ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

SUBMISSION TO THE SENATE ECONOMICS COMMITTEE
JULY 2008

1. Overview

The level of private health insurance membership (PHI) in Australia has a direct effect on the equitable supply of medical services to its citizens. In particular, reductions in PHI result in higher demand for public hospital services as persons with above average weekly earnings compete with lower income earners, aged pensioners and other persons in need. This form of overcrowding in our public health system results in delays in treatment and expansion of waiting lists for surgery that can result in prolonged discomfort and even unnecessary loss of life.

A particularly stark example of this scenario can be found in our recent history with the revamped introduction of Medicare in 1984. This submission will show that changes in budgetary policy affecting Medicare have resulted in direct effects to the level of PHI, and therefore the availability of medical services to all Australians.

With the budget policy proposal to significantly alter the income thresholds for payment of the Medicare Levy Surcharge we predict another period of overcrowding of Australia' public health system. Our position is supported by widespread expert opinion from a range of respected bodies, including federal treasury economists, who themselves predict that 485,000 people will withdraw from PHI.

Clearly it is not the intention of the Rudd Government to cause strain in our public health system. While the new income thresholds will significantly reduce the current $3 billion cost from the PHI rebate, this is a false economy in the face of major erosion to our public hospital system.

When taking into account the new increases to income thresholds (100% for singles and 50% for couples) in a period where both Employee Weekly Earnings and the Consumer Price Index (CPI) have shown considerably less growth, the new policy while well-intentioned, is not in keeping with wage and price movements (Attachment A refers). We therefore recommend that the Medicare Levy Surcharge threshold should better reflect the actual increase in the CPI since 1997, rather than the proposed more substantial upward movement. Furthermore, the College of Surgeons believes that in future the Medicare Levy Surcharge should be indexed yearly based on changes in the CPI. Indexation would serve two purposes, to ensure that reductions in discretionary income are not compromised by inflexible income thresholds, and to establish a mechanism for altering income thresholds that is non-partisan and tied only to changes in the CPI.

2. Background: Recent Changes to Funding of Australia's Public Health System

The Medicare Levy Act was introduced in 1984 by the Hawke Government to provide revenue for its revamped Medicare program that allowed bulk billing by medical practitioners and access by all Australians to medical treatment in public hospitals. At that time low income earners were exempt from payment of the levy, and for those with an income above the exempt taxable income, the Medicare Levy was discounted. In accordance with cost pressures on wages during the 1980s, regular assessments of what defined low income were made, while income levels determined who paid the Medicare Levy to ensure that Australians with high incomes did not clog up the public sector.

In 1984 PHI membership was 50%, but gradually the new policies for the public hospital system resulted in significant losses to membership as growing numbers of Australians chose to utilise free medical treatment in the public system. Unfortunately, as the graph below shows, from 1984 to 1998 there was a gradual slide in PHI membership from 50% to an all-time low of 30.6%.

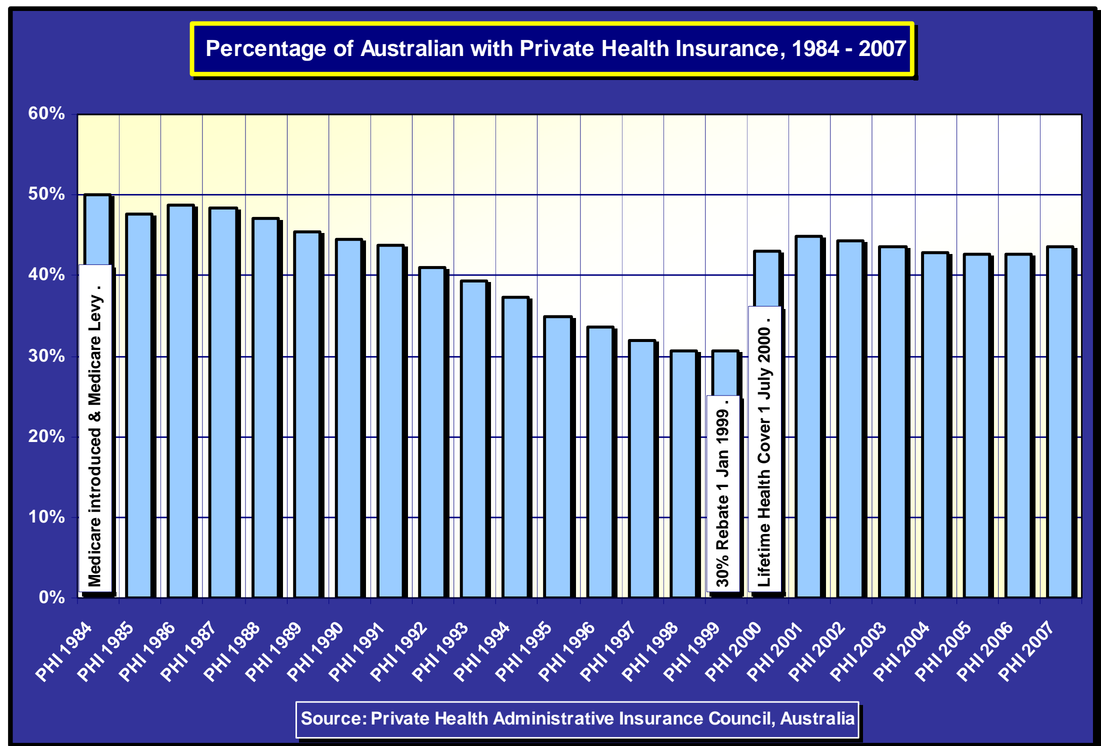
In the face of burgeoning queues for treatment in the public hospital system, and the danger that PHI membership could fall below 30%, in 1997 the Medicare Levy Surcharge was introduced. The Medicare Levy Surcharge was an additional 1% surcharge of taxable income imposed on those earning above a certain income (for a single person a taxable income of $50,000 per annum and for a couple or family a combined taxable income of $100,000) who were eligible for Medicare but who did not have an appropriate level of hospital insurance with a registered health insurer. The Medicare Levy Surcharge

was in addition to the normal 1.5% Medicare Levy.

In 2000 the Medicare Levy was raised to 1.5% under the Howard Government. Lifting of the Medicare Levy was designed to achieve two outcomes. Firstly to further ensure that high income earners who utilised the public health system paid for its use, and secondly to make PHI more attractive, particularly in conjunction with the introduction in 1999 of the 30% PHI rebate, and in 2000 the new Lifetime Health Cover (LHC) policy. Lifetime Health Cover dramatically changed the cost of Private Health Insurance in Australia.

From its inception, the intention of LHC was to expand take-up rates of PHI by imposing cumulative penalties for those aged 31 years and over, who do not insure. Persons who do not take up PHI after their 31st birthday are subject to a 2% loading for each year they remain uninsured (except for persons born prior to 1 July 1934). For persons who pay the penalty loading for 10 consecutive years, the loading is removed in the 11th year if there has been 10 years of continuous private health cover. Outcomes for this policy were meant to work alongside the 30% PHI Rebate and the 1.5% increase to the Medicare Levy.

The 1999-2000 changes to funding of the public health system resulted in a remarkable rise in PHI membership from 30.6% in 1999 to 43% the following year. In recent years, membership has stayed in the 43% - 45% range, demonstrating the importance of providing incentives and opt-out consequences for PHI membership.



3. **Lifting of the Medicare Levy Surcharge and Expert Agreement of It's Adverse effects on the Public Hospital System**

The 2008/2009 May Budget papers have introduced a dramatic lifting of income thresholds for future payments of the Medicare Levy Surcharge which will exempt millions of Australians from this payment, representing a 100% increase for singles and a 50% increase for couples and families. Table 1 shows the new income thresholds for payment of the ML.

Table 1: Budget Changes to Income Thresholds for Payment of the ML

Pre-2008 Budget: Income Thresholds for Payment ML		Post-2008 Budget: Income Thresholds for Payment ML		Percentage Increases of New Income thresholds
Singles	$50.000	**Singles**	$100.000	100%
Couples & Families	$100.000	**Couples & Families**	$150.000	50%

The new thresholds have the following anomalies:

- A disparity between singles and couples in the new income thresholds for payment of the Medicare Levy Surcharge, namely 100% for singles, and 50% for couples, and
- The percentage increases in thresholds for both groups is well in excess of increases to the CPI and Average Weekly Earnings since 2000.

Without doubt, adjustment of the Income Thresholds was a necessary requirement of this budget in order to take into account reductions in discretionary income which have been largely driven by external shocks to the CPI from extraordinary increases in the cost of oil and the downturn in the US economy.

What has surprised our College, economists, Treasury, and many other respected forecasters, is the breadth of the changes. Not only are the increases excessive, they bear no relationship to actual changes in discretionary income.

There have been numerous predictions from respected forecasters that the new thresholds will result in a new, and more debilitating, episode of overcrowding of the public health system. We concur with economic modelling from sources as diverse as Access Economics, Price Waterhouse Coopers and Treasury, that the proposed changes to the Medicare Levy Surcharge will have a substantial impact on the public hospital system, with longer treatment times for patients, and an explosion of surgical waiting lists.

Below is a sample of the diverse, yet like-minded, views of the proposed policy changes:

- ***The Age*, 12 May 2008:** "TREASURER Wayne Swan has admitted almost half a million people will dump private health insurance because of the raised Medicare surcharge threshold. The Treasury has confirmed it estimates 485,000 people will leave private insurance as a direct result of the raising of the income threshold at which people without private cover have to pay an extra fee from $50,000 to $100,000 and to $150,000 a year for couples."

- **Access Economics, The Australian, 21 May 2008:** "…a policy that harms the insurers and the private hospitals while adding further burdens to an over-stressed public hospital system and the long-term fiscal position."

- ***The AMA*, Press Release, 30 June 2008:** "The AMA has been advocating for a Federal Government cash injection of more than $3 billion to fund thousands of extra beds in public hospitals across Australia. . . "At least 3,750 more beds are needed before hospitals can cope with current demand and operate at internationally-accepted safe bed occupancy levels of 85 per cent or less," Dr Capolingua [AMA President] said. . . "And that estimate was made without any consideration of the possible additional impact on demand as a result of the Government's proposed changes to Medicare Levy Surcharge income thresholds. "The National Health and Hospitals Reform Commission should focus on the needs of the public hospital sector. . . . Population growth, increased levels of chronic disease, and an ageing population, make increasing the number of hospital beds a priority if we are to restore bed occupancy to safe levels and improve elective surgery and hospital access for patients now and into the future."

- ***The Canberra Times*, 1 July 2008:** "Federal Health Minister Nicola Roxon issued The State of Our Public Hospitals Report 2008 yesterday. . . . The report showed public hospitals were under "severe strain". . . . Nationally, 4.7 million patients were admitted to public hospitals, 6.7 million were treated in emergency departments and 556,770 had elective surgery in 2006-07. . . . The AMA warned the change [to income thresholds for the ML would encourage many Australians to dump their private health insurance and increase strain on the overstretched public hospital system."

- ***The Standard*, 17 July 2008:** "THE future of Warrnambool's St John of God Hospital would be threatened under proposed changes to Medicare, the hospital group's national chief has warned. . . He warned some aspects of his St John of God Health Care group may not survive if the surcharge threshold was lifted and private health insurance members dropped their policies."

- ***The Australian*, 11 July 2008:** "Catholic Health Australia has used government data to warn the change will lump public hospitals with a $400 million burden of providing an extra 200,000 procedures in the next 12 months. . . CHA also predicts elderly people seeking hip and knee replacements will be among the hardest hit and that the changes will trigger an unavoidable 10per cent increase in private health insurance premiums next year"

- ***The Australian*, 16 July 2008:** Predictions of the effect on the Western Australia's public hospital system; " ... the [WA Health] Department's preliminary modelling indicated it would cost an additional $53.6 million a year to deal with the influx of public patients"

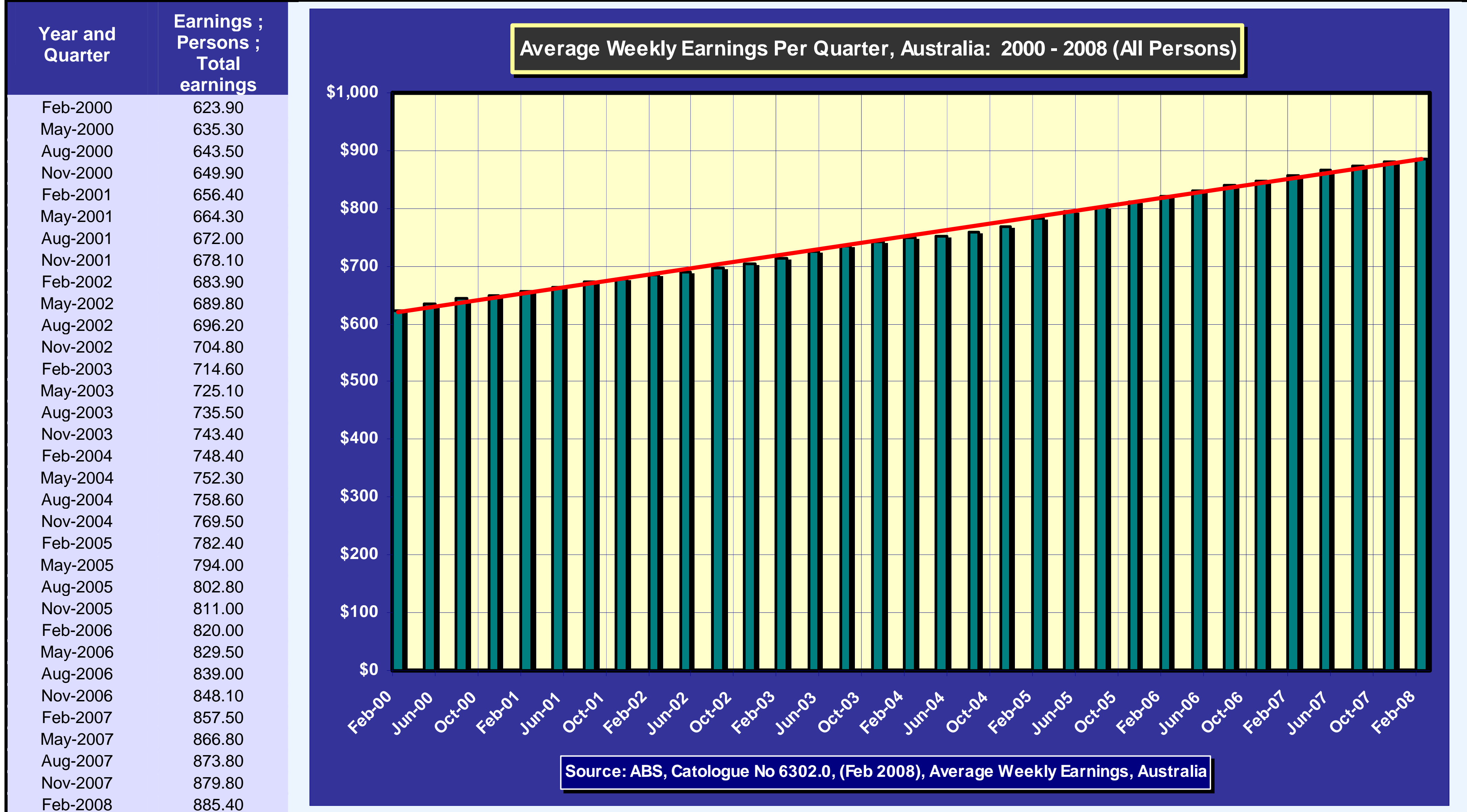
- ***The Courier Mail*, 27 July 2008:** According to the health insurance broker I-Select the new thresholds could affect: "…1,010,615 single taxpayers earning between $50,000 and $100,000" and predicts that the cost of PHI may rise by 10%, making it even less attractive.

4. Conclusion and Recommendations

In light of the adverse forecasts that the proposed changes to the income thresholds for the Medicare Levy Surcharge are expected to have on the public hospital system, we ask that this policy be modified more in keeping with actual price shifts, by increasing the income level at which the surcharge becomes payable to better reflect the actual increase in the CPI since 1997, rather than the proposed more substantial upward movement. Furthermore, the College of Surgeons believes that in future the Medicare Levy Surcharge should be indexed yearly based on changes in the CPI. This will not only ensure a fair and equitable system, but will also put into place a non-partisan process.

Attachment A: Charts and Data for Average Weekly Earnings, the Consumer Price Index and Membership of Private Health Insurance

CHART 1: Quarterly Average Weekly Earnings , Australia, 2000 – 2008



Year and Quarter	Earnings ; Persons ; Total earnings
Feb-2000	623.90
May-2000	635.30
Aug-2000	643.50
Nov-2000	649.90
Feb-2001	656.40
May-2001	664.30
Aug-2001	672.00
Nov-2001	678.10
Feb-2002	683.90
May-2002	689.80
Aug-2002	696.20
Nov-2002	704.80
Feb-2003	714.60
May-2003	725.10
Aug-2003	735.50
Nov-2003	743.40
Feb-2004	748.40
May-2004	752.30
Aug-2004	758.60
Nov-2004	769.50
Feb-2005	782.40
May-2005	794.00
Aug-2005	802.80
Nov-2005	811.00
Feb-2006	820.00
May-2006	829.50
Aug-2006	839.00
Nov-2006	848.10
Feb-2007	857.50
May-2007	866.80
Aug-2007	873.80
Nov-2007	879.80
Feb-2008	885.40

CHART 2: Quarterly Consumer Price Index, Australia, 2000 – 2008

Year and Quarter	CPI: Percentage Change from Corresponding Quarter of Previous Year ; All groups ; Australia ;
Mar-2000	2.8
Jun-2000	3.2
Sep-2000	6.1
Dec-2000	5.8
Mar-2001	6.0
Jun-2001	6.0
Sep-2001	2.5
Dec-2001	3.1
Mar-2002	2.9
Jun-2002	2.8
Sep-2002	3.2
Dec-2002	3.0
Mar-2003	3.4
Jun-2003	2.7
Sep-2003	2.6
Dec-2003	2.4
Mar-2004	2.0
Jun-2004	2.5
Sep-2004	2.3
Dec-2004	2.6
Mar-2005	2.4
Jun-2005	2.5
Sep-2005	3.0
Dec-2005	2.8
Mar-2006	3.0
Jun-2006	4.0
Sep-2006	3.9
Dec-2006	3.3
Mar-2007	2.4
Jun-2007	2.1
Sep-2007	1.9
Dec-2007	3.0
Mar-2008	4.2

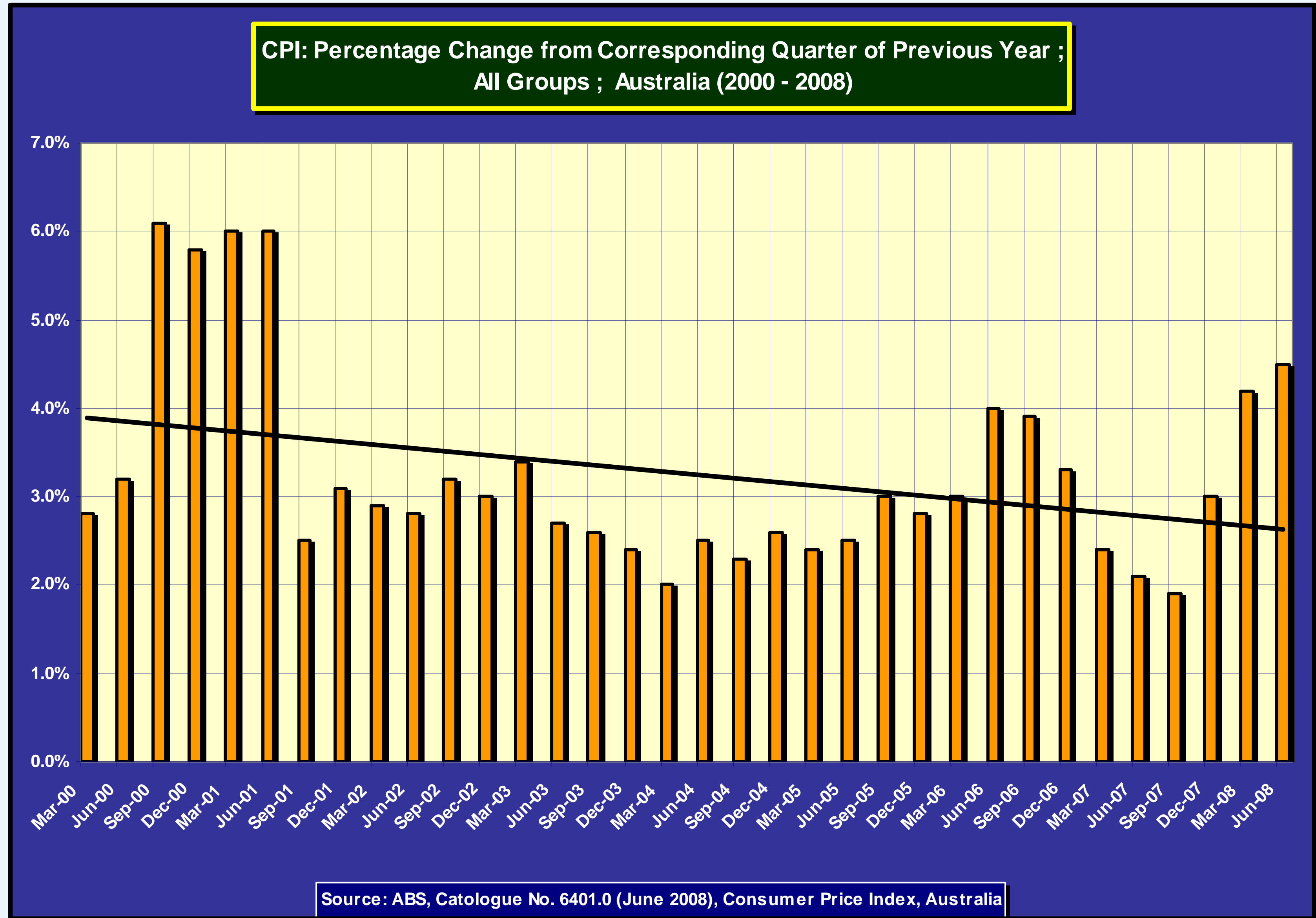


CHART 3: Percentage of Australians with Private Health Insurance Membership Since 1983

Year	Australians with Private Health Insurance Membership (%)
1983	50
1984	50
1985	47.7
1986	48.8
1987	48.3
1988	47
1989	45.5
1990	44.5
1991	43.7
1992	41
1993	39.4
1994	37.2
1995	34.9
1996	33.6
1997	31.9
1998	30.6
1999	30.6
2000	43
2001	44.9
2002	44.3
2003	43.5
2004	42.9
2005	42.6
2006	42.7
2007	43.5