



australian  
nursing federation

Submission to Fairer Private Health Insurance  
Incentives Bill 2009 and two related Bills;  
and Health Insurance Amendment  
(Extended Medicare Safety Net) Bill 2009

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## 1. Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the largest professional and industrial organisation in Australia for nurses and midwives, with Branches in each State and Territory of Australia.

With a membership of over 170,000 nurses and midwives, members are employed in a wide range of enterprises in urban, rural and remote locations in both the public and private sectors. The core business for the ANF is the professional and industrial representation of our members and the professions of nursing and midwifery.

The ANF participates in the development of policy in nursing and midwifery, nursing and midwifery regulation, health, community services, veterans' affairs, education, training, occupational health and safety, industrial relations, social justice, immigration, foreign affairs and law reform.

The ANF is pleased to provide comment to the Senate Community Affairs Committee to assist in the development of the Fairer Private Health Insurance Incentives Bill 2009 and two related Bills - Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 and Fairer Private Health Insurance Incentives (Medicare Levy Surcharge - Fringe Benefits) Bill 2009; and Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009.

## 2. The nursing and midwifery professions

Nurses and midwives form the largest component of the health workforce in Australia, providing health care to people across their lifespan. Nurses and midwives are the most geographically dispersed health professionals in Australia, working in homes, schools, communities, general practice, local councils, industry, offshore territories, aged care, retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health services, hospitals, the armed forces, universities, mental health facilities, statutory authorities, general businesses, and professional organisations.

There is a combined total of 244,360 registered and enrolled nurses actually employed in nursing in Australia, with 18,300 of these being registered midwives.<sup>1</sup> Nurses and midwives comprise over 55% of the entire health workforce.<sup>2</sup>

Nursing and midwifery are therefore key professions to engage in achieving the aim of Australia as the healthiest country by 2020.

### 3. General comments

With nurses and midwives having a central role to play in the delivery of health services, and with a large membership from the nursing and midwifery professions, the ANF has a critical interest in all issues relating to health funding, including health payment and insurance schemes.

The ANF recognises that:

- access to health care is a fundamental human right for every Australian, not a privilege
- health is a public good with shared benefits and shared responsibilities
- individuals requiring health care have a right to choose how and where that health care is provided
- publicly funded universal health insurance is an efficient and effective mechanism to distribute resources in a manner that ensures timely and equitable access to affordable health care on the basis of clinical need rather than capacity to pay
- the private health sector has a legitimate and important role as an alternate choice for the provision of health care, however this should not be at the expense of publicly provided services.<sup>3</sup>

### 4. Fairer Private Health Insurance Incentives Bill 2009 and two related Bills - Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 and Fairer Private Health Insurance Incentives (Medicare Levy Surcharge - Fringe Benefits) Bill 2009; and Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009

#### 4.1 Overview of amendments

The ANF welcomes the opportunity to make comment on the Fairer Private Health Insurance Incentives Bill 2009 and two related Bills - Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 and Fairer Private Health Insurance Incentives (Medicare Levy Surcharge - Fringe Benefits) Bill 2009; and Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009.

The changes outlined in this draft legislation will ensure that those members of the community with a greater capacity to pay will make a larger contribution towards the cost of the private health insurance scheme in which they have opted to participate. It will ensure that Australian Government support for private health insurance remains fair and sustainable in the future.

The draft legislation will also enable the Minister to determine a cap on the Extended Medicare Safety Net (EMSN) benefit payable and ensure that the mechanism is flexible and responsive to changes in circumstances that impact on the EMSN.

#### 4.1.1 Fairer Private Health Insurance Incentives Bill 2009

In relation to the Fairer Private Health Insurance Incentives Bill 2009, the ANF strongly supports the proposed legislation to implement changes to private health insurance which will provide benefits for the majority of Australians and not just the higher income sector.

Since its inception by the previous Government, the ANF has not supported incentives to make private health insurance an attractive option. There is no logical reason why the private health insurance industry should be protected in a way that other insurers are not. The ANF strongly supports a universal health insurance system to enable equity of access to all necessary health services for all Australians. The most equitable way for people who can afford to do so is to contribute more to the health system through taxation - that is, increasing the Medicare levy. Private health insurance should be an optional extra. Private health insurers should be able to offer a wider range of services with the exception of those covered by Medicare, that is out of hospital medical costs and public hospital services, with minimal government interference or financial support.

The ANF therefore welcomes the fact that the Australian Government has set up an Inquiry into the private health insurance rebate, as it has not achieved any of its objectives such as relieving pressure on the public hospital system, making private health more affordable or keeping the cost of private health services down.

It is the ANF's position that it should not be the Government's responsibility to provide incentives for the private health insurance industry to attract buyers to its membership products. The ANF is firm in its position that the public monies currently expended on providing rebates to people to take out private health cover should more correctly be spent on ensuring a health system which provides access and equity to health care for all people in Australia.

As a member of the Australian Health Care Reform Alliance (AHCRA), the ANF shares the views expressed at the AHCRA Summit 2009, that the private health insurance rebate is poor policy and that public funds should not be used to support private insurance.

The ANF appreciates the opportunity to provide input to the development of legislation which dismantles current inequalities in health care insurance cover. The ANF considers that the proposed changes to the health insurance cover will enable citizens on higher incomes to fulfil their responsibility as members of a civil society.

#### 4.1.2 Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009, Fairer Private Health Insurance Incentives (Medicare Levy Surcharge - Fringe Benefits) Bill 2009

The policy of providing public funds to subsidise private health insurers in Australia uses three policy instruments:

- the use of a negative tax incentive (an additional 1% Medicare levy surcharge for people without private health insurance);
- age-related penalty rates for 'late joiners' of private health insurance funds (the Lifetime Health Cover policy); and
- a 30% rebate on premiums for people with private health insurance.

The Medicare levy surcharge was introduced by the Howard Government following their election in 1996. The *Medicare Levy Amendment Act (MLAA)* introduced a one per cent Medicare levy surcharge for individuals with a taxable income above \$50,000 and families with combined taxable incomes more than \$100,000 who did not have private hospital insurance cover for themselves and all their dependants.<sup>4,5</sup>

The surcharge is in addition to the standard Medicare Levy of 1.5%, which is paid by most Australian taxpayers. The expressed intentions for the Medicare levy surcharge were to provide an incentive for higher income earners not to rely on the Medicare system and to take out private health insurance.<sup>6</sup>

Following the introduction of the Medicare levy surcharge by the Howard government in 1996, another incentive was offered in 1998 to further encourage people to take out private health insurance, by providing a 30% rebate on private health insurance premiums. This replaced a much more modest incentive scheme which was means tested. The new 30% rebate was not means tested and was available to anyone who took out or maintained private health insurance. Its introduction was provided for in the *Private Health Insurance Incentives Bill 1998*.

In 2000 another initiative was introduced to encourage people to take out private health insurance earlier in life and to maintain insurance throughout their life. Lifetime Health Cover required people to pay a 2% loading on top of their premium for every year they were aged over 30 when they first took out hospital cover. People aged 65 years and over were exempt.<sup>7</sup> This meant that "if you were to wait until you are 40, you could be paying an extra 20% on the cost of your hospital cover. If you wait until you are 50, you could pay 40% more. And so on, up to a maximum of 70% more."<sup>8</sup> In 2005, the 30% rebate increased to 35% for those aged between 65 and 69, and to 40 per cent for those aged 70 or older.

The introduction of these measures by the Howard government was accompanied by a concurrent reduction in the level of expenditure provided by the federal government to public hospitals. A fall of \$1 billion each year pushed public hospitals to crisis in most states and territories, amid claims from the federal government that the (mostly Labor) state and territory governments were misusing the funds, and counterclaims of under funding from the states and territories.<sup>10</sup>

#### 4.1.2.1 The effectiveness (or otherwise) of the policy

According to John Deeble (architect of Medicare and the health economist asked to report to the health ministers in 2003 on the effectiveness of the PHI rebate), the decision to remove subsidies from private hospitals in 1987 and to shift to subsidising private health insurers started a price growth in private insurance premiums and divorced the private sector, and private insurance, from the structure of Medicare.<sup>11</sup>

The stated aims of the Howard government policy (the policy being both the exemption from the surcharge and the private health insurance rebate) were that: private health insurance membership was falling, putting financial pressure on the private sector and increasing demand on the public sector, and creating a threat to Commonwealth and State/Territory health budgets. Cost was cited as the contributing factor in falling health insurance, and the injection of public funds cited as the rationale for the policy to “shift demand from the public hospitals to private providers and in the process, improve the availability of public hospital care for disadvantaged people.”<sup>12</sup>

Any suggestion that this policy has reduced pressure on the public sector is erroneous. So too the argument that falling private health insurance membership will therefore threaten the viability of the private sector is not supported by evidence.

For despite a \$2 billion injection of funds to the private insurers, the net contribution of private health insurance to the private sector has decreased,<sup>13</sup> premiums have continued to rise and the demand on the public sector has increased. At the time private health insurance was falling, the proportion of work being undertaken in private hospitals increased significantly.<sup>14</sup>

While the subsidies have been (politically) associated with an increase in the number of people taking out private health insurance, policy experts argue this has had more to do with a forceful marketing campaign,<sup>15</sup> and the introduction of the Lifetime Health Cover initiative which penalised people for taking out insurance after the age of 30 than the other policies.

Assessments by both academics<sup>16</sup> and the industry itself (the Private Health Insurance Administration Council)<sup>17</sup> reveal that in the first nine months following the introduction of the 30% rebate, private health insurance rose just 1%.

However, in the nine months following the introduction of Lifetime Health Cover (29 September 1999), until its cut-off date (15 July 2000), private health insurance jumped 31% to 43%.<sup>18</sup>

This demonstrates the argument of the private health insurance sector that raising the threshold for the Medicare levy surcharge will encourage people to drop out of private health insurance is fallacious. People do not buy private health insurance because it represents good value for money - indeed it does not, and many people will avoid declaring their private health insurance on admission to hospital to avoid paying the large gaps and out of pocket expenses associated with many private health insurance plans. The surge in membership following the introduction of the Lifetime Health Cover shows people buy it only if there is a sufficient threat associated with failing to do so.

As John Deeble has said: "despite the claims of its advocates, private insurance membership is relatively insensitive to price. Its post-Medicare decline was more related to perceptions of poor value for money, growing confidence in Medicare's stability and an increasing number of people with no history of using it. The rebate itself played almost no role in the large increase in private insurance membership in June-July 2000, nor can the introduction of 'lifetime health cover' alone explain it. Almost all of the increase came from the fear campaign associated with its implementation."<sup>19</sup>

The aims of the policy in reducing pressure on the public sector has never been realised; and in fact public hospital admissions have increased.<sup>20</sup>

Health economist, Stephen Duckett (and others) have estimated that if all government subsidies to the private health sector were redirected to public hospitals, an additional 1.5 million cases could be treated in Australia's public hospitals.<sup>21</sup>

#### 4.1.2.2 The validity (or otherwise) of the policy

It is not clear why boosting private health insurance membership should be considered the responsibility of the federal or any other government.

Falling private health insurance is a problem for private health insurers, not governments. It has been suggested by a number of commentators that if the private health insurance industry was selling a product that represented good value for money (for private health insurance is just that - a product for sale), they would not have the same level of difficulty in maintaining funds membership. Private health insurance in Australia is only "part-insurance" however, and while funds continue to sell insurance that covers only part of one's health service costs, it will not represent the sort of value that Australian consumers will choose to buy in large quantities.

The policy of subsidising private health insurers undermines Medicare, and takes funds away from public hospitals.<sup>22</sup> Any falls in private health insurance membership have more to do with the public's realisation that public hospitals are there if they need them and if they do not want to use the private system there is no advantage in having private health insurance.<sup>23</sup>

Consumer advocates, many other health care stakeholders, and independent policy analysts support the notion of strong public investment in the public sector and regulation of the private sector, but without subsidising the insurers.<sup>24</sup>

The viability of private hospitals is not threatened by the decline in the number of people with private health insurance;<sup>25</sup> it is threatened by the private health insurance companies failing to provide insurance products that people want.

#### 4.1.3 Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009

As outlined previously the draft Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009 will enable the Minister for Health and Ageing to determine a cap on the Extended Medicare Safety Net (EMSN) benefit payable. The Minister will also be able, under the new legislation, to ensure that the mechanism is flexible and responsive to changes in circumstances that impact on the EMSN.

The ANF does not support the current EMSN which has no limit on the amount of benefit payable. The ANF has long held the concern, expressed now in the Explanatory Memorandum to the draft Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009, that the effect of the EMSN would be for doctors to increase their fees with the knowledge that the majority of the cost would be funded by the Government once the person had reached the EMSN threshold. This is clearly a rort of a system set up to supposedly provide financial aid to people needing to access significant health care services. The subsequently artificially inflated fee structure then has implications for those people who have not qualified for the EMSN benefit, as pointed out also in the Explanatory Memorandum.

The ANF supports too, the setting of the EMSN in a legislative instrument so that it is subject to parliamentary scrutiny and thus gives greater assurance of protection of the public.

## Conclusion

The ANF has welcomed the opportunity to provide comment to the Senate Community Affairs Committee to assist in the development of the Fairer Private Health Insurance Incentives Bill 2009 and two related Bills - Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 and Fairer Private Health Insurance Incentives (Medicare Levy Surcharge - Fringe Benefits) Bill 2009; and Health Insurance Amendment (Extended Medicare Safety Net) Bill 2009.

Nurses and midwives play a central role in the delivery of health services and form the largest single group of health professionals in the health and aged care sectors. The ANF, as the largest professional and industrial organisation for nurses and midwives has a central concern for the professional and socio-economic well being of our members, and for the enactment of social justice within the community.

The ANF considers that the development of these Bills (as named above) is important in providing a more equitable health insurance landscape for the Australian community.

In addition to the comments made in this submission the ANF would be pleased to provide any further advice required in the development process for these Bills.

## References

1. Australian Institute of Health and Welfare 2008. Nursing and midwifery labour force 2005. Additional Material. Table 1. Available at <http://www.aihw.gov.au/publications/hwl/nmlf05/nmlf05-xx-registered-nurses-clinical-area.xls>
2. Australian Institute of Health and Welfare. *Australia's Health 2008*. Canberra: AIHW, 2006. p 317.
3. Australian Nursing Federation. 2008. *ANF Position statement: public and private health services*. Available at: [www.anf.org.au](http://www.anf.org.au)
4. Australasian Legal Information Institute, *Income Tax Regulations (Amendment) 1997 No. 141*, Explanatory Statement.
5. Australian Parliamentary Library, *A New Tax System (Medicare Levy Surcharge - Fringe Benefits) Bill 1998*, Bills Digest No. 86, 1998-99.
6. Australian Parliamentary Library, *A New Tax System (Medicare Levy Surcharge - Fringe Benefits) Amendment Bill*, Bills Digest No. 152, 1999-2000.
7. Agnes Walker, Richard Percival, Linc Thurecht and James Pearse, Distributional impact of recent changes in private health insurance policies, *Australian Health Review*, 2005, Vol 29, No. 2, pp.167-177.
8. Department of Health and Ageing, Lifetime health cover, Information for health professionals, Australian Government. Available at: [www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-lhc-providers-general.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-lhc-providers-general.htm)
9. Australian Associated Press, *Elective surgery figures 'disappointing'*, Sydney Morning Herald, June 29, 2007.
10. Governments of the Australian Capital Territory, New South Wales, Northern Territory, Queensland, South Australia, Tasmania, Victoria and Western Australia. *Caring for our health? A report card on the Australian Government's performance on health care*, June 2007.
11. John Deeble, The private health insurance rebate: Report to State and Territory Health Ministers National Centre for Epidemiology and Population Health, The Australian National University, January 2003.
12. Deeble, 2003.
13. Deeble, 2003.
14. Gwen Gray, *The politics of Medicare: Who gets what, when and how*, in Briefings Series by UNSW Press, in association with Australian Policy Online, 2004.
15. Ken Harvey, Private Health Insurance: *Where are we now and where should we be going?* Centre for Policy Development, 22nd February, 2006.
16. J. Butler, *Policy change and private health insurance: Did the cheapest policy do the trick?* NCEPH Working Paper Number 44, 2001, National Centre for Epidemiology and Public Health, The Australian National University, Canberra.
17. Private Health Insurance Administration Council (PHIAC), *Industry statistics, membership and coverage*, Available at: [www.phiac.gov.au/statistics/trends/index.htm](http://www.phiac.gov.au/statistics/trends/index.htm).
18. Charles Livingstone and Greg Ford, *Paying for our health*, Health Issues Centre, Available at: [www.hic.infoxchange.net.au/documents/items/2008/04/206394-upload-00001.pdf](http://www.hic.infoxchange.net.au/documents/items/2008/04/206394-upload-00001.pdf)
19. Deeble, 2003.
20. Deeble, 2003.

References *continued*

21. S. Duckett and T. Jackson. The new health insurance rebate: an inefficient way of assisting public hospitals, *Medical Journal of Australia*, 2000, Vol. 172, pp. 439-442.
22. Queensland Health, *Facing the future: Opportunities for a better health deal*, Publications, Queensland Government.
23. Terry Fitzpatrick, A history of health insurance in Australia, 3 November 2006. Available at: <http://www.fbeu.net/1006.html>
24. Ian McAuley, Higher thresholds for the Medicare surcharge - a welcome reform, Crikey, 14 May 2008.
25. George Palmer, Government policymaking, private health insurance and hospital-efficiency issues: Will government subsidies provide a long term solution to declining rates of health insurance coverage? *Medical Journal of Australia*, 2000, Vol 172, pp. 413-414.