Carton—I think it is a very simple argument. Broking intermediaries are a growing industry. There have been three or four new entrants come into the business this year. Their timing may not be perfect in the circumstances. But people would contact the fund; they would go to a branch office in the past and that fund would sell their products. With more and more intermediaries involved, they are dealing with three, four, five or maybe more different funds. So the consumer gets the choice of three, five or six different funds' products. There is a wider choice of products and there is a wider choice of prices.

Senator CORMANN—Why is it important to have a private health system as part of the overall Australian health system in your view?

Mr Carton—Simply, the public system would not cope; it could not cope.

Senator CORMANN—All right. You mentioned community rating; why do you think it is important that as many people as possible are part of the private health system in the context of a public policy commitment to community rating?

Mr Carton—To keep the price down.

Senator CORMANN—Can you just detail that a bit more?

Mr Carton—I am not really into the numbers on this but I agree with the boffins that it will be the healthy, better young risks who drop out. As they drop out their contributions or their money they generate will be lost to the industry. But the funds really will not save anything in terms of claims dollars because these people are not claimers. So, if you had $10.5 billion dollars worth of revenue last year, and for argument's sake we will say that $9 billion of that was in claims, and if $1 billion disappears next year, and it is down to $9.5 billion, you will still have $9 billion worth of claims, give or take a couple of hundred thousand here or there. It is not going to change much. Essentially the funds will have to put their contributions up by the amount to recover the revenue that they have lost. They have to get back to the $10.5 billion to maintain the margins they have had previously. That suggests to me that the government is going to pay 30 per cent on those increased contributions, so there is no saving.

Senator CORMANN—Treasury has told us, actually, that they did not include that effect on premiums into their forecasts of the savings they expect. They have just assumed that normal premium increases will happen in the normal course of events and, as they describe it, there will just be a one-off shock to the system, like a one-off effect. Do you believe there will be a one-off effect or do you think that this is the start of a series of second, third or fourth round effects which will lead to a downward spiral?

Mr Carton—My period working with a private fund went from 1986 to 2001, and that was during the spiral and I just watched it happen. There were virtually no new good risks coming into the system, so the average age of the insurance population was increasing roughly by one year every year.

Mr Carton—I do not know whether that effect would apply now but that one year age increase was worth two per cent in terms of rate cost, benefit cost every year. The age has been static in recent years. If we go

back to that situation where young people stopped joining, then you can add two per cent every year to what we would expect as a normal rate increase.

Senator CORMANN—If you have been involved in the industry for that long, how effective, in your experience, has the three pillar policy been—the 30 per cent rebate, lifetime healthcare and the Medicare levy surcharge to restore the balance in the health system?

Mr Carton—Individually none of it was a world beater but I think the three of them together, as I say, are the sticks and carrots. The three pillars, the term you use, has worked effectively. It has kept health insurance at a level which is almost appropriate. But it has needed government subsidies to keep it at a price that people can afford. As I say, that is the price of community rating. If we are going to have community rating and if governments are going to insist on community rating, then governments must support community rating.

Senator CORMANN—That is a very good point: if the government is going to insist on community rating they have to support community rating. Sometimes people put it as this is just support for private health insurance, but in effect these measures are there to support community rating, are they not?

Mr Carton—That is what I believe. As I say, I have been a user for a long time and I will never drop out of the system because I cannot afford to. Community rating says I am in. I work for myself, I have no income protection. I have no trauma cover because no one will cover me. If it disappears from health insurance I might as well get myself a real job because I would not be able to buy health insurance.

Senator CORMANN—When the government costed the impact of this measure, it essentially assessed the loss to the revenue by no longer collecting the Medicare surcharge from those they expect to leave, and they costed the savings for the Commonwealth, but costing the savings from not having to pay the 30 per cent rebate to those that will leave. They have not costed the impact on private health insurance premiums; they have not costed the impact on public hospital waiting lists; do you think they should have?

Mr Carton—Absolutely. There is another impact. My members are already feeling the loss. People are not buying health insurance already. They are confused, but the drop off has been quite sudden. The problem is these people are not moving into health insurance now, they are not buying it now, so those funds that put their budgets in for the next 12 months until the next rate increase comes around will not achieve it. Whatever the increase is that this will have on next year, they will have to collect the money they lose in the next nine or 10 months as well. That will be another impact on increased rates come next year's round of rate increases, unless, of course, some of them decide to put in for an earlier rate increase.

Senator CORMANN—In the lead-up to the last election was your association consulted by the then opposition and now government about the prospect of doubling the Medicare levy surcharge threshold for singles?

Mr Carton—No.

Senator CORMANN—Have you been consulted prior to this measure being announced?

Mr Carton—No.

Senator CORMANN—Have you been consulted since the measure was announced?

Mr Carton—No.

CHAIR—You were talking about premiums going up if people leave the system, and you mentioned a figure as one per cent leave?

Mr Carton—I am sorry, just going back to the nineties when people were not joining, the only people who joined during the nineties were people who chose to select against funds. If they are sitting there and the public hospital says you have got two years to wait for your hip, and the health fund says you have got 12 months to wait for your pre-existing; toss a coin—they will spend the money on private health insurance. They were coming in and they were claiming after 13 months. It still happens to some extent but it is something the funds have been able to wear to some extent because younger people are coming in. But, in those days what was happening, because the young people were not joining, the average age of the person insured was increasing by roughly 12 months. I cannot remember what that age was, but it was increasing by about 12 months each year. That meant that each 12 months in age was worth about two per cent more in claims. If we look at the figures now where the age is fairly static, we have increases of approximately five per cent every year. But if we do not get those new people coming in, I am suggesting that it will be closer to seven per cent every year.

CHAIR—So, since those days you have had an influx of younger people and you have had a substantial increase in membership? Why is it only recently that the premiums have started to level out—not drop but just level out in terms of the rate of increase?

Mr Carton—Sorry, we had an average increase of what, five per cent last year?

CHAIR—Yes. We are talking about from the nineties; we have had increases of 10 or 12 per cent since then?

Mr Carton—Yes. What you had was a huge increase from 2001. There was a massive influx and a huge number of people came in and selected against the funds. It looked wonderful when they came in; we had massive increases. Medibank, I think, was at 17 per cent, the biggest fund in the country at the time. Most funds had fairly significant increases and those people who have come in have all had their problems sorted out in hospital over three or four years. People reach a state of stasis, I suppose, with their health where they no longer have problems. What we find is they have had all their medical problems cleared up because they could. They were not on waiting lists; they could get things done. I just believe that the insured population is a reasonable risk mix at the moment.

CHAIR—Those people who joined 10 years ago have not developed any further health problems since then?

Mr Carton—No. Once they start hitting 50, 55 or 60, they will come back into the system. They have stopped having babies as well.

CHAIR—We are in the unusual position right now where they are healthy and we are about to see them start getting unhealthy?

Mr Carton—There is a lot of guesswork involved in this. I do not get access to individual funds' figures other than once a year, and they are nearly two years old at the moment.

Mr Sasson—If I could just add to your question: what actually happened in the year 2000 was that a lot of people who did not have private health insurance actually took out private health insurance. We only have to look at the figures of growth. In December 1998 I think about 30 per cent of the Australian population had private health insurance, and the recent figures now are close to 52 per cent. Bu, during the year 2000 where there was the major influx of new members joining, a lot of these were individuals that had potential claims but by not having private health insurance they were putting off these procedures. In 2001 most of these individuals had served their 12-months waiting period and consequently that is when the influx of claims came in. The funds were not ready or not prepared or the actuaries had not costed the potential impact of claims, and that is why we saw an escalating premium base which was disproportionate to what we are seeing now, so that was the peak.

CHAIR—And it continued for some years?

Mr Sasson—It went up and down; in some years we saw no increase whatsoever.

CHAIR—Which years were they?

Mr Sasson—In 2000 we saw much smaller increases, depending on the policy that one was on. This year it was 0.75 per cent depending on the health fund. We talk about an average but it is an overall average. You do have certain covers that have higher claiming than your young cover. Your young cover has had minute increases, certainly lower than the four or five per cent we are talking about.

CHAIR—We have had quite a bit of evidence that the influx to the funds occurred more as a result of the introduction of lifetime cover and a subsequent advertising campaign on the benefits of private health cover. Would you agree that that was significant?

Mr Carton—I would. At that point in time it was a massive increase. You can see the graph and you can see the impact now of the Medicare surcharge impacts where it is pushing up. That is the factor that is coming into play now.

CHAIR—Coming into play now? Why just now?

Mr Carton—When I say now, it is over the last couple of years as more and more people have come into that bracket where they are subject to the MLS.

CHAIR—Is that not precisely the point? A number of people are coming into that bracket whereas previously it was designed to get wealthy people who were just refusing to take out health insurance?

Mr Carton—That is the point, and that is why our position is that indexation probably would have been a better way to handle it rather than force a huge number of what I would regard as reasonably wealthy young people out of the system—not to force them out but to incentivise them out.

Senator CORMANN—Just to follow up on this, can I just go through the answers that you have provided to the questions from the chair. Tell me if I understand this correctly. In the nineties after years of significant drops in membership we ended up with a 30 per cent membership level in private health insurance. Some people say that means the system was out of balance. The government tried to introduce some measures which were not successful and in the end came up with a three pillar policy—30 per cent rebate, lifetime health cover and the Medicare levy surcharge which we are assessing now. If you look at what happened to the membership, it spiked initially by 13 or 14 per cent. It flattened out and then started to go back a bit, and in the last three or four years it has started to trend up again with 400,000 additional members in the 12 months to March 2008. Some 400,000 additional people joined private health insurance. Some people would argue that in recent years it is particularly the Medicare levy surcharge thresholds that have been driving that. I am just trying to understand the relationship.

Are you saying that, after the initial introduction and the initial spike in membership, there was a latent, unmet demand in the system that had to be absorbed? You came from 30 per cent to 45 or 46 per cent; was there a latent unmet demand for health services which was then absorbed by the private health system? Did it take a couple of years for things to settle down into a normal equilibrium, and that in recent years, as membership continued to trend up on the basis of the three-pillar policy, we are now probably in a more balanced environment where the sorts of increases in premiums that we have seen in recent years are more reflective of what will be happening into the future if that balanced system continues? Is that what you are trying to say?

Mr Carton—I think the year that the people came in there were no increases. There was this massive influx of people coming in; pre-existing was applicable to most of those memberships, and there were no claims, so it went without an increase. Once the 12 months was up, we had increases the next year—off the top of my head I think it was about 13 per cent on average, which was more than compensating for what did not happen the year before. My belief is what you said, that there was this demand that was sitting out there where people said, 'Oh, I can afford to get into health insurance now. I will take it and then I will have everything I need done.' This did not necessarily happen all at once. It happened over a couple of years so they were not necessarily the good risks that came in. They looked that way for 12 months because pre-existing applied.

Senator CORMANN—I guess the point is that it is not unusual for public policy changes to take a while to work their way through the system, particularly in the context of a health system where private health membership went from 65 to 30 per cent. If all of a sudden you turn it around, I guess it is fair to say that it will take a couple of years before it settles into a normal equilibrium where you can assess what the impact on private health insurance premiums and other related matters is going to be. Is that a fair summary?

Mr Carton—I suspect that the private hospital system had been severely affected in the years leading up to that and was not able to cope with the instant demand that was put on it then.

Senator CAMERON—Professor Stephen Duckett from the School of Public Health in La Trobe has issued a warning to policy makers to be careful about the rhetoric that the private health system is taking pressure off the public health system. He cites research in both Australia and Canada to demonstrate that the rhetoric is just not delivering in terms of the pressure coming off. We have had evidence here today from the Doctors Reform Society to say that it is not reducing the pressure; in fact the costs in the public health system are lower than in the private health system. Does this not make it even more confusing for policy makers to try to work through how we should balance the public and private health systems?

Mr Carton—I do not disagree with that at all. It is a very confusing industry. I do not know about comparing the apples and pears. As I understand it, private hospitals do a whole different range of procedures from the public hospitals. I think the short answer to the question is that, at the moment, Australians are putting $7 billion a year into Australia's healthcare system. I really do not think they are wasting that. I think that is going to provide services to Australians which somebody else would have to pay for and provide if they were not doing it themselves.

Senator CAMERON—I am a member of NIB. We had the chief executive of NIB appear recently before the committee and indicate that he received over $1million as a bonus for de-mutualising NIB. I must say that concerns me that these sorts of costs are building up in the system and that we have this burgeoning support system for the private health system. You see, we have the private health system, and now we have this

advisory that you have indicated is a growing industry. Where does this stop, because it can really blow the costs out, can it not?

Mr Carton—I heard Richard Bowden here say that for the last seven years HBA BUPA has had the lowest overheads and the best highest average margin of all funds in the country. I think if you then go back to 1994 you will find that HBA BUPA has never run at a loss because it is run efficiently. It needs to do so to look after its members, and its members are where its profit comes from. If a company in that situation deems that the CEO or whomever is worth being paid that money so that they can deliver the service at a price that people want to buy, then it is not my role to sit here and criticise them for it, as long as they do it properly. If they do not, somebody else is going to eat them up now.

Senator CAMERON—What is your view on those workers on that $50,000 threshold who are really doing it tough at the moment and saying, 'We would rather make the choice to have the tax relief than be forced into a private health fund'? Why is that not a proper choice in a market based economy?

Mr Carton—We agree that is probably a bit low, and indexation would have been appropriate and would still be appropriate at that level somewhere around the mid-seventies with double that for families. We have no problem with it.

Senator CAMERON—You do not disagree with the principle of what the government is doing; you disagree with the quantum?

Mr Carton—It is the numbers and the relationships between families and singles we disagree with.

Senator CAMERON—But the principle is a principle that is justifiable?

Mr Carton—We agree with the principle that it needs to move, yes.

CHAIR—Thank you, gentlemen, for coming in today.

[4.14 pm]

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

CHAIR—Welcome, Mr Rashleigh. Do you wish to make an opening statement?

Mr Rashleigh—Thank you. We represent 16 funds. Could I just emphasise from the outset that all of those funds are not-for-profit and all have declared, quite unequivocally, their intention of retaining that mutuality. I guess the composition of our funds is somewhat different from most in that, largely speaking, we represent both trade and employee based funds—including a significant number of union based funds—where our obligation is equally of a social level as opposed to providing appropriate cover. In common with the last speaker, could I just say to respond specifically to Senator Cameron's questioning that we do not disagree with the principle of indexing the thresholds in any way whatsoever.

We would have thought the more appropriate level for singles would have been based on either CPI or average weekly earnings in the order of $75,000. I guess the argument we are putting forward is that we would contest that it is too much too soon. We say that for a number of reasons. We have some concerns as to the immediate effects, although I would have to say for the 16 funds that I represent that we actually see the loss of membership as being fairly minimal. The reason we see that as being minimal is purely and simply because not one of our 16 funds has a tax tailored product. In other words, all of those 16 funds have products which are designed to cover hospital incurred expenses, and not be tax effective in their own right. We would, I think, confidently on that basis expect that, because people have purchased our products for the purpose of covering their hospital costs and not because it is going to make them more tax effective, that the effect would be minimal.

Our much greater concern is in fact the longer term impact of being able to recruit younger, healthier members. Health insurance in Australia has been underpinned by the principle of community rating. I would shudder at the thought of that being changed to a risk rated system because I think it would become such an exclusive system and such a variable in price that one would have to question the long term viability of the industry completely. If we in fact are unable to recruit the same level of younger, healthier members who, by every recognition, in fact subsidise some of the older, more expensive members—and there is no doubt you can graph it in a very clear cut way the way costs increase as people age. I think estimates have been put by various people, and I do not even pretend to be an expert in this area, but something like 80 per cent of your medical costs are incurred in the last two to three years of your life. I think that figure, however solid it is, is certainly in the right sort of ballpark and gives an indication of where the costs fall. If we have an inability to attract those younger members, in fact the average age of the insured member will increase, therefore costs will increase and therefore premiums will increase. I think that is fairly significant.

The other concern we have is risk equalisation, and I will try to make this as simple as I can, because it is probably the most complex aspect of health insurance. In the case of my funds where we expect to lose minimal members because of the structure of our products compared with some other funds that have tax minimisation specific products, we will increase our market share and therefore, depending on how far that share moves, our contribution to the risk equalisation pool will increase anywhere from 11 per cent to 26 per cent, which is a very significant number in a pool which now totals something like $2.7 billion per annum. That is my overview. I will be happy to try to respond to any questions.

CHAIR—You were talking about the risk equalisation fund. Does that mean that generally speaking the members of your fund are younger than the general range?

Mr Rashleigh—Yes, they are.

CHAIR—That would be because of the nature of your funds which are quite frequently related to work?

Mr Rashleigh—Yes.

CHAIR—I notice you have the Doctors Health Fund, so presumably that is doing a good job.

Mr Rashleigh—I hope so.

Senator CORMANN—Can you give us a bit of a snapshot of the demographic of the membership of your member funds? The chair just talked about the age profile; can you perhaps gives us a bit of an indication of the likely income ranges of members in those funds? The reason I am asking is because TUH, who I understand is a member fund of yours—

Mr Rashleigh—Yes.

Senator CORMANN—They appeared before this committee in Queensland and talked about the fact that most of their members are on incomes of about $60,000 to $70,000. I am just trying to get a bit of a picture of whether there is a consistent demographic?

Mr Rashleigh—I do not know that it is consistent, because of the number of variables. If you look across the range of our member health funds we have police, and I am pretty certain that if this was an inquiry into levels of remuneration for police they would be very glad to have a statement like yours, Senator, as to what their expectations might be. We know for a reality that their rewards are significantly less than that. Certainly in the debate which is occurring among the teaching profession in Victoria at the moment, I think you will find a much larger range of salaries than perhaps the numbers you have indicated.

Senator CORMANN—You are saying that members in your member funds earn even less than the $60,000 but they are currently taking out private health insurance?

Mr Rashleigh—Yes. As I said, a number of our member funds are in fact trade union related. Without singling them out, if you took the two transport unions which are member funds, one in New South Wales and one in Victoria, I would submit that their income levels would be significantly less than that. Likewise, if you took the two service based funds you would get an enormous range. In my case, Navy Health, you get from relatively junior seamen to very senior commissioned officers.

Senator CORMANN—Would it be fair to say that policies like the 30 per cent rebate, lifetime health cover and the Medicare levy surcharge are helping to keep private health insurance affordable for those members on incomes of $60,000 per year and below?

Mr Rashleigh—I would think unequivocally, yes.

Senator CORMANN—Treasury tells us there would be a one-off effect related to this measure, and you say that will not really impact on your funds as much as others. But, if it is going to push up the price of premiums down the track through second, third and fourth round effects, what is that going to do to members in your member funds in those sorts of income ranges?

Mr Rashleigh—Ultimately I believe it will lead to a decrease in membership. We did some conservative numbers in terms of what the immediate impact would be and came up with a figure of about a 3½ per cent loss in membership numbers.

Senator CORMANN—Was that 3½ per cent?

Mr Rashleigh—Yes, 3.5 per cent.

Senator CORMANN—So, 3½ per cent for you is your first round effect, but what you are saying is that as this works itself through the system and we have a second and third and fourth round effect, it would be fair to say it would have a particularly heavy impact on members in your member funds on lower annual incomes?

Mr Rashleigh—Yes, I believe it would. I am not quite sure—and I do not think any of us can sit in social judgment—as to what the break point in that price is, but there is a break point in the price. I do distinctly remember in my younger days having to pay a mortgage, kids' school fees and all the other costs associated with kids, and something always had to give because that is the way life is.

Senator CORMANN—You mentioned community rating, and that is obviously a unique feature in our health system. Is it fair to say that government policies that are supporting Australians taking out private health insurance, including low and middle income earners, are in effect the price the government pays for having community rating in place?

Mr Rashleigh—I think it is partially that. That is a contributor to it, yes. Despite the numbers that were quoted before, one statistic that I bring before you is the fact that, of all procedures performed in Australia, 52 per cent are performed in the private sector. If you take that away or if you take any percentage of that away, no matter what the claim, that in fact creates a different pressure on the public system.

Senator CORMANN—You mentioned that you expect a 3½ per cent drop in membership across your member funds. Have you done any modelling to come to that figure?

Mr Rashleigh—I do not know that I would grace it with the term modelling. We have sat down with some people on our board, which is a six-member board, and done some careful thinking as to what that would be. That was the sort of a worst case figure we came up with.

Senator CORMANN—How did you come to that 3½ per cent figure? Can you talk us through your thought process as you kicked that around the boardroom table?

Mr Rashleigh—We looked at the other estimates and, as you would well be aware, they range from Treasury's estimate of 484,000 contributors to the AMA claiming somewhere between one million and 1.2 million contributors. We measured those in a percentage of the industry and then each of the six of us had a look at what we thought the impact might be on our own funds and came up with that raw average of 3.5 per cent.

Senator CORMANN—Treasury last week told us in Sydney that they now concede that even their conservative estimate is 644,000 people that they expect to leave private health insurance as a result of this measure. There was a bit of confusion in the initial stages about what seems like a misunderstanding between single equivalent units and persons covered. Treasury last week told us 644,000 people. But as I listen to your approach to modelling, it sounds to me as if that could well be a pretty conservative estimate. You have not looked at it in much detail, have you?

Mr Rashleigh—No, we have not looked at it in a great deal of detail. But the point that I should make is that we have—and I talk about 'we' as the 16 funds—have significantly less churn than the rest of the industry.

Senator EGGLESTON—Less churn?

Mr Rashleigh—Yes. Particularly in the larger, open funds, there is a lot of churn from one fund to another fund. Because of the very nature and the linkage between my funds and the members, we have a much, much stronger loyalty factor.

Senator CORMANN—Whilst sitting around the boardroom table as you came to the view that you would lose 3½ per cent of your members, did you also come to a view about the likely impact on premiums for your member funds moving forward?

Mr Rashleigh—We had a view that that would probably add to an already known factor of somewhere around four or five per cent, which is about the price factor which is occurring with both facility and medical costs. It would probably add another 3½ to four per cent to that factor.

Senator CORMANN—It would add another 3½ to four per cent, even based on your conservative estimate, on top of your normal, ordinary increases?

Mr Rashleigh—Yes.

Senator CORMANN—That is a pretty heavy burden for people on $50,000 or $60,000 per annum, is it not?

Mr Rashleigh—It is, yes.

Senator CAMERON—You have introduced a couple of very important issues to the committee's consideration. One of them is this distinction between the different aspects of the private health insurance industry, that being, on one hand, the not-for-profit group and the other area which is the for-profit area. Given that you say you have more loyalty and less of a fall-off because you do not offer a sort of tax avoidance type of proposal, should government consider a different approach to both the profit and not-for-profit sector? Should there be different approaches in government support?

Mr Rashleigh—We think probably yes. If I were to answer the question in a little more detail, Senator Cameron, one of the things I would say is that I find it difficult to understand how you both satisfy your members' needs and also your stakeholders' needs if there is a distinction between the two. In the case of a not-for-profit your stakeholders and your members are one and the same. If I can just explain that a fraction further. If I look at a broad breakdown of costs across the industry, you have something in the order of 85 per cent of all contribution income going out in the form of benefits or risk equalisation contributions to the pool; you have something approaching 10 per cent of contribution income being absorbed by administrative expenses; and the balance of five per cent really goes to your reserves to ensure that you continue to top up your reserves to meet the very stringent prudential standards set by the industry regulator. According to my arithmetic, they add up to 100 per cent, so something has to give to find some margin to compensate your shareholders.

Senator CAMERON—Do you not think one of the bigger dangers for the industry is if the industry starts getting greedy and we have individual executives of health funds who, for instance, de-mutualise, and are rewarded with over $1 million as a bonus? Do you not think that is a threat to the system if we start seeing this approach in the industry?

Mr Rashleigh—I certainly do in an unqualified sense. It is certainly not one of the underlying objectives of the 16 funds that I represent, and it would not be permitted. Having dealt with all the boards of my member funds, they would not underwrite that sort of attitude and that sort of reward.

Senator CAMERON—Thank you.

CHAIR—Going back to the income levels, for a single person to be on an income of $50,000 to $100,000 is really relatively quite a large amount of money. Would you have any idea what percentage of your membership would be on that kind of single income?

Mr Rashleigh—I could not answer that question, I am sorry, Madam Chair, no.

CHAIR—With the threshold being $100,000, would it be much more likely that it would be the family income that would be critical then, and that there would not really be many single people earning over $100,000 a year in income as a percentage of your membership?

Mr Rashleigh—Probably the majority, I would think, would almost certainly be families, yes.

Senator EGGLESTON—I would like to just ask you some questions about community rating, You say in your submission, 'The most fundamental characteristic of Australia's private health insurance is that a particular policy may be purchased for the same premium regardless of the age, gender, health condition et cetera of those insured.' That means there is no risk rating in Australian health insurance. What is the age range, did you say, of your membership?

Mr Rashleigh—I think the median age range is somewhere around 38 years to 40 years of age without being able to be much more precise than that. However, we would have age ranges in terms of all our member funds from 18 years of age, when people are leaving school and starting work and therefore coming off their parents' membership, through to—I do not know if we have any in triple figures, but we certainly have a number in their nineties.

Senator EGGLESTON—There are more people in triple figures around that there used to be, I must say.

Mr Rashleigh—You might be right, but I just have not gone out to count the ones in triple figures.

Senator EGGLESTON—Certainly there are a lot of people in their eighties and an awful lot in their seventies. In other words you have the whole age range from fairly young people to quite old people? You think you are going to lose 3.5 per cent. I presume they will come from the younger groups? You must feel concerned about the future of community rating under this proposal?

Mr Rashleigh—I am, but I would be a lot more concerned for the future of the industry and the future of the Australian health system if we became risk rated. I just think that would preclude a number of people from accessing treatment.

Senator EGGLESTON—But if, in fact, we go back to where we were when the surcharge was introduced, which was the situation in which there was severely declining membership of health funds, is there not a real risk that community rating will not work any more because the risk equalisation scheme, in the end, will not be able to provide enough support for community rating to continue, or it will put it under great threat? Is that not a logical conclusion?

Mr Rashleigh—That could be a logical conclusion. With all due respect, I do not think it is the right conclusion. If I pick up on a point that was made earlier, while I concede without any argument that lifetime health cover in fact generated the fastest growth in the numbers in the funds, I would put it that had it not been supported by the 30 per cent rebate at the time, it was unlikely that those numbers would have been achieved to the levels that they did, because the private products would have been just too expensive.

Senator EGGLESTON—That is the three tiers there, so what do you think the right conclusion is? You said to me that you did not think that the right conclusion was that community rating was under threat. Do you see some stress in the system?

Mr Rashleigh—No, I do not. I think one of the difficulties and the distortions we have had, and something that we need to be careful of, are exclusion products, because the Ombudsman acts upon it. That is the way the industry as a whole has tended to be able to come up with products that could in any way be described as discriminatory. The logical ones have been to exclude obstetrics and joint replacements in particular, and many cardiac as well. The real problem with those products is that when do you remove them from being eligible to a certain market. Is the 40-year-old male being sold a fit for purpose product over the age of 40 years if it excludes cardiac? I think the Ombudsman would probably suggest not.

Senator EGGLESTON—In a way does that not by definition, although it is not quite the same, mean that the concept of community rating is not being applied any more as it was conceived? In other words, by having exclusions you are admitting that you cannot cover everybody for every thing, which has been the underlying principle of Australian health insurance?

Mr Rashleigh—To a degree that is right.

Senator EGGLESTON—Yes, it is right.

Mr Rashleigh—Although, Senator, I would make the point that the requirements surrounding exclusionary products are far more stringent today than they were perhaps back in the beginning of this decade.

Senator EGGLESTON—What do you mean by that?

Mr Rashleigh—There is a phrase which I used before which is the one used by the Ombudsman, 'fit for purpose'. Therefore, you should not be selling to a 40-year-old male, for example, a product which excludes cardiac treatment because they are not excluded from perhaps being vulnerable to that.

Senator EGGLESTON—Do you include union funds in your membership?

Mr Rashleigh—Yes.

Senator EGGLESTON—Have you had any consultation with the government or union representative or the ACTU about these possible changes to the format of the health insurance system prior to the announcement?

Mr Rashleigh—Not in a direct sense through the ACTU. However, what I can tell you is that in many cases with respect to the union based funds that I represent, I have the immediate endorsement of their boards who are union members to frame this submission in the way that it has been put to this committee.

Senator EGGLESTON—That is fine, but did you get any hint that there might be changes in the wind when the budget was brought down?

Mr Rashleigh—None whatsoever.

Senator EGGLESTON—No consultations, no hints?

Senator BUSHBY—Are you aware if any of your member funds had any consultation or indication prior to the budget coming down?

Mr Rashleigh—I think I could say categorically no.

Senator CORMANN—Would you be concerned if there were any further changes, like going down the same track? For example, changes to the lifetime health cover arrangements such as increasing the age at which it applies or means testing of the 30 per cent rebate or getting rid of the 30 per cent rebate altogether? Would you be concerned if the government were to consider changes that would go further down this path that they have started?

Mr Rashleigh—Dramatically concerned.

Senator CAMERON—You are not aware that the government is considering removing those incentives for private health, are you?

Mr Rashleigh—No, I am not. We consult frequently with the minister, with the minister's advisers and with the department. I guess what we would ask, as an organisation, in any process of change that we in fact get the opportunity to go through that consultation process and put our view forward.

Senator CORMANN—Did that happen on this occasion?

Mr Rashleigh—No.

Senator CORMANN—So, would you expect it to happen on a future occasion?

Mr Rashleigh—I would hope.

Senator EGGLESTON—Hope is probably the word.

CHAIR—Thank you, Mr Rashleigh.

[4.42 pm]

BROWN, Mr Gerald, Chief Operating Officer, iSelect

MARTIN, Mr Rowan, General Manager, Corporate Affairs, iSelect

WALLER, Mr Damien, Chairman and CEO, iSelect

CHAIR—Welcome, gentlemen. Mr Waller, do you wish to make an opening statement?

Mr Waller—Thank you for the opportunity to appear before the Senate inquiry into the Medicare levy surcharge. I would like to give you some background on iSelect. We are Australia's largest health insurance advisory and comparison service and we have been operating since 2000. Many of you may be familiar with our advertising campaigns. For half of our customers we enable them to compare policy options in one location and help them reduce the complexities associated with choosing health insurance cover. Ultimately we assist them in finding cover that suits their needs and life stage. Our focus has been on attracting new entrants into health insurance so, as such, we have a unique insight as to the impact of the Medicare levy surcharge and the proposed changes.

The average age of people who purchase through iSelect is around the mid-thirties. We represent close to 10 per cent of all the new health insurance sales in Australia on behalf of our participating funds. Last year some 1.1 million people visited our website. Our aim is to provide our participating funds with an effective and low cost acquisition channel.

We estimate that we represent approximately 80 per cent of all health insurance policies sold through intermediation in Australia. iSelect's primary concerns with the proposed threshold changes are: first, that there seems to be a lack of modelling in terms of, in particular, the second and third round impacts of the Medicare levy surcharge changes; secondly, that there has been a lack of consideration of the impact of the key drivers of health insurance being MLS, LHC and rebate and their interdependence; and thirdly, the detrimental impact the proposed change will have on community rating which is a key pillar of private health insurance, and the detrimental impact this proposed change will also have on our public hospital system, private health insurance premiums, health fund and intermediaries' viability and the loss of health funding via a significant decrease in premiums' revenue, much of that being voluntary.

We also hold the view that there are many ways that productive reform or change could occur which do not necessarily produce such a detrimental impact on Australia's health care system and which would meet the government's objectives. These of course would be subject to further discussion and analysis. These may include: leaving the thresholds as is and providing other tax relief generated from the public system savings of having the benefits of the Medicare levy surcharge as is; potentially a lower MLS tax rate for lower income earners; setting the thresholds currently at average weekly earnings; or providing a higher rebate for under-thirties. We believe that the proposed new thresholds are likely to have a marked and lasting impact on the private health insurance industry and its members. We see this impact as playing out through a first round loss of members over a period of time, a second round loss of members due to future premium increases due to the initial loss of members, and also a third round and, we believe, a very significant loss of people who would have otherwise joined health insurance over the next few years. These impacts will mean a substantial shifting of episodes of care into the public system combined with issues around inherent capacity and funding constraints, and also substantially higher premiums over a period as opposed to the thresholds being left as is.

We are very concerned that this approach serves to diminish and put at significant risk a vital component of the health funding, namely, voluntary contributions not just of younger members but many others in private health insurance who may be forced to drop their cover due to increased premiums. Voluntary health funding is critical to Australia and is needed to meet our long term health needs, and the costs of health care are forecast to reach 7.3 per cent of GDP in the next 40 years, and this is under the second *Intergenerational Report*.

I would like to make a comment on what iSelect has already experienced post the budget announcement of the levy change. This is despite the fact that the amendments are still not widely known by many Australians, they have not actually been enacted as legislation, and in fact in the official ATO tax pack the threshold is displayed as the previous regime. We can confirm there has been a significant impact already. In the period since the May budget announcement, iSelect has seen a significant slowing, with the number of new people joining health insurance down 27 per cent versus the same time last year. I guess the point is it is not theory anymore; it is actually having a real impact on this market. We have all noted the majority of this decline is

attributed to younger, healthier members who are critical to the community rating system and in subsidising the less healthy in our community and ensuring premiums remain affordable to all Australians.

Despite opinion to the contrary, many of these new singles into health insurance are not buying lower cover basic policies. The average premium of new singles through iSelect as at July 2007 is about $1,300, and that is at a key MLS-driven tax time. That is compared to a lower tax based policy of around $600 to $800. To assist in our internal forecasting, iSelect has commissioned one of Australia's leading and best known economic consultancies, Access Economics, to examine the impact of the changes. This work has taken some time. We expect the final report to be completed in the next few days. As soon as the report is completed, we will furnish the members of the enquiry with this report as an addendum to our submission. The report has modelled the first, second and third round impacts together with implications of private health insurance, public hospital sectors, premiums and so forth. As a community we must ensure that we seek the optimum balance of the private and public systems. MLS has only recently in the last two to three years been very effective in driving significant growth into health insurance which in turn has helped in delivering lower premiums and fewer loads on the public system. We must be very carefully not to dramatically change MLS and the benefits derived simply by indexing a 1997 level where the policy had minimal or no impact at that time. Given the critical role MLS has played in encouraging healthier and younger members to invest in private health insurance, not just for their own health requirements but to support many other Australians which in turn is repaid to them at a later date, we ask the Senate to consider retaining existing threshold levels for the foreseeable future and, if the amendment to the threshold is considered necessary, that in-depth analysis and an open consultation with all stakeholders is completed. Thank you.

Senator CORMANN—In your submission you mention that 70 per cent of the members that you referred to health insurance products are in fact new to health insurance?

Mr Waller—That is correct.

Senator CORMANN—When did you say you started?

Mr Waller—In 2000.

Senator CORMANN—It is fair to say that, faced with a health system that was out of balance and where in 1998 only 30 per cent of Australians took out private health insurance, you are really at the forefront of bringing new members into the private health system?

Mr Waller—That is right.

Senator CORMANN—With that sort of background and having been operating through that period of massive growth in the private health system, can you just talk us through how you have observed the three-pillar policy of 30 per cent rebate, lifetime health cover and Medicare levy surcharge work over the years?

Mr Waller—Sure. The 30 per cent rebate was put in place before 2000 and the effect was not that strong. The lifetime health cover initiative was put in place and that saw the market grow significantly, about 50 per cent. Then the growth in the market has actually been below population growth over that time. What has happened in the years 2006, 2007 and 2008 is that the Medicare levy surcharge and the thresholds have had a significant impact on the market, on new growth and in younger members. We have experienced that directly both in terms of the growth of our business and the new members that are coming into the market.

Senator CORMANN—What you are saying is that the Medicare levy surcharge actually in recent years has become increasingly effective in achieving the objective of encouraging more people into private health systems?

Mr Waller—That is correct, yes.

Senator CORMANN—You mentioned in your opening statement that, contrary to the Treasury statement which was that they expected only a one-off effect, a one-off shock to the system, you thought there would be second and third round effects involving very significant loss of members. Could you define for us what your expectation is of very significant loss?

Mr Waller—I would rather not quantify it but I can certainly give you a qualitative statement. We will share the report with the senators in due course. What you will see is initial loss of members over the next 12 months. That loss will drive a higher premium increase next year which in turn will generate another loss of members. But the real issue will be the changes to the MLS threshold will result in far fewer people joining health insurance over the next four years, and these are critical members and memberships which will help keep the community rating system in place. With those members not joining the system what you will see is

declining growth in the sector in private health insurance and you will see premiums going up, and that will create a downward spiral.

Senator CORMANN—You mentioned how you have commissioned Access Economics to do some forecasting, some economic modelling for you. Can you just describe for us in your experience as experts in the health financing area, in the broadest possible terms, why that is important, and can you perhaps offer a comment as to whether state and territory governments would equally be able to commission similar research forecasting the impact on their areas of responsibilities, namely public hospitals?

Mr Waller—I think anyone in health insurance or the health sector can commission a report similar to Access Economics.

Senator CORMANN—But why did you commission a report? There is obviously a reason as to why you did it. You thought there would be an impact on your business and you thought it would be prudent management to quantify the impact so you could plan and prepare for it. Is that a fair comment?

Mr Waller—Yes.

Senator CORMANN—Do you think it would be equally prudent for other players on the public side of the system to do so?

Mr Waller—I think it makes sense for everyone who has a key role in this sector to generate their own reports and make their own conclusions.

Senator CORMANN—Some people have said that modelling is not very reliable and, of course, modelling is only as reliable as the underlying assumptions. The more facts and figures you have in front of you to inform your assumptions, the more reliable your outcomes. Do you think it would be helpful if Treasury, for the benefit of private health insured Australians, for the benefit of state governments and for the benefit of everybody involved in the health system, actually made its modelling available so that all of those stakeholders are able to have the most informed basis on which to reach their conclusions?

Mr Waller—I think the more open consultation and the more sharing of information between all stakeholders, as we intend to do with our report, is beneficial so that any decision that the senators make is an informed and balanced one.

Mr Martin—Can I add also that one of the things in terms of engaging Access Economics is that we wanted, I suppose, confidence from them that they had access to and there was available sufficient data in order to do this point of work, because there was little point in us commissioning work if the appropriate data was not available. That was a key point of making sure that they had confidence around the availability of data. Obviously they would seek more ideally but they were confident in terms of the level of information that is available to do that sort of modelling.

Senator CORMANN—You mentioned a relationship between those policies supporting people taking up private health insurance and community rating. Why is it important to have as many people as possible in the private health system? Why is that an important goal from a public policy point of view?

Mr Waller—I would not necessarily say as many people as possible. I would not necessarily use those words. I would say that it is important to have a balanced spread of various risks in the system because if you have fewer younger people joining the system, that will put up prices for the remaining people. Younger people who join the system may not claim as much as others, and that helps bolster the system for the elderly and the chronically ill.

Senator CORMANN—Is it fair to say that the more younger people who are in the system and ultimately the more people who are in the private health system, the more affordable it is for everybody because the risks are spread across a broader cohort when more people are in the system? Is that a fair statement?

Mr Waller—Yes, that is correct.

Senator CORMANN—Any policy that actually discourages people from either joining or encourages them to leave, particularly very good risks, necessarily goes in the wrong direction, does it not, because it makes it less affordable?

Mr Waller—I think the other key factor there is not just about the community rating system but it is the impact on the public system. What we should be doing as a community is looking at what is the return on investment or the cost benefit of these changes in terms of what is the net cost in terms of the government, not just the rebate and the MLS savings but also the public system costs. We should be looking at whether this is

the right thing to do as a community. We are potentially putting up prices for a huge number of people who are in private health insurance and, as a government, we actually have a net outflow of funds to support this initiative.

Senator CORMANN—When you say we should assess the net cost to the government, what you are saying is that Treasury and the health department should have assessed what they called second round effects and not only assessed the impacts on revenue and on expenditure? Is that right?

Mr Waller—That is right. Whether it is federal or state, it does not matter. It is: what is the net public sector cost of this initiative and what are the long term effects in terms of people who do not have a choice, who have to stay in the system because they are ill, chronically ill, et cetera? As we have put in our submission, a large number of people, 28 per cent, are earning under $50,000 that actually have private health insurance.

Senator CORMANN—And, of course, those people will be on the receiving end of increased premiums as a result of this measure as well?

Mr Waller—Yes.

Senator CORMANN—Do you think there is a better way of giving one per cent tax relief to singles in the $50,000 to $100,000 income bracket that are not on health insurance than what is currently proposed?

Mr Waller—I guess all I would say is that, from the work that we have done, the MLS changes will create a large net outflow of government funds. So it would seem strange why we would not just provide that tax benefit through the tax system.

Senator CORMANN—Would you be concerned if the government was also considering measures like increasing the age at which the lifetime health cover loading applied or introducing means testing of the private health insurance rebate? If you are concerned, would you expect that, contrary to what happened this time around, the government would be consulting with industry and stakeholders?

Mr Waller—We would be very concerned, and I would hope that they would consult with the wider industry.

Senator CORMANN—Are you aware as to whether the government at any time before the election, before the budget or since the budget consulted with anybody in the industry?

Mr Waller—No, there was no consultation.

CHAIR—Can you just take me through how iSelect works? By the sound of it, it is an online kind of system. Is that the only way that people are contacted?

Mr Waller—No, we have approximately 100 staff, so we have consultants who can help people over the phone choose appropriate levels of cover. So you can either do it online or you can do it over the phone. Effectively it is a comparison service from a range of funds to help people find appropriate cover for their needs.

CHAIR—How are you paid for that service? Is it per call or a percentage of the policy? How does that work?

Mr Waller—We receive a fee from the health insurance providers which is very, very cost effective for the insurance providers relative to their other forms of acquisition, and we are a very, very high growth channel. A lot of the funds that are participating in iSelect actually are the fastest growing funds in the industry.

CHAIR—With respect to the fee that you receive from the funds, is that a flat fee or is that a percentage of the policy sold?

Mr Waller—It varies depending on the commercial arrangement. But generally speaking it is within a fairly narrow band.

CHAIR—You are saying that most of the people that sign on to your service are in their mid-thirties, is that right?

Mr Waller—That is correct.

CHAIR—Do you see that as a reflection of that being a combination of coming in to that lifetime ratings system and also that is an age in which people are probably coming into that $50,000 range?

Mr Waller—I think it is a combination, because most of our business, some 70 per cent, is new to health insurance. A lot of those members who are new are, by their very nature, younger members and they will be

coming in for a range of reasons both in terms of their health insurance needs or benefit needs: a young couple planning a family, someone may have need of extras benefits et cetera, and also a combination of the use of the LHC, lifetime health cover, and also the Medicare levy surcharge. It is not just one thing in isolation necessarily. Gerard has some stats in terms of how many people are buying the tax only policies, if you like, and it is generally a fairly small percentage. However, the Medicare levy surcharge prompts people to come in to the system, and once they are in the system they can enjoy the benefits of the cover that they buy.

Mr Brown—The bulk of our sales are actually derived from talking to one of our advisors. People may be driven to us via Medicare levy surcharge and LHC, but by talking to someone and doing what we call a needs analysis we actually deliver to a fund someone who has a policy that matches what they want. As Damien said earlier, for the vast majority of people—let us take singles—coming through, the average premium was $1,300 in July 2007. If they were coming on board just for tax reasons they could take a policy for maybe $550 to $650.

CHAIR—You said that there are other ways to meet the government's objectives and then you talked about tax means or increases in subsidies. What do you see as the government's objectives in this measure?

Mr Waller—In the government's objectives? I think the savings are very well publicised in terms of the budget and to provide a tax break to people earning in that range above $50,000.

CHAIR—Your solution is to provide further rebates to those who do take out cover?

CHAIR—I would not say that is our solution. Our recommendation would be not to do anything unless there has been some further detailed analysis and work done in this area and further consultation. The concepts that we mentioned earlier may be the right ones, they may not. There may be others we have not mentioned. All we are saying is that I think we have to be careful not to go forward with a knee-jerk reaction to a policy where it could actually create a very damaging, long term consequence to the health care sector. We just feel that there needs to be a lot more analysis, a lot more open discussion about these changes.

CHAIR—So, your business derives from business who reach their thirties, are affected by the lifetime health cover, and affected by their $50,000 income? Might not there be other ways to stimulate people to think about whether they take out health insurance other than making people on $50,000 pay an extra tax, in effect?

Mr Waller—There may be, yes.

Mr Martin—That was the point we were making in the introduction around the fact that there may be other measures that can assist this. Again, we have not done our modelling on that. We are saying that some of these ideas could be included once there was further analysis conducted on them.

Mr Waller—One of the key items to take into account is that the younger people who are coming in are actually paying a significant portion of their premiums for the benefit of others. If we had a risk rated system, although we would not recommend that system, these younger people would actually pay far less for their policies and you would have far more younger people coming into the system. That is why policies like the MLS and other polices are needed to prompt younger people to take out cover maybe a little bit earlier than they otherwise would. In turn that provides support to the community rating system.

CHAIR—It is a fairly blunt instrument, though, by making people pay another one per cent more tax.

Senator CAMERON—Mr Waller, how would you describe your company? Is it a company that provides a public service or are you a recruitment agency for the health funds?

Mr Waller—I think we do both. We disseminate information; we help consumers purchase the right levels of cover. The fact that we are comparison service means we can help consumers save money rather than just go with the fund that their parents were with or just stumble into an office and take out any cover. As Gerald said, we do a detailed needs analysis, so we ensure that people are on the right level of cover for their needs, which is often not the case. In that sense I think we are providing a large public good in the private health insurance sector. We are promoting competition. On the other side, what we are doing is we believe we are lowering the costs of premiums in the sense that our acquisition channel is cheaper than many other channels out there, and it is a very effective growing channel.

Senator CAMERON—You do not represent all health funds, do you?

Mr Waller—No.

Senator CAMERON—That is not clear on your website. I had a look at your website some time ago. It was not clear that you only did a selective group of health funds. Would it not be better for you to be open and say you do not represent all health funds, that it is a fee for service type proposition?

Mr Waller—It is the first time I have heard that. I think the website is extremely clear. In fact consumers have to opt in that they have been told that we have a limited number of funds.

Mr Martin—On the homepage of our website the logos of each of our participating funds are clearly disclosed and, as Damien has said, customers have to acknowledge that we are a service representing only participating funds, and we make that very clear.

Senator CAMERON—Okay.

Mr Waller—One point I would make is the service is open to all funds. It is not a limited service.

Senator CAMERON—I am just trying to get clear, because I was not sure from your answer, do you get your return from the funds on the basis of the policy amount that someone takes out? Is there a percentage of the policy amount comes to you?

Mr Waller—That is correct, yes. We get a fee based on the policy.

Senator CAMERON—What is the control measure that you have in place to make sure your agents do not try and maximise the return to the company as distinct from what is best for the member or the potential member? If you are on a trailing fee and it is a percentage, is it not in your interest to boost up the—?

Mr Waller—Not at all, no. Gerald, do you want to talk about our needs analysis?

Mr Brown—We do a full needs analysis that is recorded both in terms of storage and also voice wise. We are very open in terms of the process we go through with our participating funds and also the likes of PHIIA. So everything is very open, very transparent. Our funds will come in and audit what we are doing, just as we have had government representatives in as well. The compliance we have and the finding out what a customer actually needs we feel is very, very high relative to the industry.

Senator CAMERON—Do you represent any of the not-for-profit funds?

Mr Brown—Yes, we do.

Senator CAMERON—What kind of turnover did the company have last year?

Mr Brown—We are happy to supply some information on a confidential basis.

Mr Waller—I am not sure if it is public—

CHAIR—If it is not public information you are not required to provide it or you may do it on an in-camera basis.

Senator BUSHBY—Yes, exactly. If you do submit it in-camera the committee can decide to release it as well. So be aware of that before you make a decision.

Senator CAMERON—The reason I am asking is that I think one of the problems for the not-for-profit and the profit industry is that it is a very confusing product to buy. I think you have come in at a real niche to say look we can guide you through that. Is not one of the problems for the industry not so much what the levy is but that people are confused about the product and they are not sure what benefit they will get? Is that not the basis of your business?

Mr Waller—Can we quote that on one of our ads?

Mr Brown—It is a confusing product per se. I think there are 37 health funds out there. I will just go back to the point earlier. People who are coming in who have health insurance already, there is not a huge difference in terms of say the premiums of someone who is new to health insurance. I would say that what we are delivering to the funds is a policy that that person actually does want; otherwise you would find a big difference. The service we do provide, yes, it is a comparison service but we have invested a lot in terms of people to talk to people. A big training element goes into those advisors akin to under AFSL in terms of the amount of work we put into the advisors. I would say that the advice we are giving is paramount, and we are very transparent about that. We would not really have survived for nine years in this industry if it was not, and most of the funds that are on our service are actually not-for-profit.

Senator CAMERON—Access Economics do lots of work for the big end of town, and I was quite surprised that iSelect would be seeking such a big project from Access Economics because it will not be a cheap proposition. This brings me back to this issue that we really need to look at costs in the industry, and if

government is putting so much public money into this industry, if a service provider to the industry can afford to go out and get Access Economics to do econometric modelling, then I have a real worry about where all this money is going that the government is putting in.

Mr Brown—I would say that we feel we need to do that. As Damien said earlier, it is incumbent upon us to do that. In terms of cost of acquisition, the funds are not forced to work with us. We are working and competing with internal costs of acquisition of the funds. They clearly see it as cost effective. If you look at it at a high level, we are advertising on TV and radio, and providing that service for the participating funds. There is an economy of scale in terms of the TV commercials we put out there. If you took every single fund in our service and they had to spend the same amount of money on TV advertising, that would add up to a lot more. So we would debate that fact. We would say that, as an intermediary, we are offering a pretty cost effective service because those funds are still with us and working well with us.

Mr Martin—Can I also add, Senator Cameron, it obviously was a significant decision for an organisation of our size—we are not a large organisation—to get a body like Access Economics to do the work. That being said, we would have liked them to do more work but it is still a confined piece of work and there is still an opportunity to look at a range of issues with other stakeholders. But it was something that was a significant decision for our organisation that we felt was an important decision to ensure that we were well informed as well about the potential impacts of the decision.

CHAIR—Thank you.

Senator CAMERON—I will add your submission to the battle of the models.

CHAIR—Thank you, iSelect, for coming in this afternoon.

[5.16 pm]

SCULLIN, Mr Peter, Managing Director, Health Link Consultants

CHAIR—Good afternoon, Mr Scullin. Thank you for coming along today. Would you like to make an opening statement?

Mr Scullin—I would indeed, thank you. We are a Melbourne based but Australia wide health insurance consultancy service. I have read and understood most of the various submissions made to this Senate economics committee and to start off I would just like to explain that Health Link Consultants conducts a similar service to iSelect with a particular focus on the employer market which I would like to talk about later in my submission.

On the back of our card it simply says that we evaluate Australia's private health funds for our corporate and personal clients. We then advise the most suitable cover based on quality care at cost effective rates. That is really what we do. I have just heard iSelect's submission, and because I am the last cab off the rank here this afternoon I did not want to weary all the members of the committee by repeating the same things over and over again. It is at the end of the day so I would like to try to make some new contributions if I can rather than repeat many of the points I am sure you have heard over and over again.

I would like to single out one particular submission I read from a Mr Terry Barnes of 1805 Consulting. Because I run a small business myself, I have only six staff and we are very much at the coalface, I take calls from private health insurance inquiries myself in our office. I read Terry Barnes' submission to this committee and I must say, as a practitioner at the coalface I felt I would really like to endorse his submission. I thought it was an excellent submission. I realise that Terry Barnes does have somewhat of a political background. I am not a political animal at all, but with his having been an advisor to the previous minister, I hope that this committee would look at that submission for the truth, honesty and accuracy I felt it really gave. I would put a plea to the committee to look at that as much as possible in a non-political way because I felt it was really an excellent submission.

I would like to make three key points if I could, and the first one I would like to talk about are the proposed changes to the Medicare levy surcharge. I would like to put to the committee that this was actually put together in what I would call a different time and a different place. This all really took place, I guess, in either between February and March of this year when the budget estimates committee was doing all of its work. I submit to the committee that that was a different time and place because the way the economy has changed out there now since then is quite dramatic. When these things were put together, for example, altering the Medicare levy surcharge and the impact that I can see that it will have now, I do not think the people who were doing that work could have seen that simply from February to March how much the economy would have changed up until now.

I would submit that the working families with whom I deal are really feeling the pinch at the moment with rising petrol prices, rising food prices, and the mortgage stress through higher interest rates. I feel that people are really feeling this. I feel we could almost have a repeat of the situation that the late and great Senator John Button wrote in a book called *As It Happened*. There is a chapter of the book where he talks about how things had changed so rapidly in Melbourne and Sydney and yet people in Canberra had not really got on to how rapidly they had changed. I say this because our inquiries have slowed since all this publicity concerning the Medicare levy surcharge has taken place. Amongst the many clients that I have, small business enterprises and retailers are telling me that they are really feeling the pinch. I feel that by opening up the opportunity to allow a lot of younger, fitter Australians, the best quality type of health fund members, to drop their private health insurance, it is potentially a real train wreck on the way. If up to one million Australians drop their private health insurance, to try to reverse that will be incredibly difficult.

I say to this committee: why do it now? Why not amend the legislation? First of all, I do not oppose the increases. Even though I run a small business and I have a vested interest which I am quite prepared to admit, I do not oppose them. I think they could be changed to be in line with the CPI indexes going back to 1997, which I roughly understand to be about $76,000 for singles and about $156,000 a year for families, couples and sole parents. I understand the need for that and what the government is trying to do. But, in particular, I would say that allowing young affluent single people, many of whom are now earning more than 75,000 a year, not to be taught to manage their own private health insurance is sending all the wrong signals, and it is not a good piece of policy.

The second point I would like to make is that Medicare levy thresholds are tied to hospital excess levels. For example, as a single if you have an excess of more than $500 a year or an excess of more than $1,000 a year as a family couple or sole parent, that is where the Medicare levy thresholds are set. One of the ideas I would like to put forward—we were talking about ideas a moment ago—is why not adjust those hospital excess levels in line with the indexing of the Medicare levy thresholds, so the $500 would become, say, $750 and the $1,000 would become $1,500. The final point I would like to make—and this is another new thing I would like to put forward to the committee—is that in all the submissions I have read no-one seems to have taken into account the detrimental effect on Australia's employers. When employees drop their private health insurance, it severely adds to the hidden costs of the add-on costs of employment. With respect to issues such as absenteeism and presenteeism, a lot of employers now are just realising how much that is costing them. When someone does not come to work, there is a huge cost associated with that. When young fit people or even the families that are going up to, say, the $150,000 levy threshold, drop their private health cover, that cost will be reflected in the employer market. At 6 o'clock this morning I was at the Mooney Valley City Council in the council depot presenting a health plan to all the workers there. The Mooney Valley City Council cannot possibly fund private health insurance contributions.

They are trying to subsidise the plan through the hospital excess. I feel that if the hospital excess was raised in line with the CPI indexing, this would become a negotiable benefit at the workplace. It could be put on the table with EBAs or AWAs and become a really worthwhile negotiable instrument. They are my main opening remarks, thank you.

Senator FURNER—You alluded to the fact that you represent employers. In closing you were commenting on how you were discussing health benefits out at a council site. Is it a case that you represent employers to bring about an encompassing benefit for the employees of the employer? Is that how your business operates?

Mr Scullin—Yes. Certainly I utterly oppose the American involvement of employers in health care. I think that is a massively wrong direction. In Australia, because of FBT, there is really no encouragement for employers to get involved in subsidising health cover at all, yet I can see they are really interested in doing something to help. Yes, I am trying to assist the employees retain their health cover by encouraging the employer to subsidise it in some small way, not by paying contributions, but by helping to subsidise the cost of the hospital excess.

Senator EGGLESTON—I was quite interested in this question of employer involvement because in many countries health insurance is provided by employers. In Germany, for example, health insurance is provided by your employment, and so it is in the United States. That is quite a different pathway to go down for Australia. You have said what you just said, but do you think it is a real option in Australia to introduce employer provided heath cover, because it would become a fringe benefit and be taxed and so on?

Mr Scullin—No, I do not, because private health insurance is subject to FBT. The way the system is at the moment, all Australians pay for their own health insurance contributions. It will give employers an added burden of having to pay for health insurance contributions, when a lot of manufacturing employers and so on are struggling to pay wages as they are, although we do have a buoyant economy. My case would be to subsidise the cost of private health cover. For example, with the hospital excess—and this is not really the business of this committee—but if the FBT was taken off the cost of subsidising excesses, I think employers would want to become a lot more involved. But my concern to this committee is if a lot of fit, healthy and young—the better quality members as other people before me have submitted—leave the system, it will be incredibly difficult to get them back. That is why I think what this committee does is so important.

Senator EGGLESTON—Can I bring you back to indexation, because you suggested the threshold could have been indexed rather than this jump for singles to $100,000. Effectively people seem to think $75,000 would be about the threshold for a single person had indexation occurred, and also effectively that means the couple rate is reflecting that at $150,000. What do you think the impact of setting a threshold at $75,000 would be in terms of loss of membership, increased stress on public hospitals and so on?

Mr Scullin—I still feel it will be detrimental. Obviously being in the business I am in, I would much prefer it if the Medicare levy thresholds stayed as they were. Being realistic, and seeing that the government does have an agenda of trying to provide some health relief to even those people who do not have private health cover, and trying to look at the broader picture, at $75,000 we will lose a lot of members anyway. Because I run a small business and I do not have a research house, I can only go by the modelling that the Treasury did, which even they have admitted included errors, and the modelling that was done by Access Economics for the

AMA. I listened to what iSelect said because they are a much bigger organisation than me, so I would think it would probably be in the order of up to half a million people will leave.

The plea I want to put to this committee is to not do it now, because the economy out there is really turning. If you give the people that are already struggling with the petrol, the food, the mortgage rates, the opportunity to drop their private health cover, they will take it and they will be lost. Then the pressure on the public system will be absolutely overwhelming. It will be in my view a train wreck on the way. I feel it would be a major mistake to do that.

Senator EGGLESTON—We are concerned about the pressure on the public system and the need for additional funding, but the Treasury figures I think were members of health funds rather than individuals, and that was about 486,0000 or some figure like that. If we put an indexation figure at $75,000, which is about half way, we could assume I suppose that the people on lower incomes would drop out and I suppose that might be two-thirds of that group or something like that, do you think? It would still have a significant impact on public hospital waiting lists and so on as we have agreed. One of the corollaries of this surely has to be that there is an obligation on the Commonwealth government to provide additional funding to the state governments to ensure that the public hospital congestion is mitigated to some extent and that the increase in the rate of lengthening of the waiting lists is reduced or contained?

Mr Scullin—In running a small business as I do, I do not have huge research facilities, so I could answer your question anecdotally. With regard to the state governments, first of all the state governments have a vested interest in private health insurance remaining healthy, in my view, because from what I can see of it, all of Australia's state governments are already struggling to run an adequate public health, public hospital system anyway. I read that the Commonwealth has just handed out another $1.6 billion, but the pressure does not seem to ease, it seems to always remain the same. The waiting lists go on and on and on, and it does not seem to be addressed. In my view one of the great ways of addressing this is to give people choice, and I think Australia has it right at the moment; having this choice between a public and a private system and encouraging both of them to be healthy is nothing but a good thing.

Senator EGGLESTON—That is true; I agree with that. The state hospital systems are funded under the Commonwealth-state hospitals cost sharing agreement under which the Commonwealth provides grants to the states to provide a public hospital service. Having taken this action of lifting the threshold with the Treasury modelling, flawed though it may be, suggesting a very large number of people now flow into the public hospitals, I would have thought it was incumbent on the Commonwealth having done that to also have made public a very clear policy decision to increase funding to the states on a very substantial basis. Would you not agree with that? I am surprised that they have not.

Mr Scullin—My plea to the Commonwealth is: there is an old saying, 'If it ain't broke, don't fix it'. I feel the tripartite system of the Medicare levy surcharge, of the lifetime health cover and the 30 per cent rebate working in unison are delivering. I take the point that the indexing needed to take place, but my response to that is to avoid a lot of people leaving private health cover, if you raise the hospital excesses which are tied to the Medicare levy thresholds, it will allow health funds a lot more flexibility. From my point of view, with employers looking to subsidise excesses for employees, if the excess levels are higher, there is a greater amount of flexibility available in EBAs and AWAs, if there is a higher amount of excess to be put on the table and be negotiated. I am sure Senator Cameron knows much more about EBAs and AWAs than I do.

Senator CAMERON—I just hope you are not out there negotiating AWAs.

Mr Scullin—At the moment there is not very much to talk about. Superannuation is a dead duck; employees want more wages; employers do not want to pay more, and so on. Putting health cover on the table as a negotiable instrument, and particularly with a prevention and protection strategy—in other words, wellness programs at the workplace—that is the right direction for Australia.

Senator CAMERON—I do not want to make a commentary on your submission, other than let me say have a look at what happened in the United States, ask GMH, ask Ford if they want to replicate the American system in Australia. It just would be an absolute disaster according to them. You talk about train wrecks and disasters; it is a bit like the sky is falling in. Have you looked at the academic research analysis into what could happen if the private health sector does not deliver all the benefits that it has claimed in terms of reducing waiting times?

Mr Scullin—Yes.

Senator CAMERON—Whose analysis have you looked at?

Mr Scullin—PHIAC, the Private Health Insurance Administration Council, puts out a lot of research. There is the private health insurance ombudsman and there is a whole range of people monitoring what is going on in the private health insurance industry.

Senator CAMERON—When you say that people should be taught to manage their own private health insurance and that you are for choice, should it not be a choice for those workers under $100,000 whether they want to be in a health fund or not? Is that not the best choice for them? If the health funds can provide a product that people want to buy, a product that people understand and a product that is relevant to their needs, then they should have the choice whether they are in or not?

Mr Scullin—I think choice can be a subjective thing. In a society like ours we have to have rules and regulations to make things work properly. I feel that the three-tiered approach that I mentioned before—the rebate, lifetime health cover and the Medicare levy threshold—have all been working. Getting back to your question about the tax, a lot of people will still retain their private health insurance. Tax will not come into it. It will be really an issue of their wanting to manage their own health because they feel that having the protection of private health cover gives them peace of mind and a sense of security.

Senator CAMERON—Is that not a positive from your perspective? That will mean that fewer people will drop out because of the triple approach?

Mr Scullin—What I have been saying is that if the Medicare levy threshold changes go through, a lot of people who were not considering doing anything with their private health insurance, due to the publicity that has already occurred—and you have heard what iSelect has had to say—what will happen is a lot of people will abandon their private health cover when in fact it was never on the agenda.

Senator CAMERON—But would not private health industry respond? The private health industry will not just sit back and do nothing; it will adjust to the circumstances. One of the issues you have raised is about education. If the private health industry is providing a robust product, then it will get out and educate the public about the benefits, perceived or otherwise, of the industry. Would not that be one of the responses that will mitigate this 'sky is falling in' approach?

Mr Scullin—One of the things the private health insurance industry has not even properly addressed yet is the broader health cover reforms as a result of the Private Health Insurance Act being changed. These measures have not even got off the ground yet, and I feel they probably will not get off the ground because the private health insurance industry will probably look to restricting benefits more and restricting products more if it loses a million or so members and the worst happens. I do not want to use emotive terms, if you find that is a problem, but I mean fundamentally—

Senator CAMERON—Use whatever terms you like.

Mr Scullin—What I am trying to get to is that, with regard to the state of the industry the way it is, I feel it is healthy and basically the dual system is working, and by that I mean the public and the private system. By making this change, we will have a very big adjustment which I feel will be detrimental.

Senator BUSHBY—Thank you Mr Scullin for your evidence today; it has been very useful and interesting. As I understand it, you are saying that in terms of the current climate, because things are so uncertain and there are significant cost pressures on working families, to use the term, at the moment, they are looking to cut something back because they have to. What this may well do if it goes through, removing the surcharge may well make it easy for them to choose private health as the thing that they cut back on?

Mr Scullin—Unfortunately, yes. I think that is an accurate observation. I am old enough and silly enough to have been around in the early 1990s when we had a similar situation, and that is exactly what happened.

Senator BUSHBY—We have heard evidence over the course of this inquiry from academics and a couple of other people that, when the Medicare levy surcharge was introduced in 1997, it had very little impact on take-up rates for insurance.

Mr Scullin—Yes.

Senator BUSHBY—Then, as a result down the track, the lifetime health cover and the 30 per cent rebate were introduced. In your opinion do all three need to work together? Are they necessary? On their own they do not have the impact that they do together; a synergy is involved that does not exist individually?

Mr Scullin—I think the three of them do work well together in sync. Going back to your point about when the Medicare levy threshold was first introduced, in 1997 $100,000 a year was a huge income for a family, and even $50,000 for a single was huge, so I feel it did not have so much impact then as what it will have now. But

what has happened is the whole system has evolved. We had the Medicare levy threshold first, then we had the 30 per cent rebate, and then we had the lifetime health cover. So those three things have evolved so they now all work in sync, and I believe that we now have a really workable practical outcome out of that.

Senator BUSHBY—What do you think the consequences would be of weakening any one of those three as we are discussing doing today?

Mr Scullin—I think about working families in the far flung suburbs of Melbourne that are driving long distances to work, who have huge petrol bills, who are facing increasing food prices, and who are really concerned about the cost of their mortgage. A lot of people out there are doing it tough. I am talking to my small business clients, retailers, people like that, and there has been a big change from what I can see of it. So the timing of this is critical. I would urge at the very least that this committee recommends to the parliament that this matter be deferred or put off and not be done at the moment because to do it at the moment would be, in my view, a major mistake.

Senator BUSHBY—It has been put to me that the way this could possibly play out, and particularly with the effect on public hospitals, if it is introduced you would have a number of people who are low risk. The younger people generally will tend to let their insurance lapse or they will not take up insurance as they might otherwise have done, which then will not have that much of an impact on public hospitals because they are unlikely to have a great demand on the public health system. Then what would happen is that the private premiums will need to rise because they do not have the premiums coming in from the lower risk people which will then mean—and I do not know whether this is a second round, a third round or a fourth round effect—that some people who have private health cover and who have quite serious healthcare needs will not be able to afford private health insurance. It is when those people drop out of private health cover that you will actually start seeing the big impact on public hospitals. Would you think that is a fair assessment of how it might play out?

Mr Scullin—Yes, I do, Senator, and I go back to Terry Barnes' submission. As I say, I am a non-political person, even though my surname is Scullin. I read that and, being a practitioner at the coalface, to me it accurately summarised exactly what the position is. As I said, Mr Barnes has a background as a political advisor, but I would ask the committee to put that out of their minds and read that report because, being at the coalface in health insurance everyday as I am, I assure you that is a really accurate portrayal of what is going on.

CHAIR—Thank you, Mr Scullin, for your evidence today.

Committee adjourned at 5.47 pm