



Mr John Hawkins
Secretary
Senate Economics Committee
Parliament House
CANBERRA ACT 2600

Dear Mr Hawkins

On behalf of the Australian Private Hospitals Association (APHA), I attach a submission to the Senate Economics Committee's Inquiry into the *Fairer Private Health Insurance Incentives Bill 2009*, the *Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009* and the *Fairer Private Health Insurance Incentives (Medicare Levy Surcharge – Fringe Benefits) Bill 2009*.

APHA is the peak national body representing the interests of the private hospital sector, with a diverse membership that includes large and small hospitals and day surgeries, for profit and not for profit hospitals, groups as well as independent facilities, located in both metropolitan and rural areas throughout Australia. The range of facilities represented by APHA includes acute medical surgical hospitals, specialist psychiatric and rehabilitation hospitals and also free-standing day hospital facilities.

APHA would be pleased to expand on the material in this submission at the public hearing scheduled by the Committee.

Please contact me if APHA can assist further on this issue.

Yours sincerely

Michael Roff
CHIEF EXECUTIVE OFFICER
9 June 2009

SUBMISSION BY THE AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION TO THE SENATE ECONOMICS COMMITTEE INQUIRY THE FAIRER PRIVATE HEALTH INSURANCE INCENTIVES BILL 2009, THE FAIRER PRIVATE HEALTH INSURANCE INCENTIVES (MEDICARE LEVY SURCHARGE) BILL 2009 AND THE FAIRER PRIVATE HEALTH INSURANCE INCENTIVES (MEDICARE LEVY SURCHARGE – FRINGE BENEFITS) BILL 2009.

1. Background

Australia's health system is funded by governments, private hospital owners and operators, and private health insurance payments. Our balanced system of public and private care provides access to health services which are delivered predominately by private practitioners in private settings.

Both history and contemporary international experience indicate that neither governments nor the private sector, acting alone, can deliver a health system that is equitable, efficient and sustainable. In effect, the policy principle underpinning private health insurance is the same as that which underpins the policy in relation to government support for independent schools. No government could afford to fund schools and teachers for the entire school-age population. Therefore, governments provide funding to independent schools so their services become more accessible, in recognition of the fact that parents who choose private education for their children are taking pressure from the taxpayer funded government schools. In the same way, people who choose to insure their health care take pressure off the public hospital system, and off the taxpayer. The government has assisted those people with the cost of their private health insurance.

Australia's balanced health care system has achieved great success by drawing on the strengths of the private and public sectors, and arguably performs much better overall than countries such as the United Kingdom and the United States.

2. The Australian Private Hospitals Sector

While some of the large acute medical/surgical private hospitals provide similar services to their public sector counterparts, this holds true largely in the densely populated metropolitan areas. For the most part, private hospitals are quite different from public hospitals in size and types of services offered. For example, private facilities in the mental health sector provide treatment for quite distinct conditions from those treated in the public sector. The majority of chemotherapy treatment for people with cancer is delivered in the private sector. Most of the rehabilitation for people who have had accidents, injuries or falls is provided in private hospitals. Patients needing in-hospital rehabilitation are transferred after surgery and initial recovery in a public or private hospital sectors to a private rehabilitation hospital. And nearly all in-hospital palliative care services for the dying are private hospitals, especially in regional Australia.

Contrary to the views expressed by some commentators, the private hospitals sector does provide a comprehensive range of services; does treat older patients; does not merely provide 'profitable' services (whatever these may actually be); does provide training for medical, nursing and allied health staff; does provide safe and quality services; and does contribute significantly to the balance and sustainability of the Australian health system.

The Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS) and the Private Health Insurance Administration Council (PHIAC) all report a range of data on aspects of the hospital system, both private and public. Selected highlights of the latest data¹ include:

- Private hospitals treat almost 40% of all hospital patients;
- Private hospitals provide 32% of all hospital beds;
- Private hospitals perform 56% of all surgery;
- Private hospitals provide 69% of sameday mental health treatment and 43% of all hospital-based psychiatric care;
- Of the total 662 different procedures and treatments undertaken in Australian hospitals, private hospitals provide 658;
- Private hospitals treat over 1 million patients aged over 65 years each year;
- Private hospitals employ over 50,000 staff (FTE);
- Private hospitals invest over \$35 million of their own funds in the education and training of health professionals; and
- Each year public hospitals treat over 430 000 patients whose treatment is funded by private health insurance and private hospitals treat over 100,000 public patients.

3. Why support choice in health care health insurance?

Private hospitals are funded by their owners and operators, not by the taxpayer. The services provided to patients treated in private hospitals are partially or fully subsidised from a variety of sources, including private health insurance funds, the Department of Veterans' Affairs, third party insurers, State and Territory governments and out-of-pocket payments by patients.

Privately insured patients account for 77% of patients treated by private hospitals (2.3 million patients in 2006-07). In addition, as noted above, over 430,000 privately insured patients received their treatment in a public hospital in the 12 months ending on 31 March 2009. Public hospitals received more than \$558 million in revenue from treating these patients.

These patients and other insured consumers elect to provide funding towards their hospital, medical and allied health costs and, in recognition of this personal effort, the Australian Government provides consumers with direct support through the 30%, 35% and 40% rebates which offset part of the cost of private health insurance premiums. People who choose to insure their health care take pressure off the public hospital system, and off the taxpayer

In addition to direct support for consumers, the Australian Government also provides indirect support for private health insurance through Lifetime Health Cover and the Medicare Levy Surcharge.

This support for private health insurance enabled almost 2.7 million privately insured patients to be treated in 2006-07 in private and public hospitals. These patients represented 35% of all patients treated in that year.

Private hospitals are efficient. The Commonwealth Department of Veterans' Affairs, in evidence to the House of Representatives Standing Committee on Health and Ageing on 4 September 2006, said:

¹ Australian Bureau of Statistics, *Private Hospitals Australia 2006-07*; Australian Institute of Health and Welfare, *Australian Hospital Statistics 2006-07*; Private Health Insurance Administration Council, *Operations of the Private Health Insurers, Annual report 2006-07*.

“The work we have done basically suggests that we pay significantly lower prices in the private sector than we do in the public sector.”²

DVA officials have subsequently confirmed that the price difference between public and private hospitals is in the order of 20%.

Private hospitals treat 61% of all patients funded by the Department of Veterans’ Affairs.

Support for choice in health care has resulted in Australia’s unique balanced health system. That is, although 100% of Australians are eligible to access taxpayer-funded public hospitals, almost 50% of them choose private health insurance, that provides access to private hospitals, thereby reducing the burden on the public hospital system and the taxpayer.

4. A Broken Promise

The present Government has reiterated its support for private health insurance on a number of occasions, both before and since being elected to office.

On 20 November 2007, four days before the election, the then Leader of the Opposition said:

“Both my Shadow Minister for Health, Nicola Roxon, and I have made clear on many occasions this year that Federal Labor is committed to retaining the existing private health insurance rebates, including the 30 per cent general rebate and the 35 and 40 per cent rebates for older Australians”.

Health Minister Roxon has stated on a number of occasions that she supports the existing system. In February 2009, she told *The Age* newspaper:

“The Government is firmly committed to retaining the existing private health insurance rebates”.

The proposed measure breaches a firm election commitment, recently reiterated. Consumers had a right to rely on these commitments. Private hospital operators, whether for-profit or not for profit, had a right to rely on these commitments in planning for expansion in services and improvements to service delivery. The government’s proposal removes any policy certainty from the operational environment. In the period since the Budget on 12 May, neither the Prime Minister, the Health Minister, nor any other Government spokesperson has given any assurance, or indeed, made any comment, that these proposed changes will be the last changes to Australia’s system of private health insurance.

This has caused serious concerns within the private hospitals sector about further changes in subsequent Budgets, in an economic climate where the consensus is that significant further cuts to outlays will be required to meet Government spending targets.

5. A Hasty Measure with Insufficient Scrutiny

APHA is concerned that the proposed measure is apparently being rushed through the Parliament. The scant time given for submissions to the Committee, together with the timing of the public hearings, means that neither the private health sector, consumers, the media, nor any other interested party will have the benefit of access to the Hansard record of Budget Estimates hearings in which both Health and Treasury officials gave more details of the proposed measure. Nor, as submissions to the Inquiry are due on the same day as the public hearings, will the Committee have the benefit of considering the submissions from those appearing before it, and from others.

² House of Representatives, Standing Committee on Health and Ageing, Reference: Health Funding, 4 September 2006.

The haste with which the Government is acting gives rise to questions about how genuinely it is inviting public scrutiny of the proposed changes. Furthermore, it is not clear why this legislation has not been referred to the Community Affairs Committee rather than the Economics Committee. It is a Health Budget measure. As such, the Community Affairs Committee is the appropriate forum to consider the legislation.

These changes are complex. Why is the Government in such a hurry to have them passed when they are not scheduled to take effect until 1 July 2010? There is ample time for proper and considered scrutiny.

6. Impact of the Government's proposals

6.1 Erosion of Community Rating

Community rating essentially means that all individuals pay the same premium for the same health insurance product. This is mandated by law. In this regard, PHI differs from all other forms of insurance, which are risk-rated: that is, the premium is set by the insurer on the basis of the level of risk of the insured person. The fundamental problem for community rating caused by the Government's decision to means test the PHI rebate is that the 'good' risks (those less likely to make a claim), are those most likely to drop their private health insurance, thus leading to an imbalance in the composition of the insured population.

Insured people aged 65 years and older comprise 13% of the insured population. This same group accounts for 45% of private health insurance benefits paid from hospital tables. The average benefit paid per person aged 65 and older is approximately 5.4 times the average benefit paid to those aged under 65, who comprise 87% of insured members.³ It can be seen therefore that major changes that undermine the fragile age balance of the insured population (such as the proposed changes to the PHI rebate) will have severe effects on the capacity of health insurers to continue to pay claims without needing to raise premiums.

The measure will also cause greater inequity for those people trapped on public hospital waiting lists because those lists and accompanying waiting times can only increase under the Government's new means test.

6.2 Effect on drop out rates and propensity to insure

We know, from the Government's Budget announcement and subsequent discussions, that the Federal Treasury expects only approximately 25 000 people to drop out of private health insurance as a result of the proposed introduction of the 10 tiers of private health insurance.

APHA had a briefing on the proposed measure from officials from the Departments of Treasury and Health and Ageing on 1 June. In the discussion of the assumptions underlying the measure, officials informed us that the modelling technique used was identical to that used for the modelling of the effects of the 2008 Budget proposal to increase the thresholds for the Medicare Levy Surcharge. The same sample was used; that is, the same tax records from 2005-2006 personal income tax data. Other sources relied upon to produce the modelling were PHIAC data, and data from the Department of Health and Ageing (DOHA).

³ Private Health Insurance Administration Council, *Quarterly Statistics*, March Quarter 2009

This must give rise to concern. Treasury has reached the figure of 25 000 by using the same sample, the same data sources and the same methodology that produced the estimate of 492 000 people who would drop their private health insurance or not take up cover as a direct result of the 2008 increases in the thresholds for the Medicare Levy Surcharge. PHIAC data from the 2008 December and March quarters indicate that 110 000 people have taken out private health insurance. This is good news for the sector. However, it is still too early to state that the changes to the MLS have not had an effect on coverage.

What can be stated is that Treasury's estimate of the effect of this relatively simple change proposed in 2008 was wrong. In the briefing on 1 June, Treasury officials confirmed that this was so. However, contrary to this admission from Treasury, officials from DOHA told the Community Affairs Committee's Budget Estimates hearing on 3 June that DOHA stood by these 2008 estimates.

The changes to the rebate proposed in the 2009 Budget are much more complex. However, both Treasury and DOHA, in providing advice to the Government, have made some assumptions that are, to say the least, open to serious questioning.

The steps taken by Treasury to derive the drop-out estimate were as follows⁴:

“Step 1 - estimate the number of people in the affected income ranges (tier 1) using Treasury personal income tax data, and benchmark this data with PHIAC data on private health insurance membership;

- For Tiers 2 and 3, as the percentage increase in MLS is very similar to the percentage increase in out-of-pocket costs for those facing a reduced PHI rebate (see Table 1 below for details), it was assumed that there would be no net change in PHI coverage for these two tiers.

Step 2 - estimate the price elasticity for private health insurance demand.

Academic and empirical research suggests that private health insurance demand elasticity is around -0.3 but this applies to all income categories. There is evidence (most recently, an August 2008 Access Economics report estimated a price elasticity -0.335) that price elasticities are lower at higher income levels, so a price elasticity of -0.2 was used for Tier 1;

Step 3 - estimate the proportional increase in cost of insurance to people in the affected income ranges after the relevant rebate reductions (i.e. for a person aged under 65, a 10 percentage point reduction in their PHI rebate increases their net PHI premium cost from 70 per cent of the gross premium to 80 per cent. This represents a 14.3 per cent increase in their net PHI outlay);

Step 4 - estimate the drop out rate by multiplying price elasticity by the proportional increase in cost;

Step 5 - estimate the number of singles and couples who will drop out by multiplying the dropout rate by the number of singles and couples within the affected income range; and

Step 6 - estimate the total number of people who will drop out by factoring in the number of people in a couple and the average number of dependents/children in a couple/ family.

The six steps outlined above were used to derive the estimate that around 25,000 individuals (6,500 singles and 5,500 couples and families) with PHI cover and earning between the MLS thresholds and \$90,000 (singles) and \$180,000 (couples) will opt out of PHI.

This represents a decrease in the number of people with PHI of around 0.26 per cent (a

⁴ Briefing note provided by Department of Treasury to APHA 1 June 2009. A copy of the briefing paper is at Attachment A to this submission.

0.3 per cent decrease in singles and a 0.25 per cent decrease in couples and families.”

The drop out of 25 000 is assumed to occur as soon as the measure takes effect, that is, on 1 July 2010, with no further drop out. Treasury indicated that they have assumed “rational” (in the sense that terms is used by economists) consumer behaviour to reach this figure. However, in the same briefing, it was acknowledged that consumers do not behave “rationally”, and that this is borne out in the consideration of price signals in health insurance.

There are some key points to note about the Treasury methodology. The personal income tax micro-simulation model used to estimate the number of people in the affected income ranges is based on a sample derived from 2005-2006 personal income tax data. Since that time, health insurance membership has increased by 9.6%, or almost 900 000 people. This fact immediately raises questions about the validity of the sample used, and therefore the accuracy of the estimates produced by the model.

Although Treasury officials advised APHA that this sample had been “adjusted”, they would not divulge how this adjustment was made. It is therefore impossible to assess if the methodology is valid.

If Treasury modelling has underestimated the number of people in the affected income ranges, this will have a multiplier effect in terms of underestimating the final drop out figures.

Further, Treasury has stated that:

“For Tiers 2 and 3, as the percentage increase in MLS is very similar to the percentage increase in out-of-pocket costs for those facing a reduced PHI rebate (see Table I below for details), it was assumed that there would be no net change in PHI coverage for these two tiers.”

However, using Treasury’s own figures (see Attachment A to this submission), for people in Tier 2, the estimated increase in the out of pocket cost for health insurance is 28.6%, as compared to a 25% increase in the cost of the Surcharge. Treasury has assumed rational consumer behaviour in reaction to the proposed measure. Therefore, it should be expected that this group will drop their PHI cover. But Treasury asserts exactly the contrary.

Turning to the assumption in regard to price elasticity contained in Step 2 above, this is not supported by evidence that is on the public record. APHA is not aware of any work done by the Government to establish the price elasticity of private health insurance. A reference is made to a report prepared in August 2008 by Access Economics for health insurance comparator iSelect, which estimated an elasticity factor of -0.335, and another unsourced reference to a factor of -0.3. However, Treasury has chosen to use a figure of -0.2 on the grounds that it is those in the lower income group that will be most sensitive to price. Again, this is an assumption. If it is wrong, the assumption in regard to price response could be inaccurate by close to half, with concomitant impact on the overall costing model.

The modelling assumes that the only choices that people will make as a result of the measure are to retain their existing cover or to drop their health insurance. That is, Treasury assume that no person will downgrade his or her cover to a cheaper policy (restricted cover, lower benefits, higher excess etc). This is a serious omission, which again calls into question the validity of the modelling.

No estimate is provided of the effect on propensity to insure (that is, people who would have taken up cover but now will not). APHA assumes that this is because the wrong estimate of 492 000 in 2008 included an unspecified figure for people who would not take up cover.

There are many omissions and speculations in the modelling. Given that it is this model which has been used to underpin the savings figure of \$1.9 billion over four years for the proposed measure, these savings must at the least be subject to doubt.

6.3 Effect on public hospitals

As with the 2008 Budget measure on the MLS increases, neither the Treasury nor the Department of Health and Ageing believes that it would be necessary to include in their modelling the possible impact of the measure on public hospitals. At the briefing on 1 June 2009, APHA was told by officials that this was because the *Charter of Budget Honesty Act* prohibits the reporting of such second round effects of policy if modelling would be based on speculation, which in this case it would be as there were a number of speculative assumptions in the modelling of first round effects. This does not exactly engender confidence.

However, those who drop their health insurance cover will be forced on to public hospital waiting lists, as there is nowhere else for them to go. Some of them will not be treated in hospital at all. The Menadue Report prepared in 2000 for the NSW Department of Health⁵ quoted that Department as estimating that up to 30% of patients who received services such as renal dialysis and chemotherapy in the private sector would not be admitted to a public hospital.

6.4 Uncertainty for consumers

In addition to potentially facing waiting lists or no services, consumers will find the proposed changes will introduce 10 tiers of private health insurance, which is very complex and unwieldy compared to the current system. People who wish to register for the rebate through their health fund will need to estimate their taxable income for the forthcoming year. If they under-estimate it, they will pay extra tax at the time their tax return is assessed. This measure does not take into account the fact that many small business people and farmers cannot accurately estimate their income over a year. Nor does it cater for wage and salary earners who may work overtime, be promoted or receive a bonus during the year that pushes them into a different tier.

The proposed measure takes a simple system that is easy to understand and works well and makes it complex, confusing and likely to deter people from taking out private health insurance.

6.5 Uncertainty for the private hospitals sector

In the current economic climate, certainty for investment is more important than ever. Private hospitals need some clarity around likely demand for services and the future operational environment. This measure greatly increases uncertainty.

First, the Government's policy intentions in regard to private health are now unclear. During the recent Senate Estimates hearing for the Department of Prime Minister and Cabinet, the following exchange took place:

Senator CORMANN—*I have got some questions in the area of domestic policy. I assume we can deal with them in general questions. In relation to the budget measure to means-test the private health insurance rebate,*

⁵ Report of the NSW Health Council (Menadue Report), NSW Department of Health, 2000.

when did PM&C first provide advice on that?

Mr Mrdak—I will ask officers who deal with this matter to come forward to the table.

Ms Cass—The Department of Prime Minister and Cabinet provided advice to the government on this matter in the budget context and advice was first provided in February.

Senator CORMANN—Have you got a specific date?

Ms Cass—23 February.

Senator CORMANN—Before providing advice in the budget context⁶

However, on the 24 February the Minister for Health and Ageing stated in an interview that “The Government is firmly committed to retaining the existing private health insurance rebates”.⁷ Just before the 2007 election, the Prime Minister, then Leader of the Opposition, stated:

“Both my Shadow Minister for Health, Nicola Roxon, and I have made clear on many occasions this year that Federal Labor is committed to retaining the existing private health insurance rebates, including the 30 per cent general rebate and the 35 and 40 per cent rebates for older Australians.”⁸

APHA recognises and supports the need for fiscal discipline and rigour. However, this measure does not appear to be based on sound evidence or any coherent policy. It appears to have been crafted as an “easy” saving, with no consideration of the likely increase in the burden on the public hospital sector, for which the States and Territories are likely to seek additional financial support.

The second way in which the measure creates uncertainty is related to mixed messages about demand. In 6.2 above we point out the speculative nature of the modeling of the drop out rate. But there is also ambiguity about the rate of PHI coverage going forward. In its Portfolio Budget Statement, the Department of Health and Ageing sets out Key Performance Indicators for “Measures to Support Sustainability” of Private Health Insurance. These KPIs state that the number of people covered by PHI will remain constant at 9.7 million from 2008-09 to 2012-13.⁹ On 1 June, DOHA officials informed APHA that provision for growth in PHI coverage has been made in the Contingency Reserve, and that this provision was approved by the Department of Finance and Deregulation. However, neither the projections nor the basis for them could be revealed as they were classified as Commercial in Confidence.

This lack of clarity makes sound planning close to impossible. On the one hand, Treasury, using methodology it has agreed has produced errors in the past, predicts a decrease in membership. On the other, DOHA and the Department of Finance are projecting unspecified growth in demand. Both cannot be right.

That is, if little or no growth is forecast, it means that the proportion of Australians covered by private health insurance will decline as the population increases, and more people will rely on public hospital services. If growth is forecast to return to, or close to, the underlying trend, then the \$1.9 billion of savings will surely prove illusory.

Indeed, private hospital infrastructure developments worth hundreds of millions of dollars are currently underway. These were undertaken on the basis of the Government’s repeated commitments to maintaining current policy settings. There are now serious questions as to whether some of these investments will be able to generate their predicted returns. In addition, future investment in private hospital infrastructure is likely to be adversely affected by these measures,

⁶ Senate Committee on Finance and Public Administration, Budget Estimates 2009-2010, p. F&PA 72.

⁷ Hon. Nicola Roxon MP, interview with *The Age* 24 February 2009.

⁸ Hon. Kevin Rudd MP 20 November 2007

⁹ Department of Health and Ageing, Portfolio Budget Statement 2010 Budget, p. 56.

leading to increased future reliance on public hospitals, and a subsequent increase in government outlays.

The ABS data also indicates that approximately 26% of all private hospital beds (6,332 beds) are located outside the capital cities. These hospitals play a vital role in local communities in the provision of health care services, as substantial employers of local residents, as purchasers of goods and materials from local businesses and, together with local public hospitals, as a means of attracting medical practitioners to live and work in the area.

Uncertainty over the proportion of the population who will remain covered by health insurance can only cause disquiet and apprehension in these communities who know only too well how fragile rural infrastructure can be. The loss of a rural or regional private hospital or even the loss of particular specialist services has a ripple effect on the local community.

7. Inconsistency with other action being taken by the Government

At the same time as the Government is proposing these changes, it has also asked the Productivity Commission to conduct a major study into the relative efficiency of the public and private hospital systems, to report in November. Notably, the Commission has been asked to “advise the Government on the most appropriate indexation factor for the Medicare Levy Surcharge thresholds”. However, the legislation that is the subject of the current Inquiry already specifies an indexation factor. This provokes the question of why the Government is moving so hastily to have the legislation passed when it will not receive advice on a key aspect of it until November 2009.

In addition, the Government’s own National Health and Hospital Reform Commission (NHHRC) is due to present its final Report by 30 June. The Government will presumably respond to that Report in the second half of the calendar year, and set out its overall direction and plan for Australia’s health system. In its Interim Report, released in February this year, the NHHRC included the following “reform direction”:

We want to see the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution maintained over the next decade.”¹⁰

Arguably, the changes to private health insurance proposed in the legislation will drastically alter this balance of spending, which the NHHRC sees as one of the strengths of our health system. In pursuing this legislation, the Government is pre-empting its own major inquiry into the health system. Does the Government reject the NHHRC’s position?

The proposed changes to private health insurance, with the uncertainty of their impact on the private hospital sector, seem even more hasty and ill-considered in the light of these other initiatives.

APHA urges the Committee to recommend that the Bills be, at the least, delayed until the Productivity Commission and the NHHRC have reported.

We also contend that the policy underpinning the legislation is incoherent and ill-devised, and that the measure should not proceed. It has the potential to remove choice in health care for many, increase complexity and discourage people from taking responsibility for their own health care.

¹⁰ A Healthier Future for all Australians, NHHRC Interim Report, Australian Government, 2009, p. 306.