# TAX FORUM 4-5 October 2011

## STATEMENT OF REFORM PRIORITIES

### PARTICIPANT NAME AND POSITION

Prue Power, Executive Director, Australian Healthcare and Hospitals Association (AHHA)

### ORGANISATION

The Australian Healthcare and Hospitals Association (AHHA) is the independent peak membership body and advocate for the Australian Public and not-for-profit healthcare sectors and a national voice for universally accessible, high quality healthcare in Australia - since 1946. The AHHA is uniquely positioned to facilitate collaboration between clinicians, academics, policy makers, administrators and politicians.

The Australian Healthcare and Hospitals Association believes that all Australians have the right to universal health care that provides:

- Equity of access to the healthcare system;
- Health services of high quality, delivered by skilled professionals that are appropriate and responsive to their needs and coordinated across all settings.

Australia should have national healthcare policy solutions that are socially, economically and environmentally sustainable. Our national healthcare services must be efficiently and adequately resourced to ensure sustainability and safety.

### STATEMENT OF PRIORITIES

**What are your priority reform directions for the tax and transfer system?**

An important foundation to ensure sufficient resourcing of our health industry is an Australia tax and tax transfer system that adequately and appropriately funds the health system now and in the future. The tax system should ensure equity, simplicity and efficiency. The AHHA believes the process of Reform of Australia's Future Tax System, and the October 2011 Tax Forum are a key opportunities to review the system and to introduce change.

**1.1 Medicare, Oral Health and Private Health Insurance**

**Medicare**

The AHHA supports continuation of Australia's publicly funded universal health care system, Medicare, which underpins equitable access for resident citizens and permanent residents to health care services including public hospitals (funded jointly by the states / territories and the Australian Government) and affordable treatment by doctors and some allied health professional services, with copayments by users when the services are not bulk-billed. The AHHA contends that Medicare, as a compulsory, tax-funded public insurance scheme, is an efficient and sustainable system even as healthcare costs increase with greater use of complex technologies and population ageing.

According to the OECD definitions, Australia's health expenditure as a proportion of GDP was 0.4 percentage points lower than the median for member states in 2008. Australian Government funding of health expenditure as a proportion of total health expenditure in 2008 ($112.8 billion) was 66.8% as compared to the median for OECD countries of 74.8% [i].

**Out-of pocket costs**

The AHHA warns that the increasing percentage of health funding by individuals ('out of pocket') costs has the potential to undermine the principles of equity inherent in Medicare and the PBS. Real growth in funding by individuals between 1998–99 and 2008–09 was 5.2% per year [ii].

**Oral health**

The AHHA believes that that an improved oral health system is an essential part of a more equitable and effective health system. Apart from a brief period in the 1990s, lack of public funding for at least the last 30 years has resulted in a growing crisis in oral health for a significant proportion of the Australian population, particularly young children and the aged.

The AHHA recommends that Australia adopts a phased approach over the next decade to include oral and dental health services in Medicare, funded (in part or in full) by an increase in the Medicare Levy. Initially, funding should be sufficient to enable children (0-18 years) and eligible adult card holders to receive a check-up and basic course of preventively focused dental care at least every 2 years.

Capital funding for additional public dental clinics would need to be increased. In the interim, Commonwealth funding should be committed to the establishment of a viable and sustainable national public oral health program, aimed at improving and maintaining the oral health of Australia's most disadvantaged.

**Private Health Insurance**

The AHHA supports the private health sector as complementary to publicly funded services and agrees with recommendations of the Final Report of the Australia's Future Tax System Review (Henry Review) that the Medicare Levy Surcharge and assistance for private health insurance be reviewed as part of the tax and non-tax policies relating to private health insurance.

In this context, the AHHA contends that, as presently structured, the Private Health Insurance Rebate (a taxation rebate of at least 30% of any private health insurance premium introduced in 1999) is an inefficient, inflationary and inequitable method of funding healthcare services. Between 2001-02 and 2010-11 the cost of the PHI rebate grew from $2.1 billion in to $4.7 billion.

Consequently, the AHHA supports the Government's Fairer Private Health Insurance Incentives legislation (re-introduced into the House of Representatives in July 2011). The key changes proposed by this legislation are a means-test on tax-funded rebates for private health insurance (PHI) for those on incomes above a specified threshold and a higher Medicare Levy Surcharge for people on high incomes who choose not to purchase PHI. The AHHA believes that the impact on PHI membership, and consequently public hospital activity, will be relatively minor. In a position paper prepared for the AHHA, Professor John Deeble argues that only about 31,000 out of the 1.53 million people likely to be affected by the changes would drop their cover. The Commonwealth Treasury has also predicted membership declines of a similar order.

**1.2 Health and the environment**

Maintenance of a healthy population requires diverse approaches including legislation, fiscal measures, taxation and organizational change to discourage unsafe conditions and environments, poor nutrition, pollution and occupational hazards [iii]. The AHHA supports a tax system which includes measures to discourage environmentally damaging activities and, therefore, supports the Government's proposed tax on carbon.

**Tobacco tax**

The AHHA supports increasing the tax on tobacco. While smoking rates in Australia have fallen by about 24% over the past two decades, approximately 17% of Australians continue to smoke daily. And smoking remains the single most avoidable cause of ill health and death in Australia [iv]. Economic evidence indicates it is

perfectly feasible to use higher rates of tax to reduce consumption while at the same time increasing tobacco tax revenue for use on health promotion policies.

**Alcohol tax**

The AHHA supports a tax on alcohol on the basis of the strong link between price, consumption of alcohol, and harms. In particular, young people's drinking is very sensitive to price because their discretionary income is relatively small [v]. Based on the experience of three other broadly similar countries (Norway, the United States and Italy), Collins and Lapsley have estimated that taxation measures, including differential tax rates on forms of alcohol which are particularly subject to abuse, could reduce the social costs of alcohol in Australia by between 14% and 39% (or between $2.19 and $5.94 billion in 2004–05 dollars) [vi]. Extra revenue generated should be used to prevent harmful alcohol use and address alcohol-related harms [vii].

**1.2 Superannuation policy**

Australians have a right to information and an administrative system that will help them plan for their retirement, including sufficient income to keep them healthy and active, involving ongoing part-time work if they choose. The AHHA supports the recommendation of the Final Report of the Australia's Future Tax System Review (Henry Review) that superannuation be taxed at a taxpayer's marginal rate of tax less a rebate to ensure greater equity and encourage couples to invest separately in the superannuation account of the lower income earner. The AHHA also endorses encouraging superannuation funds to offer, and members to take up, annuities instead of lump sums on retirement. The spouse superannuation offset should be reviewed with a view to increasing its effectiveness in encouraging contributions for a spouse. . These objectives should also apply to Self Managed Superannuation Funds.

**1.3 Security and sustainability of pensions and income for ageing Australians**

In 2009–10, people aged 55 years and over accounted for 53.7% of 8.6 million admissions for patient care in Australian hospitals [viii]. The AHHA supports simplification of concessional offsets for Age Pensions and removal of relevant offsets as long as they are replaced by adequate outlay rates for senior pensions that guarantee the health and wellbeing of recipients. For too long, Age Pensioners have struggled to pay for increasing costs of healthcare. Services such as podiatry and other allied health treatments available for those enrolled in schemes such as the Chronic Disease Management (CDM) – GP Care Plan are valuable but highly restrictive. For example the anaesthetic fee for podiatric surgery is also still not covered by the MBS schedule and podiatric surgery is effectively restricted to the private sector and yet there is increasing evidence that access to podiatric surgical intervention is essential for those with diabetes and or potential for falls risk. Increasingly Age Pensioners, who should be accessing such cost effective health services that would increase their health and quality of life and reduce the likelihood of hospitalisation, do not do so because of costs.

While the AHHA notes the Australian Government's recent increase in pension rates and the Work Bonus for Age Pensioners who do some part time work, those who cannot work or choose to leave the workforce earlier due to disability should not be penalised. The AHHA notes and supports the Henry Review comments that exceptions to removal of concessional offsets should apply where a dependant is unable to work due to disability or carer responsibilities, or either the taxpayer or dependant has reached Age Pension age.

**How are your proposals financed over the short and longer term?**

**Oral Health**

The cost of including oral and dental health into Medicare could be funded through a small increase in the Medicare Levy. The cost of implementing public oral health program has been calculated as $380 million in the first full year of operation and increasing to $490 million in the fifth year, after which expenditure would be expected to stabilize as fewer eligible adults suffer dental emergencies and more have regular check-ups and timely dental care. This could be cost neutral to total Government expenditure on oral and dental health as savings of this amount can be made to the Medicare Chronic Disease Dental Scheme by modifying available

treatments and tightening eligibility. While the need for additional public dental infrastructure varies between the states/territories, initial estimates suggest that at least $37M should be provided in year 1 lifting to $49M in year 5.

**Health and the environment**

Increasing taxation on tobacco and alcohol should continue to generate extra revenue which should be used to fund programs for health prevention programs.

**Superannuation policy**

The proposal to tax superannuation at a person's marginal tax rate will redirect investment in superannuation away from high income earners, who currently invest more in superannuation than low income earners.

**Security and sustainability of pensions and income for ageing Australians**

The Australian taxation system overall should be robust enough to sustain pensions for those who are aged in our community.

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[i] AIHW 2010. Health expenditure Australia 2008-09. Health and welfare expenditure series no. 42. Cat. no. HWE 51. Canberra: AIHW

[ii] Health expenditure in Australia 2008–09. Australian Institute of Health and Welfare, Canberra; Cat. no. HWE 51

[iii] Ottawa Charter (21November 1986) to achieve Health for All by the year 2000 and beyond

[iv] Australian Institute of Health and Welfare - Cardiovascular disease Australian facts 2011

[v] Steven J Skov. Alcohol taxation policy in Australia: public health imperatives for action. A statement by the Royal Australasian College of Physicians. MJA 2009; 190 (8): 437-439

[vi] Collins and Lapsley. The avoidable costs of alcohol abuse in Australia and the potential benefits of effective policies to reduce the social costs of alcohol. Commonwealth of Australia 2008

[vii] National Alliance for Action on Alcohol. Alcohol Tax Forum Communiqué; 28 September 2011

[viii] Australian Institute of Health and Welfare Australian hospital statistics 2009-10: http://www.aihw.gov.au/publication-detail/?id=10737418863&tab=2