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**Submission to the Inquiry into the
Tax Laws Amendment
(Medicare Levy Surcharge Thresholds) Bill 2008**

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Gerardine (Ged) Kearney
Federal Secretary

Lee Thomas
Assistant Federal Secretary

Australian Nursing Federation
PO Box 4239 Kingston ACT 2604
T: 02-6232 6533
F: 02-6232 6610
E: anfcanberra@anf.org.au
www.anf.org.au



1. Introduction

The Australian Nursing Federation (ANF), established in 1924, is the national union for nurses with branches in each state and territory of Australia. The ANF is also the largest professional nursing organisation in Australia. The ANF's core business is the industrial and professional representation of nurses and nursing.

The ANF's 160,000 members are employed in a wide range of enterprises in urban, rural and remote locations in the public, private and aged care sectors, including hospitals, health services, schools, universities, the armed forces, statutory authorities, local government, offshore territories and industries.

The ANF participates in the development of policy in nursing, nursing regulation, health, community services, veteran's affairs, education, training, occupational health and safety, industrial relations, immigration and law reform.

Nurses are the largest health professional group providing health care to the population of Australia. According to the Australian Institute of Health and Welfare (AIHW) Nursing and Midwifery Labour Force Survey (2005) there are 285,619 nurses in Australia, comprising 230,578 registered nurses and 55,042 enrolled nurses. Nurses constitute more than 54% of the health workforce.

2. Background

This submission responds to the recent changes made by the Rudd Government to lift the income threshold for which people are obliged to pay an additional 1% surcharge on the Medicare levy if they do not hold private health insurance. It provides an overview of the policy since its introduction in 1996, and considers its effects over the last 10 years, before considering the effects of the recent policy change.

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.^{1,2}

¹ Australasian Legal Information Institute, *Income Tax Regulations (Amendment) 1997 No. 141*, Explanatory Statement.

² Australian Parliamentary Library, *A New Tax System (Medicare Levy Surcharge - Fringe Benefits) Bill 1998*, Bills Digest No. 86, 1998-99.



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There are precedents for this policy: in the Fraser years (1975 to 1983), people were allowed to opt out of the Medicare surcharge if they had private health insurance, and in the latter part of this government's term, in 1982, a 30% tax deduction on all private health insurance premiums was introduced, paralleling the current system. Until 1986-87, subsidies were paid direct to private hospitals. This had the effect of reducing both their charges and the cost of insurance to cover them.³

The current surcharge is in addition to the standard Medicare Levy of 1.5%, which is paid by most Australian taxpayers. The expressed intentions of the Howard government 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.⁴

The Rudd government's recent lifting of the Medicare levy surcharge means it now applies only to single people earning more than \$100,000 or families earning more than \$150,000 per annum.

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.⁵ 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."⁶ 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

³ 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.

⁴ Australian Parliamentary Library, A New Tax System (Medicare Levy Surcharge - Fringe Benefits) Amendment Bill, Bills Digest No. 152, 1999-2000.

⁵ 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.

⁶ 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



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misusing the funds,⁷ and counterclaims of under funding from the states and territories.⁸

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.⁹

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.”¹⁰

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,¹¹ 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.¹²

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,¹³ 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 academics¹⁴ and the industry itself (the Private Health Insurance Administration Council)¹⁵ reveal that in the first nine months following the introduction of the 30% rebate, private health insurance rose just 1%.

⁷ Australian Associated Press, *Elective surgery figures 'disappointing'*, Sydney Morning Herald, June 29, 2007.

⁸ 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.

⁹ Deeble, 2003.

¹⁰ Deeble, 2003.

¹¹ Deeble, 2003.

¹² 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.

¹³ Ken Harvey, *Private Health Insurance: Where are we now and where should we be going?* Centre for Policy Development, 22nd February, 2006.

¹⁴ J. Butler, *Policy Change and Private Health Insurance: Did the Cheapest Policy do the Trick?* NCEPH Working



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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%.¹⁶

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 pockets 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.”¹⁷

The aims of the policy in reducing pressure on the public sector has never been realised; and in fact public hospital admissions have increased.¹⁸

Health economist, now senior health bureaucrat and health and hospitals reform commissioner 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.¹⁹

It is estimated that the subsidy will cost Australian taxpayers \$4.8 billion in 2007-08.

There is a view that the subsidisation of private health insurers was an attempt by the previous government to undermine Medicare, in an exercise to demonstrate the failure of a universal system to be sustainable and meet the demands of the community. With a concurrent policy of under funding the public hospital sector, the former Coalition government, with their market based philosophy, could show why choice was necessary; that a public system for everyone was unsustainable, and that the public health system was intended for the most disadvantaged. This approach however ignored the analysis that clearly shows the policy has failed its objectives to reduce pressure on the public sector.

Paper Number 44, 2001, National Centre for Epidemiology and Public Health, The Australian National University, Canberra.

¹⁵ Private Health Insurance Administration Council (PHIAC), *Industry Statistics, Membership and Coverage*, Available at: www.phiac.gov.au/statistics/trends/index.htm.

¹⁶ Charles Livingstone and Greg Ford, *Paying for our health*, Health Issues Centre, Available at: www.hic.infonchange.net.au/documents/items/2008/04/206394-upload-00001.pdf

¹⁷ Deeble, 2003.

¹⁸ Deeble, 2003.

¹⁹ 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.



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Progressive think tanks and health economists however suggest that an ageing, but healthier, population will not lead to unsustainable health expenditure, and point to Scandinavian countries with similar demographics that have relatively low percentages of Gross Domestic Product (GDP) spent on health (around 10%).²⁰

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 however 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.²¹ 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.²²

Despite concerns expressed by the private health Insurance industry and the Australian Medical Association about the lifting of the levy surcharge, there is an alternate view that raising the threshold will allow consumers to make a choice how they spend their money on health care.²³

The support of stakeholders with vested interests, such as the Private Hospitals Association and the Private Health Insurance Association, for the subsidisation of the private sector is to be expected.

However 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.²⁴

Consumer advocate Choice says the antagonistic response of the private health industry to the changes shows how dependent they are on government policy to

²⁰ Stephen Leeder and Ian McAuley. The future of Medicare and health service financing, *Medical Journal of Australia*, Vol 173, pp.48- 51, 2000.

²¹ Queensland Health, *Facing the Future: Opportunities for a Better Health Deal*, Publications, Queensland Government.

²² Terry Fitzpatrick, A history of health insurance in Australia, 3 November 2006. Available at: <http://www.fbeu.net/1006.html>

²³ Gary Sauer-Thompson, Scaremongering on health care, Weblog, 20 May 2008. Available at <http://www.sauer-thompson.com/archives/opinion/2008/05/scaremongering.php#more>

²⁴ Ian McAuley, Higher thresholds for the Medicare surcharge – a welcome reform, Crikey, 14 May 2008.



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force consumers to take up private health insurance – arguing that if the industry provided a product that offers consumers value, it would not require a government subsidy.²⁵ The loss of members from private health insurance may be a loss for private health insurers, but is unlikely to have profound impacts on public hospitals as many of those affected are young people are less likely to need hospital care and “if they do need hospital care they are likely to use a public hospital, rather than bear the surcharges and excess payments associated with [private health insurance products]”.²⁶

Thus the viability of private hospitals is not threatened by the decline in the number of people with private health insurance;²⁷ it is threatened by the private health insurance companies failing to provide insurance products that people want.

SUMMARY OF KEY DATES	
1975	Medibank introduced by the Whitlam government
1976	Fraser government scraps Medibank
1983	Hawke government elected and Medicare introduced
1983-1996	Private health insurance membership falls from 70%-30%
1996	Howard government elected and pledges to retain Medicare
1998	Howard government introduces Medicare levy surcharge for people without PHI
1999	Howard government introduced 30% Medicare rebate
2000	Lifetime Health Cover introduced
2005	30% rebate increased to 35% (for those 65-69 years), and to 40% (for those 70+).
2008	Medicare levy surcharge threshold lifted for singles from \$50,000 to \$100,000 and those who are members of a family from \$100,000 to \$150,000.

²⁵ Choice, Health insurers should stop quibbling, Media release, 19 May 2008.

²⁶ Ian McAuley, Higher thresholds for the Medicare surcharge – a welcome reform, Crikey, 14 May 2008.

²⁷ 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.