APPENDIX 1

SUBMISSION NO. 1 – COMMUNITY AND PUBLIC SECTOR UNION

CPSU SUBMISSION TO COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Health Insurance Commission (Reform and Separation of Functions) Bill 1997

Introduction

On 10 April 1997 the Government announced its decision to separate Medibank Private functions from the Health Insurance Commission. The Government made its decision in response to the Productivity Commission's inquiry into the private health insurance industry. The Productivity Commission's report to the Government referred to complaints from the private health insurance industry that co-location of Medibank Private operations with Medicare operations gave an unfair competitive advantage to Medibank Private. CPSU contends that the Government has bowed unnecessarily to these complaints based on an incorrect assertion that separation of Medibank Private from the HIC will somehow restore 'competitive neutrality'.

This paper will show that separating Medibank Private operations from the Health Insurance Commission is unjustified, will be highly disruptive to staff employed in the Health Insurance Commission and will lead potentially to cost increases.

Competitive neutrality

Medibank's efficiency

The Productivity Commission's inquiry into the private health insurance industry found that the Health Insurance Commission (a Commonwealth statutory authority) is Australia's largest health insurer with the lowest management costs. The Australian Medical Association submitted to the inquiry that the Health Insurance Commission had the lowest cost of processing claims due to its use of information technology.

The Productivity Commission recognised that the HIC had access to significant economies of scale due its size and its market presence in every state and territory. Medibank's branch office network, advertising campaigns, contracts with health service providers and computer facilities are examples cited in the report of economies of scale available to large funds like Medibank private.

Medibank's efficiency and productivity is derived from its size and economies of scale, not from any competitive advantage from its association with Medicare.

Cost apportionment

The *Health Insurance Commission Act 1973* requires the Minister for Health to determine financial principles to apply to cost apportionment between Medibank Private and non-Medibank operations. Under the Act and the Minister's principles, the Health Insurance Commission must nominate each cost centre as being either Government programs or Medibank Private. Joint cost centres must be broken down into either branches, processing

centres or overheads. The number of respective computer transactions for Medibank and Medicare is used as a simple and equitable yardstick to determine cost apportionment.

It has been clear for some time that the cost apportionment arrangements operating on Medibank Private is fair. The Minister's cost apportionment principles have been determined in consultation with Treasury and have been found to be acceptable to the Commonwealth Auditor-General. Furthermore, the Joint Committee of Public Accounts (JCPA) conducted an inquiry into cost apportionment in 1992 and found "while the cost apportionment system may not allow accuracy at the lowest level of the proportions of costs charged to each function, it does meet the requirements of predictability, administrative simplicity and equity in the distribution of total costs between Medicare and Medibank Private". Further, the JCPA found no evidence "that cross subsidisation occurs of Medibank Private and Medicare".

The strict cost apportionment guidelines with the Health Insurance Commission ensure that Medibank Private does not enjoy a competitive advantage from its association with Medicare.

Staff Issues

Mobility rights - sections 18 and 21

Section 21(2) of the Bill gives the Minister power to forcibly transfer staff from the Health Insurance Commission to Medibank Private Limited.

> *"(2) The Minister may, by written instrument, declare that a specified employee:*
>
> *(a) ceases to be employed by the Commission at a specified time (the employee's transfer time); and*
>
> *(b) is taken to have been engaged by the nominated company as an employee of the nominated company at the employee's transfer time."*

This means that the power could be exercised *against* the expressed wishes of a staff member. The Health Insurance Commission has advised CPSU that in order for some conditions of employment to follow employees into Medibank Private, the Minister must have the power to transfer employees to Medibank Private Ltd. HIC wrote to CPSU on 7 July 1997 stating "We have received legal advice indicating that the protection of mobility rights hinges on the compulsory transfer of staff from HIC to Medibank private. As far as I am aware, there are no other rights/benefits protected by the compulsory nature of the provisions."

If this is true, in order to counter-balance the Minister's unfettered power, HIC employees must be given the right to freely transfer between the Health Insurance Commission and Medibank Private. The Minister's power can be delegated to either HIC management and/or Medibank Private Ltd. management (section 34).

Many of our members in the HIC have been employed there for several years. Staff turnover is not high. Therefore members employed by HIC have careers built on a mixture of Medicare and Medibank Private work.

Section 28(2) of the Bill refers to the Minister's power to *re-transfer* staff from Medibank Private Ltd. back to HIC. CPSU supports such a process but we have two major concerns with application of this particular power.

> *28(2) The Minister may, by written instrument, declare that a specified employee:*
>
> > *(a) ceases to be employed by the nominated company at a specified time (the employee's re-transfer time); and*
> >
> > *(b) is taken to have been engaged by the Commission as an employee of the Commission at the employee's re-transfer time.*

Firstly, the Bill states that there is a 12 months time limit on re-transfer opportunities. After the expiry of 12 months from the date of separation of Medibank from HIC, an employee will no longer have the opportunity to transfer back to HIC (or from HIC to Medibank). This period is too short in duration and should be extended to a three year period. A three year period reflects the 'standard' in the Australian Public Service where employees transferred from the Service to a statutory authority have up to three years to revert back to their original employment in the Australian Public Service. The APS entitlement is contained in the *Public Service Act 1922*.

Secondly, the ability to re-transfer is also predicated on the agreement of the Minister or his/her delegate. An employee should have a re-transfer *right* to counter-balance the Minister's power to forcibly transfer in the first instance. An employee should have the right to elect to re-transfer back to HIC where they are not satisfied with the original decision to transfer to Medibank Private Ltd.

The separation of HIC staff into Medibank and non-Medibank employment will be highly disruptive and lead to unwarranted effects on staff careers unless there is a genuine choice for staff whether to stay with HIC or transfer to Medibank Private Ltd.

Separation of assets and staff - sections 17-19

Medibank Private is the owner of many of buildings occupied by HIC. Medibank Private also owns the extensive computer hardware and computer centre in Canberra which the Medicare Program must use to process the billions of Medicare claims lodged annually. In discussions with the Health Insurance Commission, CPSU has learned that HIC proposes to 'contract' many operations and administrative arrangements between HIC and Medibank.

For example, HIC cannot afford to purchase a new Medicare computer centre so it will have to lease Medibank Private's computer operations at a price. Similarly, shared corporate operations such as finance and personnel will have to be contracted from HIC to Medibank Private. Once Medibank Private establishes itself, these contractual arrangements may cease thereby leaving HIC with potentially redundant staff. These are added reasons why the transfer period should be extended to three years.

Separation of Medibank Private will lead to complicated contractual arrangements and could lead to adverse effects on staff performing contractual work for the other organisation.

Privatisation - section 35(2)

CPSU views the decision to separate Medibank Private from the Health Insurance Commission as the likely first step in the ultimate privatisation of Medibank Private. It is comforting to acknowledge that section 22A of the Bill specifically denies the Government the option of divesting itself from ownership of Medibank Private. CPSU strongly supports the on-going ownership by the Commonwealth of its private health insurance operations.

> *35(2) The Commonwealth must not transfer any of its shares in the nominated company.*

It is not uncommon for state-owned organisations to undergo excessive staff reductions as a precursor to complete privatisation. Privatisation would create job insecurity amongst our members employed in Medibank Private.

Secondly, privatisation of Medibank Private would be at odds with the reasons for establishing Medibank Private in the first place. Medibank Private has acted as a brake on excessive price increases in the private health insurance market and it has been a recognised pace setter in terms of innovative health insurance products. Privatisation of Medibank would likely give the private insurers greater ability to impose price increases at a time when prices are already rising steeply for other reasons.

If there is little justification for the upheaval associated with separating Medibank Private, then CPSU wonders whether the real intention is to set up Medibank Private for privatisation.

Effects on Medicare

Separation of Medibank Private operations from the HIC creates two individual organisations with greater risk of exposure to exterior threats. Together, Medicare and Medibank offer a more diversified range of operations and therefore greater opportunities to survive if one of its component parts is threatened or attacked. HIC employees are offered greater job security where their employer has a more diversified range of operations than an employer with a more limited focus of operations.

Separation will weaken the combined strength of Medibank Private and the Health Insurance Commission and this will adversely affect the job security of both groups of staff.

SUBMISSION NO. 2 – AUSTRALIAN HEALTH INSURANCE ASSOCIATION

AHIA COMMENTS TO THE SENATE COMMUNITY AFFAIRS LEGISLATION COMMITTEE ON HEALTH INSURANCE COMMISSION (REFORM AND SEPARATION OF FUNCTIONS) BILL 1997

1. AHIA welcomes the much needed division of the Health Insurance Commission into two sensible entities: the trading operation of Medibank Private and the Government program operations of Medicare, the PBS and other Government functions. Since the introduction of Medicare, the integration of a trading arm with a government social program has led to a number of internal and financial anomalies, the most important of which has been the marketplace advantage given to Medibank Private by virtue of its capacity to share costs and resources with Medicare: or, to put it another way, to enjoy at least in potential terms a working subsidy from the taxpayer.

2. The separation of the commercial entity from the Government program function is a welcome step towards restoring genuine competition between a Government owned registered benefits organisation and non-Government operators. Such competition will only be genuine, of course, if the financial advantages Medibank Private has accrued over the years are removed. It is not clear to AHIA precisely how these advantages are to be adjusted, but is certainly our view that a truly competitive situation demands that they are. Over the years the advantages conferred on Medibank Private have included:

- failure by Government to claim interest on funds advanced for establishment costs - in effect providing Medibank Private with a commercial advantage unavailable to all organisations with which it was competing.
- a capacity to reduce or conceal administration costs below industry norms by virtue of sharing costs with taxpayer funded activities.
- the existence of a captive tenant arrangement which allowed the Commission to invest in property which is funded by the taxpayer.
- the guarantee of a captive client and guaranteed throughput as claimants on Medicare have been required to use Medibank Private offices, etc.
- a capacity to share staff and office resources in co-located shopfronts, further reducing administration costs.
- Ministerial approval to transfer reserve moneys between States to maintain solvency levels in the early years of the introduction of Medicare. This effectively allowed individual Medibank Private funds in different States to undercut their competition without breaching viability requirements, although Funds operated in each State were expected to operate on a free-standing basis for reserve purposes.

3. Although the Commission has traditionally claimed that the assets attributed to Medibank Private were acquired from profits which the Fund itself generated AHIA argues the contrary: that the nature of the Medibank Private accounts has made it impossible to determine whether assets acquired could genuinely be attributed to MP. Certainly the knowledge that Medicare would be required to rent, or meet its share of rental costs, in properties built for or acquired by the Commission in the name of Medibank Private allowed the HIC to invest with much greater confidence than other insurers. Over the years the HIC

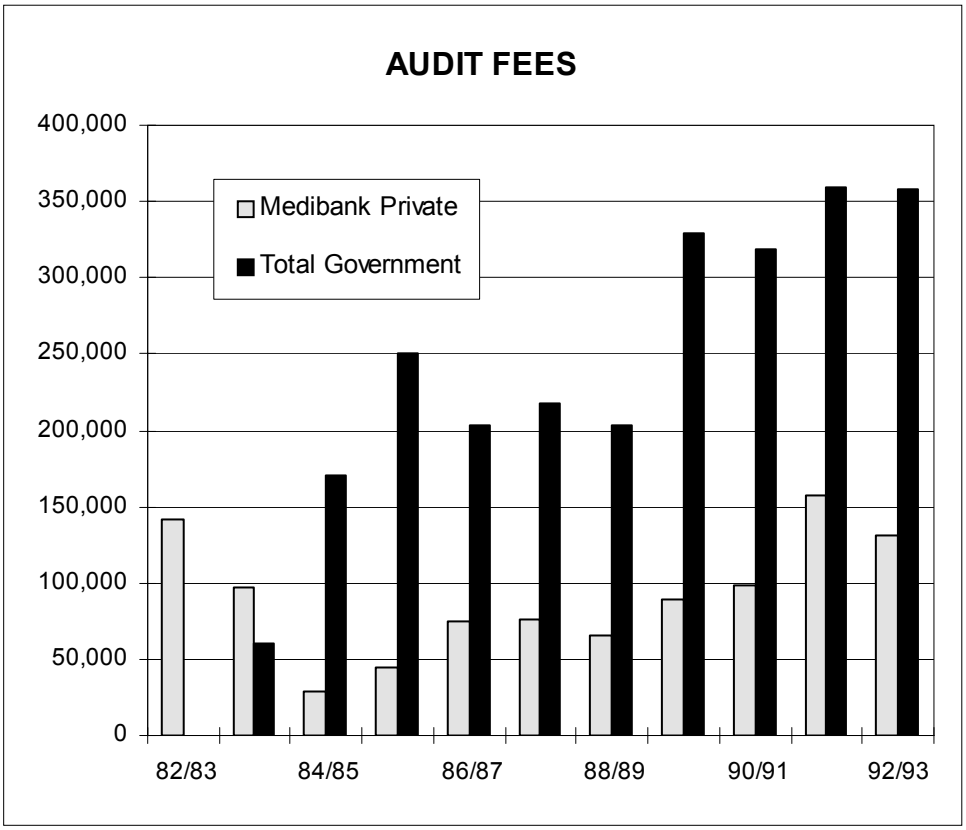
accounts have consistently shown that most assets which yield income are held in the name of Medibank Private.

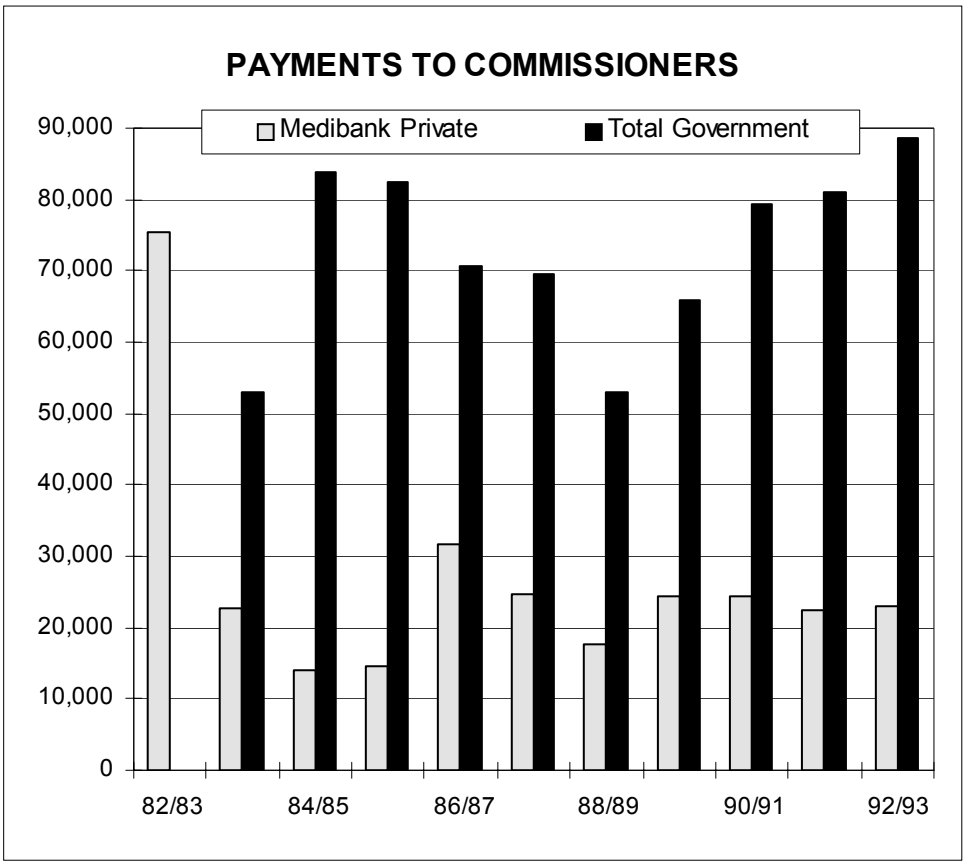
4. AHIA asserts that joint operation has allowed Medibank Private over the years to have generated surpluses which, in real terms, may not exist if they are based on a false allocation of salary and other costs to Medicare. Certainly they do not reflect the surpluses that would have been generated had Medibank Private's accounts been handled on a free-standing basis rather than a complex cost sharing formula determined by the Minister of the day.

5. The benefits of cost sharing are very simply illustrated by comparing Medibank Private's pre-Medicare situation with that after Medicare's introduction: In 1982-83 (pre-Medicare) Medibank Private paid audit fees of $142,000; in 1992-93 its audit fees were $10,000 less, though the Commission's total audit cost was much greater. Similarly Medibank Private's payments to Commissioners (the Board) dropped from $75,389 in 1982-83 to $23,050 in 1992-93. This should not be seen as the Board taking a pay cut: Medicare more than filled the gap.

6. Since 1992-93 the HIC accounts fail to specify the amounts allocated between functions, but AHIA has no reason to believe the above advantages have not continued.

7. The following tables show the cost shifting of audit fees from Medibank Private and Medicare (and other Government programs) and the shift in payments to Commissioners from MP to taxpayers since 1982-83 (the year before Medicare's introduction). Since 1992-93 the Commission has not provided a breakdown of these costs between functions, but under the cost shifting formula AHIA believes the same or very similar relativities would apply.

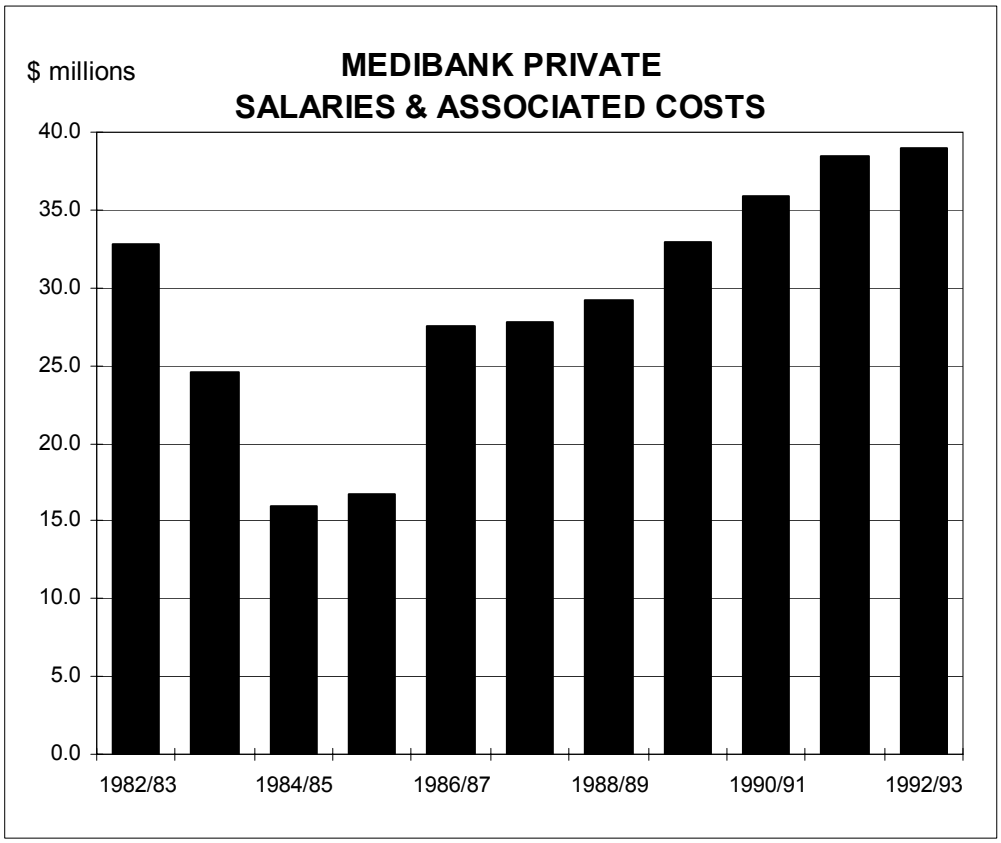




SALARIES

8. The HIC total salary bill in 1994-95 was $161.9 million. Total HIC staff was 4,955 - an average salary of $32,688 per employee. Medibank Private was charged $13.1 million for staff (which equates to 400 employees), and approximately $20.3 million of apportioned salaries which equates to an additional 620 employees working for the function; i.e. the Commission attributes a total of 1,020 staff to the Medibank Private payroll. A survey of AHIA members indicates an industry average staff ratio of one employee per 790 single equivalent units (SEUs). Medibank Private has 1,124,348 SEUs. Applying the industry average, Medibank private would actually require 1,420 staff or 400 (39%) more than the cost allocation formula suggests. **Using the average salary per employee ($32,668), Medibank Private should have paid an additional $13 million in salaries in 1994/95.**

9. The cost allocation formula has been of considerable benefit to Medibank Private since the introduction of Medicare: for the first six years of joint operation Medibank Private's salary costs were lower than in 1982-83. Even allowing for some reduction in staff levels directly attributable to private health insurance as a direct result of Medicare's introduction Medibank Private has obviously benefited considerably from cost shifting to Medicare.



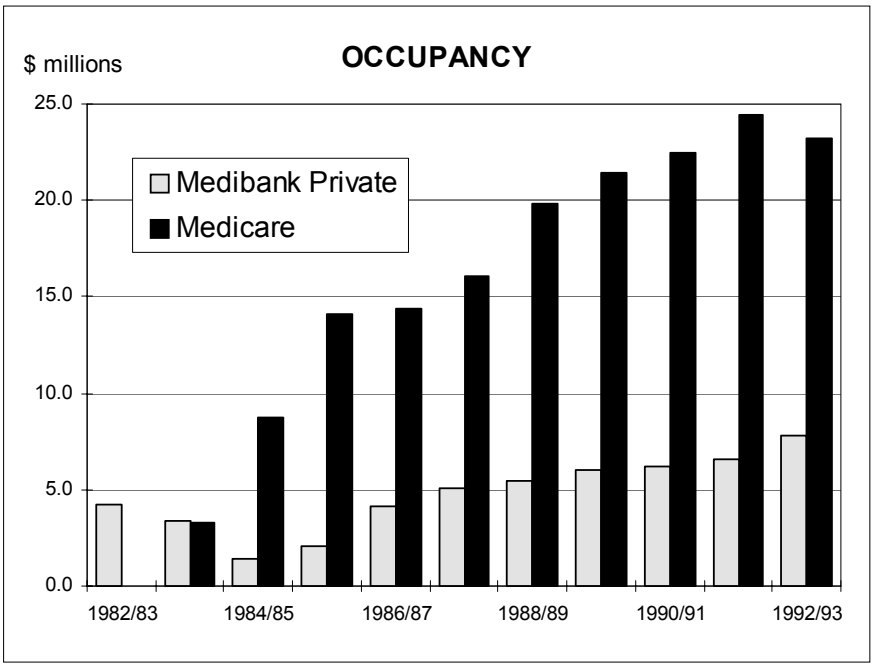
10. Had Medibank Private's salaries increased at CPI from 1982-83 it would have paid $293 million more in salaries.

OCCUPANCY

11. In 1982-83 (the year before Medicare was introduced) Medibank Private owned 22 out of 194 branches including head offices around Australia. These were bought either from the original Government grant or trading activities. However Medibank Private appears to have enjoyed a windfall benefit from Medicare activity due to the cost apportionment formula which allows it to act as "landlord" and Medicare as "tenant", perhaps even in premises bought with Medicare money.

12. Occupancy as defined under management expenses refers to rental charges on land and buildings. In 1994/95 Government Programs paid approximately $34 million dollars in Occupancy costs - Medibank Private paid approximately $7.9 million. **If all land and buildings were classified as belonging to the Government, or Medibank private paid for all occupancy costs, then Medibank Private would have paid an additional $34 million in 1994/95**. (Approximations - for 1993/94 and 1994/95 the apportioned costs of management expenses allocated to each function were not broken down by item, so the ratios by item that were available in 1992/93 have been applied to 1994/95)

13. Medicare's occupancy costs have risen significantly over the period, as shown by the graph below. The increase has overall been a direct cash benefit to Medibank Private. If all land and buildings had been classified as belonging to Medicare, or Medibank Private paid for all occupancy costs, then Medibank private would have paid an additional $228 million since the introduction of Medicare.

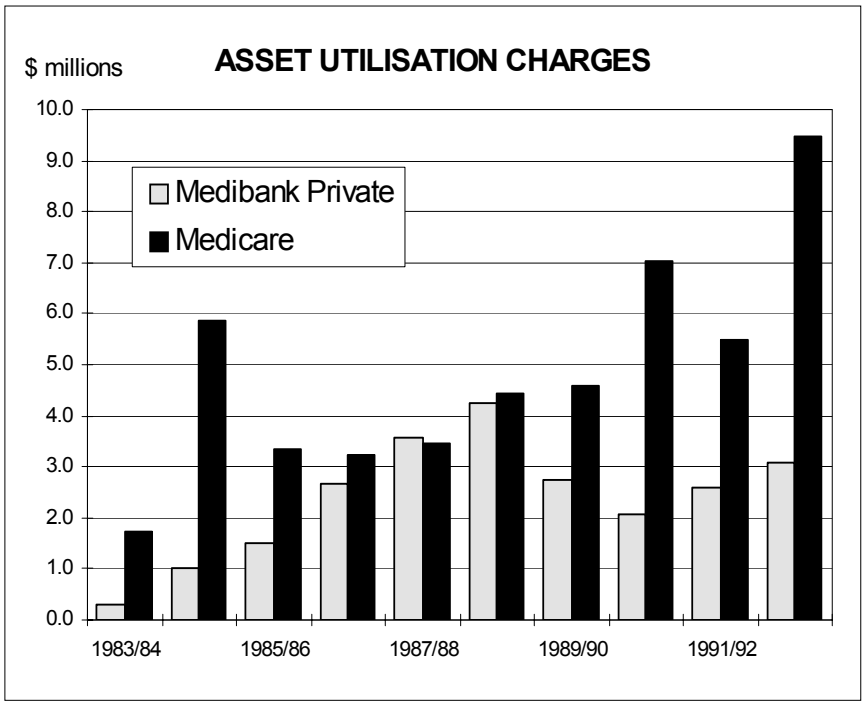


ASSET UTILISATION

14. Asset Utilisation Charges are defined as asset rental charges for assets other than land and buildings. In 1994/95 Government Programs paid approximately $14 million dollars in Asset Utilisation Charges - Medibank Private paid approximately $3 million. **If all other assets other than land and buildings were classified as belonging to Medicare, or Medibank private paid for all other asset utilisation costs, then Medibank Private would have paid an additional $14 million in 1994/95.** (Approximations - for 1993/94 and 1994/95 the apportioned costs of management expenses allocated to each function were not broken down by item, so the ratios by item that were available in 1992/93 have been applied to 1994/95)

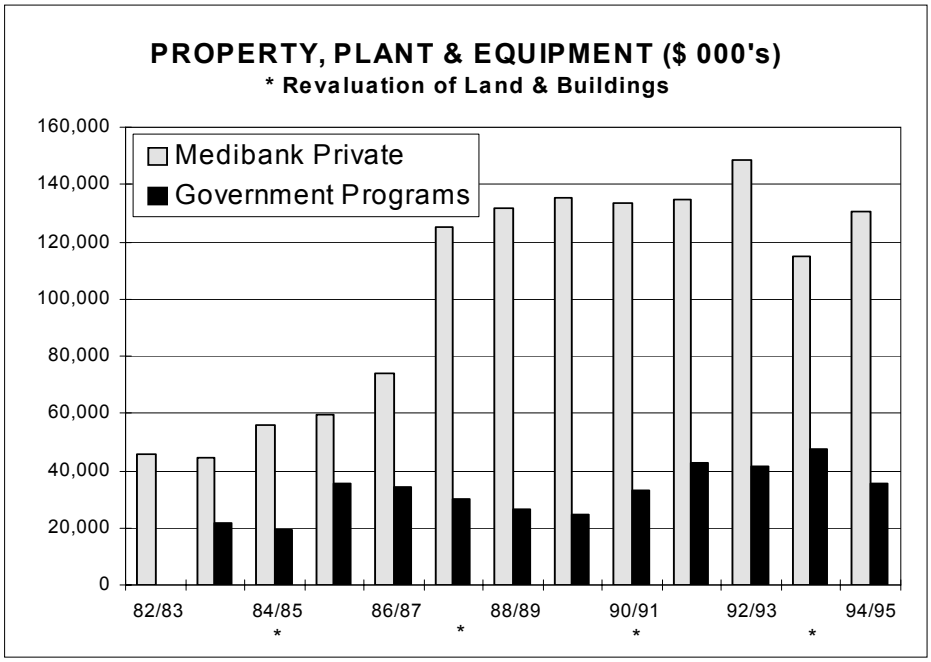
15. If all assets other than land and buildings were classified as belonging to Medicare, then Medibank Private would have paid an additional $73 million since the introduction of Medicare.

16. The following table shows the variation in asset utilisation charges between the two functions.



PROPERTY, PLANT & EQUIPMENT

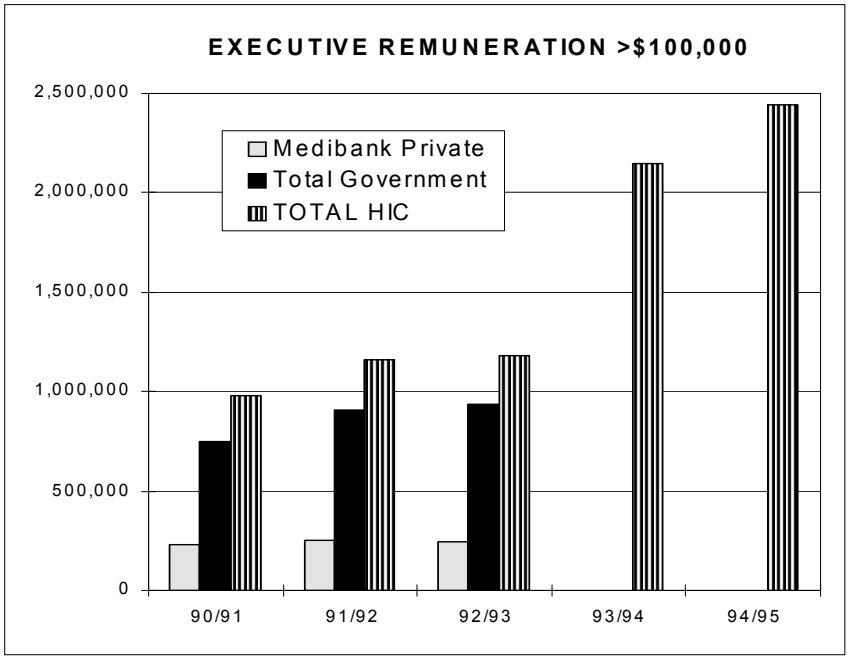
17. The allocation of property, plant and equipment to Medibank Private has grown considerably since conjoint operation with Medicare. Since 1982-83 property, plant and equipment has increased by $85 million - from $46 million to $130 million - an increase of 186 %. Given the nature of the HIC apportionment it is not possible to determine what property was, in fact, bought from profits generated by health insurance trading activities.



SENIOR STAFF REMUNERATION

18. This item was first reported in 1990-91, but from 1992-93 the split has not been outlined in the annual reports. One assumes the relativities continue. Given that Medicare is basically a Government program it is difficult to see why such a large number of senior executive time

should be provided to Medicare administration rather than the marketplace activities of a very active "private" health insurance operation.



RETAIL ACTIVITY

18. AHIA has already indicated its concern about "one stop shopping" in joint Medicare/ Medibank Private offices. The legislation should make it clear that this activity will cease on fund transfer day if not before.

THE NEW HEALTH INSURANCE COMMISSION

19. AHIA welcomes the new role of the HIC as an information agency. Given the interest of the health insurance industry generally in relation to information related to health sector initiatives AHIA is concerned that the Bill appears to require consultation only with State and territory governments in respect of possible representation on the Board of the HIC. Now that the trading arm - Medibank Private - has been separated from the HIC, the industry and the Commission would both benefit from a representative of the health insurance industry being appointed to the Board, and AHIA would hope the legislation is either amended or the Government prepared to give an undertaking to ensure this occurs.

R J Schneider
Chief Executive
Australian Health Insurance Association