



COMMONWEALTH OF AUSTRALIA

PARLIAMENTARY DEBATES



**THE SENATE**

**PROOF**

**TAX LAWS AMENDMENT  
(MEDICARE LEVY SURCHARGE  
THRESHOLDS) BILL 2008**

**Second Reading**

**SPEECH**

**Monday, 15 September 2008**

BY AUTHORITY OF THE SENATE

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## SPEECH

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**Questioner**  
**Speaker** Eggleston, Sen Alan

**Source** Senate  
**Proof** Yes  
**Responder**  
**Question No.**

**Senator EGGLESTON** (Western Australia) (1.32 pm)—Australia has ‘The Best, Worst Health System’ in the world, according to Jim Hoggett, who wrote in the *IPA Review* in December 2003. Hoggett was no doubt referring to the fact that no-one is ever happy with their health service because, of course, there is always more that could be done to provide more comprehensive and equitable health care. But his article made the point that the unique features of the Australian health system, which include a balance between the public and private sectors and community rating, mean that Australia does in fact have one of the better health services in the world, if not in fact the best.

By contrast, in the United States, where health services are predominantly private and costly, and health insurance premiums weighted for risk, those who cannot afford to have private health insurance have to fall back on the United States public hospital system, which is generally regarded as woefully inadequate. In fact, this morning I heard on Radio National’s *The Health Report* that 45 million US citizens do not have health insurance so cannot access reasonable health care. In Canada and the United Kingdom, health services, by contrast, are largely public, with a smaller private sector. Having worked for the British National Health Service I can say that, while I admire the standard of care, hospital infrastructure is often old—many hospitals are actually converted 19th-century work houses—wards are overcrowded and waiting lists are long. ‘Why?’ we might ask. The answer to that is: because governments never provide enough funding to upgrade the facilities in the public sector. That is a point to emphasise: no matter what is stated in election promises by Labor idealists, the track record of governments in providing sufficient funding for the public health sector is very poor.

Most importantly with respect to private health insurance, in both Britain and the United States, if you have an adverse medical history, such as being diabetic, or a family history which suggest you may be at risk, should you desire to take out private health insurance your premiums will be weighted for risk and it is possible you could be refused health insurance cover. As I said, in Australia we have a system where there is a balance between public and private care. And, most importantly, in Australia, health insurance premiums are not rated for risk. This means that,

regardless of your personal or family medical history, everyone pays the same premium for health insurance. This system is called community rating. Community rating works by virtue of the fact that the premiums of younger people, whose claim rate is low, go into a re-insurance pool to cover the cost of claims for treatment by older people, who have a much higher rate of claims for illness and surgery.

The Australian system is unique in the world and delivers excellent health cover to our community. But—of relevance in the context of this proposed legislation to abolish the Medicare levy surcharge—the success of the Australian system fundamentally depends on preserving the balance between the private and public medical system. Regrettably, the Rudd government proposal to abolish the Medicare levy surcharge will destroy the balance in the Australian health system and will result in chaos. The balance will be destroyed because abolition of the Medicare levy surcharge will result in a large number of families and individuals dropping their private health cover. As the Australian Medical Association said in their submission to the Senate economics committee inquiry:

Australia’s health system is a delicate balance between the public and private sectors. The effectiveness and efficiency of the public system relies on a strong private sector. A high rate of private health insurance membership is a key part of the private sector.

During the Senate inquiry evidence was given that, notwithstanding Treasury modelling, which is widely regarded as being flawed, other estimates show that when all of the secondary flow-on effects come into play, somewhere between 800,000 and one million people will no longer be covered by private health insurance if this measure goes through and will therefore be unable to access the private hospital sector, so will turn to public hospitals for treatment. This, in turn, will create enormous additional pressure on the public hospital system. Inevitably, it will mean delays in treatment and longer waiting lists for elective surgery in the public hospital sector. In their submission to the Senate inquiry, Catholic Health Australia summarised the impact of the Medicare levy surcharge as follows:

The Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008 is likely to have several adverse

consequences which will result in new barriers in access to health care by low and middle income earners.

The summary states that these adverse impacts are likely to include:

- Increases in public hospital surgery waiting times as upwards of 200,000 new episodes of care will need to be carried out in public hospitals;
- Specific longer waiting times for older Australians requiring cataract surgery or hip and knee replacements;
- Immediate increased costs on public hospitals of a likely \$400million;
- An initial decline in State and Territory public hospital revenue of \$35million in direct hospital accommodation benefits and an additional \$20million in other services—

I add that this is because fewer patients being treated in public hospitals will have private cover, so state governments will no longer be able to double dip—that is, receiving both Medicare funding from the federal government while charging patients' health insurance funds for the same service. Catholic Health goes on to say there will be:

- A likely initial increase in private health insurance premiums of up to 10%, which will be felt most by those low and middle income earners with private health insurance;
- Future unpredictable increases in demand on public hospitals as private health insurance becomes more expensive;
- Over \$400million lost from the operational budgets of private hospitals.

The Catholic Health submission went on to describe how the workload will be transferred from the private sector to the public sector as follows:

Catholic public not-for-profit hospitals will in turn be impacted as episodes of care that would have been carried out in private settings shift across to public settings.

Catholic Health Australia further points out that it would be the low- and middle-income earners who would be most affected by this ill-considered measure by the Rudd government, saying:

The Treasury modelling of the impact of the proposed threshold changes has deficiencies. These deficiencies have partially shielded the likely consequences of the proposed threshold changes. The likely consequences will be most felt by low and middle income earners, who will bear the brunt of increased cost pressures on public hospitals if waiting times

for surgery [and/or] struggle to maintain their private health insurance membership ...

I think senators would agree that low- and middle-income earners are rather surprising casualties indeed for a Labor government measure. It is typical of the fact that the Rudd government does not seem to think through its policy initiatives.

What is so difficult to understand about the Rudd government introducing this measure is that these outcomes are all predictable on the basis of what happened to the Australian health system following the introduction of Medicare in 1984. Prior to the introduction of Medicare, which was touted as a universal health system, around 60 per cent of Australians had private health insurance. However, over the next 13 years, until the introduction of the Medicare levy surcharge, membership of private health insurance funds in Australia dropped to about 30 per cent of the population and because no serious steps were taken by the government of the time to increase the capacity of the public sector, the result predictably was the all important balance between the private and public health sectors, which I referred to earlier, was destroyed and Australia faced a crisis in health care. Because so many people had dropped their private health insurance, there was enormous pressure on the public hospital system. There were ever-increasing waiting lists, which particularly disadvantaged older people, and the public hospital sector was bursting at the seams, unable to cope with the workload. By contrast, adjacent private hospitals were empty. Theatres and wards in private hospitals were not being used while old ladies with arthritic knees and hips were on two-year waiting lists, if not longer, for their surgery to be undertaken in the public hospitals sector. People suffered unnecessarily and no doubt the delays aggravated their medical conditions.

To end this unprecedented crisis, the Howard government took urgent action to encourage Australians to take up private health insurance to take the pressure off the public system. To restore balance to the Australian health system, the Howard government introduced three measures: firstly, the Medicare levy surcharge on 1 July 1997; secondly, the 30 per cent taxation rebate on private health insurance premiums on 1 January 1999; and, thirdly, Lifetime Health Cover in July 2000. Given the desperate situation in which these measures were introduced, it is quite clearly nonsense for the Rudd government to claim that the Medicare levy surcharge was introduced as a revenue-raising measure.

The history of this matter leaves no doubt that the surcharge was introduced as one of a suite of three measures designed to restore balance to the Australian health system and to overcome the crisis which we

faced in 1997. Quite clearly these three measures worked, because participation rates in private health insurance have risen steadily to be over 50 per cent of the population and once again Australia has a health system which delivers high-quality health care to our citizens and is in fact the envy of the rest of the world.

It is totally beyond my comprehension why the Rudd government would want to disturb our uniquely Australian health system by introducing this legislation to abolish the Medicare levy surcharge: this is particularly so because it is clear that so many of those involved in the delivery of our health services believe this proposal will have seriously adverse consequences for the Australian health system. Accordingly, I trust that common sense will prevail and that the Senate will reject this legislation.