SENATE COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Consideration of Legislation Referred to the Committee

HEALTH INSURANCE COMMISSION (REFORM AND SEPARATION OF FUNCTIONS) BILL 1997

SEPTEMBER 1997

ISSN 1038-2755

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HEALTH INSURANCE COMMISSION (REFORM AND SEPARATION OF FUNCTIONS) BILL 1997

1. THE INQUIRY

1.1 The Health Insurance Commission (Reform and Separation of Functions) Bill 1997 was introduced into the House of Representatives on 27 June 1997. On 28 August 1997 the Senate, on the recommendation of the Selection of Bills Committee (Report No.12 of 1997), referred the provisions of the Bill to the Committee for report by 24 September 1997.

1.2 The Committee considered the Bill at a public hearing on 4 September 1997. Details of the public hearing are referred to in Appendix 2 The Committee received two submissions relating to the Bill and these are included as Appendix 1

2. THE BILL

2.1 The Bill has two main objectives:

- to separate Medibank Private from the Health Insurance Commission (HIC) and to create a new Medibank Private corporation; and
- to widen the role of HIC and allow it to take on additional functions, specifically health payment services and provision of health information.

2.2 The Government's aim in implementing these changes was outlined in evidence:

> The aim of the government in putting forward the bill to separate Medibank Private and the Health Insurance Commission was...to address the issue of the perception and reality of competitive neutrality, first. That is not to say that the government accepted that there was any real cause for concern. The arrangements that were made between the government programs side of the Health Insurance Commission and Medibank Private were as sensible and robust as could be desired. Nonetheless, there was a perception and a reality of being able to establish Medibank Private on a competitively neutral basis with other funds.
>
> But just as important-and perhaps more importantly-in terms of what the government was seeking to achieve by the separation was that both organisations...face significant challenges and opportunities, and they were seen to be best addressed by being the focus of single organisations, single managements and single boards...[1]

Medibank Private corporation

2.3 The Bill provides for the establishment and nomination of a company which is to be the company that will take on the functions of Medibank Private from the HIC. All of the share capital of the new company is to be owned by the HIC. After a period of transition, the shares will be transferred to the Commonwealth.

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1 *Transcript of Evidence,* p.13.

2.4 The Bill provides that during the transition period:

- HIC is prohibited from transferring any of the shares in the nominated company and the company cannot issue shares to any other person;
- the nominated company must seek registration as a registered health benefits organisation under the *National Health Act 1953*;
- HIC's functions are extended to facilitate the transfer of Medibank Private to the nominated company; and
- HIC may enter into service arrangements with the nominated company, on a cost-recovery basis, to effect the separation.

2.5 The transfer of the business of Medibank Private to the company is to be through a scheme determined by the Minister. The scheme is to be notified in the Gazette and must provide for the transfer to take place on the fund-transfer day which is a day to be determined by the Minister. The scheme must provide that the transfer does not affect the continuity of a person's status as a contributor to the fund.

2.6 The Minister is to make declarations for the transfer of assets, contractual rights and obligations and liabilities from the HIC to the nominated company. Ministerial declarations are to be notified in the Gazette. Contracts between the HIC and a supplier of goods or services can be split by the Minister into two separate contracts so that certain rights and obligations can be transferred to Medibank Private and the remainder left with the HIC.

2.7 The Bill provides for the transfer of staff from the HIC to the nominated company:

- staff cannot be transferred any later than 12 months after the shares in the nominated company have been vested in the Commonwealth;
- staff must be employed by the nominated company on the same terms and conditions as they were immediately before the transfer; and
- accrued benefits and continuity of service are to be maintained.

The Bill does not preclude variations of staff conditions of service at a later date under any law, award, determination or agreement as would be the case under their existing employment.

2.8 The Bill also provides for the re-transfer, to the Commission, of employees who had originally transferred to the nominated company. Re-transfer provisions only apply during the transitional phase while the nominated company is owned by the HIC and for a period of 12 months after the transfer of ownership to the Commonwealth.

2.9 Other provisions of the Bill provide for:

- the exemption from State and Territory taxes in respect of matters necessary to carry out the separation;
- the transfer of records which relate to Medibank Private from the HIC to the nominated company;
- the transfer of pending legal proceedings to the nominated company where appropriate;

- the nominated company not to be taken to be a Commonwealth authority, a Commonwealth agency or instrumentality of the Crown; and
- complaints to the Ombudsman, Freedom of Information applications, applications to the Administrative Appeals Tribunal and complaints under the Privacy Act, which may have been or have been made prior to the fund-transfer day, and which relate to Medibank Private, to be completed.

Role of the HIC

2.10 The Bill provides for the functions of the HIC as follows:

- Medicare functions - substantially unchanged
- service delivery functions - enables the HIC to enter into service arrangements with a Commonwealth authority for the provision of services to that authority and the HIC may receive payment for the services so provided;
- spare capacity functions - the Minister may approve the provision by HIC of services or facilities on a commercial basis to any person. The provision of these services or facilities must either utilise the HIC's spare capacity or relate to a designated matter including a matter related to external affairs or the executive power of the Commonwealth; and
- additional functions - three functions conferred by the *Health Insurance Commission Act 1973*, conferred by regulation and conferred by written delegation of the Minister.

2.11 The Bill also allows the States and Territories to confer powers and functions on the HIC. With the approval of the Minister the HIC may perform those functions and exercise those powers.

3. ISSUES

Competitive neutrality

3.1 In his second reading speech, the Minister stated that:

> Through the separation, the Government will ensure that Medibank Private cannot be perceived to have any competitive advantage over other private health funds through its association with Medicare or other government programme functions of the HIC.[2]

3.2 The issue of competitive advantage of Medibank Private has often been raised. Matters such as co-location with Medicare which results in 'free' advertising of Medibank Private and the ability to lease or own prime commercial sites at a significantly lower cost than other funds were given as examples of this advantage. Two inquiries have commented on Medibank Private's competitive advantage. First, the 316th Report of the Joint Committee on Public Accounts stated:

> The Committee is not persuaded by evidence to the Inquiry that cross subsidisation occurs of Medibank Private by Medicare. It notes further that the HIC, Medibank Private and Medicare are subject to audit by the ANAO. The

2 Minister for Health, second reading speech.

> auditing process includes scrutiny of the cost apportionment and asset rental systems. Were instances of cross subsidisation to be noted by the audit process they would be reported by the ANAO to the Parliament. In the absence of such reports the Committee has been unable to substantiate allegations of cross subsidisation.[3]

3.3 In February 1997, the Industry Commission reported on private health insurance. The Commission found:

- Medibank Private appears to have played a 'catalytic role in intensifying competitive pressure in the industry;
- Medibank Private appears to derive significant market advantages unavailable to other insurers through its co-location with Medicare; and
- there are governance and competitive neutrality principles associated with the relationship between HIC and Medibank Private. The Commission found that Medibank Private had lower management costs per members than some other funds but it was unsure if this was due to 'a statistical artefact, genuinely higher technical efficiency or cost shifting to Medicare'.[4]

3.4 In evidence the Australian Health Insurance Association (AHIA) noted that there had been much concern about 'one-stop shopping in joint Medicare and Medibank Private offices, which has led to the perception of commercial advantage, whether real or not'.[5] The AHIA also stated that as a result of the separation 'there will be a level playing field. The fact that we are not competing with an organisation which, in our view - and I acknowledge it is disputed - is receiving a special advantage by virtue of its association with the Medicare program'.[6]

3.5 The AHIA also submitted that separation of the HIC and Medibank Private was 'a welcome step towards restoring genuine competition between a Government owned registered benefits organisation and non-Government operators'.[7] The AHIA stated Medibank Private had received cost advantages through co-location with Medicare and Medibank Private 'has been able to artificially undercut [other private health funds]'.[8] These cost advantages included:

- that funds advanced by the Government for establishment costs did not attract interest payments;
- 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;

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3 Joint Committee of Public Accounts, Report 316, *The Administrative and Financial Relationship between Medicare and Medibank Private*, AGPS, Canberra, 1992, p.15.

4 Industry Commission, *Private Health Insurance,* Report No 57, AGPS, 1997, pp.358-9.

5 *Transcript of Evidence*, p.2.

6 *Transcript of Evidence*, p.3.

7 Submission No.2, p.1 (AHIA).

8 *Transcript of Evidence*, p.4.

- a capacity to share staff and resources in co-located shopfronts; and
- Ministerial approval to transfer moneys between States to maintain solvency levels in the early years of the introduction of Medicare.

3.6 The AHIA also asserted that the joint operation has allowed Medibank Private over the years to generate a surplus that may not have existed if its accounts had been free-standing and not based on the cost sharing formula determined by the minister of the day. The AHIA provided the examples of where it believed Medibank Private had enjoyed a benefit from cost sharing with Medicare:

- *audit fees and payments to Commissioners*: these two costs had both decreased for Medibank Private following the establishment of Medicare;[9]
- *salaries*: using industry average staff ratios, the AHIA suggested that Medibank Private's salary bill should be $13 million (39%) greater;
- *occupancy*: the AHIA suggested that Medibank Private should have paid an additional $34 million in occupancy costs in 1994-95;
- *asset utilisation*: the AHIA suggested that Medibank Private should have paid an additional $14 million in asset utilisation costs in 1994-95.

3.7 In its submission, the Community and Public Service Union (CPSU) disputed the claim that Medibank Private enjoyed a competitive advantage and noted that the Industry Commission had found that the HIC is the largest health insurer with the lowest management costs. Further, the HIC had access to significant economies of scale due to its size and market presence in every State and Territory. The CPSU also stated that the cost apportionment arrangements operating with Medibank Private and Medicare are fair with the Minister's determination on apportionment being made in consultation with Treasury and being acceptable to the Auditor-General. Further:

> This has shown that the cost apportionment guidelines between the two sectors of the Health Insurance Commission do not give a financial advantage to one side of the organisation or the other. We would strongly argue that the statutory cost apportionment guidelines which currently apply do provide the level playing field that the private industry is so concerned about.[10]

3.8 In response to the evidence received from the AHIA, the HIC noted that when Medibank Private first came into the market there were major disadvantages as the organisation did not have knowledge of the private health insurance industry, it was not a household name and it had no infrastructure.

3.9 The HIC also responded to the AHIA's claims that Medibank Private had received advantages from the Government. It was noted that Medibank Private was granted $11 million in compensation for a payment of $13.8 million to Medibank Standard in the 1970s to reimburse benefits for members who had incorrectly claimed. At the same time,

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9 Submission No.2 p.2 (AHIA).

10 *Transcript of Evidence*, p.7.

other private funds had been reimbursed for such repayments. However, Medibank was disadvantaged as it did not get the $2.8 million difference.[11]

3.10 In regard to the cost apportionment matters raised by the AHIA, the HIC stated that both Anutech and accountants KPMG had examined the cost apportionment principles and found them to be a 'fair and equitable distribution of costs incurred by the HIC'.[12] In regard to the claim that Medibank Private had been able to transfer reserves between State operations, the HIC noted that the National Health Act allowed all funds that operate in more than one market to transfer reserves and that Medibank Private was not the only fund which had taken advantage of these provisions.[13]

3.11 A further matter that was raised before the Committee was that of the possible future privatisation of Medibank Private. The CPSU stated that it and its members saw the legislation as a first step toward privatisation of the organisation.[14] While the AHIA noted that it had never asked for Medibank Private to be privatised.[15] In response, Dr Loy, DHFS, stated that it was not the Government's aim to 'privatise' Medibank Private. The Government:

> wanted this legislation to ensure that government ownership of Medibank Private was embedded in the legislation. That is not to tie down the hands of any future government or any future parliament...But the government, having made a commitment in the election context, was anxious to ensure that the legislation ensured that government ownership of Medibank Private remained.[16]

Consumer interest

3.12 The CPSU stated that the consumer interest would not be served by the separation of Medibank Private and the HIC. It noted there will be a significant reduction in the number of retail outlets available to the public for Medibank Private business, with the present number of outlets where Medibank Private business can be conducted dropping from 270 to approximately 70.[17] As a result not only would prospective customers of the private health insurance industry suffer, but also current policy holders would be disadvantaged and 'might possibly be pushed out of the private sector health insurance market altogether'.[18] The CPSU concluded that 'we do not understand the rationale for this legislation. It is going to be highly disruptive to the careers of our members. I do not think the taxpayer or the public will be any better off. It is arguable that they will be worse off.'[19]

3.13 The AHIA noted that if:

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11 *Transcript of Evidence*, p.20.

12 *Transcript of Evidence*, p.20.

13 *Transcript of Evidence*, p.21.

14 *Transcript of Evidence*, p.7.

15 *Transcript of Evidence*, p.5.

16 *Transcript of Evidence*, p.14.

17 *Transcript of Evidence*, pp.6-7.

18 *Transcript of Evidence*, p.7.

19 *Transcript of Evidence*, p.13.

> Medibank Private has not been subsidised by a conjoint operation with Medicare, there is no reason why its costs would increase. If the assertions that there has been no subsidisation are true, there will be no change. If our assertion that there has been subsidisation is true, it is a problem for Medibank Private, but at least the taxpayer no longer subsidises that operation.[20]

3.14 The HIC responded to the CPSU's concerns about office closures by noting that Medibank Private business was not distributed evenly across the Medicare network. Medibank Private would be targeting where it opens an office or where it uses another form of distribution strategy to address the needs of its members in the area. Further, it was noted that more people are moving to direct billing and that in dealing with hospitals, health funds were making more direct payments to hospitals and in some instances co-payments were also being made at the time of a members hospital visit. The HIC also noted that a significant proportion of members contributions were made by group payments, that is through employers' payroll deduction schemes, rather than by cash over the counter.[21]

3.15 The HIC responded to the AHIA by stating that separation will not be the cause of premium increases. Further, Medibank Private had been successful as it had not diversified from its core business like some other private health funds.[22]

3.16 In evidence, it was also noted that there were some disadvantages to Medibank Private of co-location with Medicare. For example, customer service was constrained as Medibank Private customers had to queue with Medicare customers before being served. Mr MacDougall, General Manager, Medibank Private, also noted that Medibank Private would have more freedom to act after the separation such as expanding its distribution network through other organisations. This had not happened in the past, 'but a separate entity out there will allow it to establish a primary distribution network to enable it to deliver customer service and then look at how it can expand that distribution network throughout Australia'.[23]

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20 *Transcript of Evidence*, p.4.

21 *Transcript of Evidence*, p.18.

22 *Transcript of Evidence,* p.21.

23 *Transcript of Evidence*, p.19.

Staffing

3.17 In his second reading speech, the Minister stated that:

> Staff affected by the transfer will be treated fairly. Where an employee is transferred under these provisions, their terms and conditions of employment and other rights and entitlements defined in the Bill, have been preserved.

3.18 The CPSU in its submission to the Committee, raised two areas of concern. The first matter related to mobility rights of staff. The CPSU noted that the Bill gives the Minister power to forcibly transfer staff from the HIC to the new company, thus 'the power could be exercised *against* the expressed wishes of a staff member'.[24] In evidence it was stated that approximately one-quarter of staff (1,200 people) are dedicated to Medibank Private work and will be required to staff the new company.[25] The Union suggested that less than 1,200 wished to transfer to the new company.

3.19 The CPSU noted that it had been advised by the HIC that legal advice had indicated that in order for some conditions of employment to be preserved, the Minister must have the power to transfer employees to the company. The CPSU argued that if this is the case, 'in order to counter-balance the Minister's unfetted power, HIC employees must be given the right to freely transfer between the Health Insurance Commission and Medibank Private'.[26] It also noted that staff turnover was not high, with many members building a career on a mixture of Medicare and Medibank work.

3.20 The CPSU also raised the matter of the Minister's power to re-transfer staff from the company to the HIC and pointed to two major concerns:

i. The re-transfer arrangements are only available to staff for a period of 12 months from the date of separation. The CPSU considered that this period was too short and should be extended to three years to reflect the 'standard' that applies in the Australian Public Service when employees are transferred from the Service to a statutory authority.

ii. Re-transfer is predicated on the agreement of the Minister or his/her delegate. The CPSU was of the view that an employee should have a re-transfer right to counter-balance the Minister's power to forcibly transfer in the first instance.

3.21 The CPSU also noted that while it was stated that staff would be transferred with all terms and conditions, legislation based conditions of employment were not picked up. This included maternity and long service leave. Following representations by the union, the HIC has agreed to incorporate the long service leave and maternity leave into the HIC award.[27]

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24 Submission No.1, p.2 (CPSU).

25 *Transcript of Evidence*, p.10.

26 Submission No.1, p.2 (CPSU).

27 *Transcript of Evidence*, p.9.

3.22 The CPSU concluded that the separation of staff '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'.[28]

3.23 The second matter raised by the CPSU was the separation of assets and staff. The CPSU noted that the HIC proposes to contract many operations and administrative arrangements, such as computer processing of claims and some corporate operations, between HIC and Medibank Private. The CPSU was of the view that 'once Medicare Private establishes itself, these contractual arrangements may cease, thereby leaving HIC with potentially redundant staff'.[29]

3.24 In evidence, Mr A Kelly, Manager, Employee Relations, HIC, informed the Committee that an enterprise agreement had been reached and that staff were being invited to indicate their preference as to whether or not they wished to join Medibank Private. While the HIC could not guarantee that staff would receive their preference, the HIC had, where possible, undertaken to 'maximise those preferences for them'.[30] Where a person did not receive their preference, there would be an opportunity for review.

3.25 Mr Kelly also stated that the HIC believed that the 12 month time limit for re-transfer was 'a fair and reasonable time limit' and that people would know within that time whether or not they wished to continue employment with Medibank Private.[31] In addition to the re-transfer provisions, Mr Kelly informed the Committee that a 'job swap' arrangement had been set up. Under this arrangement, if a person in the HIC wished to move to Medibank Private and a person in Medibank Private wished to move back to the HIC, then with agreement of both organisations such a swap could take place. This option would also be available for a 12 month period.

3.26 The Committee was also informed that the HIC did not expect that there would be any need for staff redundancies as the workload would not change. There was in fact, some expectation that the work of Medibank Private would expand and increase following the separation.[32]

3.27 In relation to terms and conditions, Mr Kelly noted that the legislation provides for those moving to Medibank Private to bring across the same terms and conditions they enjoyed with the HIC. Other Commonwealth legislation which covers such matters as workers' compensation issues, occupational health and safety issues will be recognised. Mr Kelly also stated that discussions are being held with the Department of Workplace Relations and Small Business in regard to long service leave and maternity leave. He stated 'while we have not secured a guarantee there, what we have undertaken with the CPSU is that we will use a pick-up clause in our award to cover both Medibank Private and also HIC' to ensure these provisions apply.[33]

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28 Submission No.1, p.3 (CPSU).

29 Submission No.1, p.3 (CPSU).

30 *Transcript of Evidence*, p.15.

31 *Transcript of Evidence*, p.16.

32 *Transcript of Evidence*, p.17.

33 *Transcript of Evidence*, p.16.

Financial aspects

3.28 In evidence, the AHIA stated that on separation, there should be an appropriate allocation of assets between the HIC and Medibank Private. The AHIA stated that it 'would strongly argue that Medibank Private should only obtain those which can genuinely be attributed to its marketplace operations, which we suspect will be very difficult to identify'.[34]

3.29 The HIC stated that in the existing structure, parts of the assets are owned by Medibank Private and parts by Medicare. The HIC 'will transfer for a value that proportion that belongs to Medibank Private clearly to Medicare, because it required that post-separation Medibank Private is establishing its own network'.[35] In relation to buildings owned by Medibank Private, the Committee was informed that HIC is currently paying market rental based on proportional use. Medibank Private will retain ownership of these properties following separation and the agreements for HIC tenancy will be through a normal commercial lease.

3.30 The HIC noted that the legislation allows for some service agreements to be split between Medibank Private and the HIC. The object of this is to allow the organisations to manage costs such as information technology costs. The sharing will continue for a number of years to allow time for the other organisation to determine what sort of technology strategy it would like and to manage the costs of that strategy.[36]

4. RECOMMENDATION

4.1 The Committee reports to the Senate that it has considered the Health Insurance Commission (Reform and Separation of Functions) Bill 1997 and **recommends** that the Bill proceed.

Senator Sue Knowles
Chairman

September 1997

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34 *Transcript of Evidence*, pp.1-2.

35 *Transcript of Evidence*, p.22.

36 *Transcript of Evidence*, p.22.

DISSENTING REPORT BY THE AUSTRALIAN LABOR PARTY

Introduction

The Health Insurance Commission (Reform and Separation of Functions) Bill 1997 has two purposes. The main purpose is to separate Medibank Private from the Health Insurance Commission (HIC) and establish a separate corporation to be known as Medibank Private Ltd.

The second purpose is to allow the HIC to take on additional functions, specifically health payment services and provision of health information.

The specific details of the legislation and the nature of the evidence presented to the Committee by the various witnesses are adequately summarised in the majority report.

With respect to the proposal to widen the role of the Health Insurance Commission we are not opposed in principle to such changes provided they do not in any way threaten the existing role of Medicare and the Pharmaceutical Benefits Scheme (PBS).

However, the ALP Senators cannot agree with the majority recommendation that the Bill proceed. We are not convinced that the main purpose of the legislation is either desirable or in the public interest. In our view the evidence provided to the Committee during the inquiry supports the maintenance of the current arrangements namely that Medibank Private remain within the HIC.

The "Perception" of Competitive Advantage

The major reason advanced by those supporting the separation of Medibank Private from the HIC is a "perception" that Medibank Private enjoys a market advantage over other private health insurance funds.

Mr Schneider, representing the Australian Health Insurance Association, explained it in the following terms:

> …Ever since the introduction of Medicare, the private health insurance industry has been concerned about the existence of a conjoint operation in which Medibank Private has shared operations with a government program, Medicare. We have historically believed that led to an unfair marketplace situation, so our concern in relation to this legislation is principally to ensure that it does achieve a level playing field as between Medibank Private and the private health insurance sector. (Hansard *Transcript of Evidence*, p 1)

and,

> There are two other aspects that we would wish to comment on. One is retail activity on the part of Medibank Private. As we have pointed out, there has been much concern about one-stop shopping in joint Medicare and Medibank Private offices, which has led to the perception of commercial advantage, whether real or not. We would certainly hope that from fund transfer day, as I believe it is called, that operation would cease and that the Medicare transactions would take place in offices separate from those operated by Medibank Private. Alternatively, of course, it would be appropriate to offer a similar service via the private health insurance industry. (Hansard *Transcript of Evidence*, p 2)

It is interesting to note that the concern of the AHIA is with the "**perception**" that Medibank Private has some advantage. During the hearing the AHIA was unable to provide any data or evidence that the private health insurance funds had suffered as a result of the co-existence of Medicare and Medibank Private. Rather they acknowledged that such evidence was anecdotal and that it had, in any event, been disputed by Medibank Private and the HIC on many occasions.

In his evidence Dr Loy, on behalf of the Department, acknowledged that:

> The aim of the government in putting forward the bill to separate Medibank Private and the Health Insurance Commission was, as has been mentioned several times during the hearing today, to address the issue of the perception and reality of competitive neutrality, first. (Hansard *Transcript of Evidence*, p 13)

However Dr Loy then went on to say:

> That is not to say that the government accepted that there was any real cause for concern. The arrangements that were made between the government programs side of the Health Insurance Commission and Medibank Private were as sensible and robust as could be desired. Nonetheless, there was a perception and a reality of being able to establish Medibank Private on a competitively neutral basis with other funds. (Hansard *Transcript of Evidence*, p 13)

In his second reading speech the Minister stated that:

> Through the separation, the government will ensure that Medibank Private cannot be perceived to have any competitive advantage over other private health funds through its association with Medicare or other government program functions of the HIC.

This issue of competitive advantage has been examined previously. As the majority report notes the Joint Committee on Public Accounts in 1992 stated that it was "not persuaded by evidence that cross-subsidisation occurs" and the Committee specifically noted that Medibank Private, Medicare and the HIC were all subject to audit by the Australian National Audit Office (ANAO).

Given that no real evidence has been presented to prove that Medibank Private gains an actual competitive advantage by virtue of co-existence within the HIC we are not persuaded that there is any good policy reason to separate Medibank Private from the HIC and corporatise it. The concerns of the private health insurance industry about "perceptions" are not a sound basis for such significant change in the structure and administration of a successful public enterprise.

Impact Upon Medibank Private Members

The ALP Senators believe that members of Medibank Private, and indeed, members of other funds, may be disadvantaged as a result of the legislation.

Firstly the Government has previously announced that 43 Medicare Offices will be closed. This reduces the number of Medicare offices throughout Australia from 269 to 226. Whilst this decision was a separate matter it nevertheless results in fewer offices providing dual services for Medicare and Medibank Private.

It is further proposed, as a result of this legislation and the separation of Medibank Private and the HIC that, in future, Medicare offices will no longer provide services or facilities for Medibank Private. Rather Medibank Private will be required to open their own new office locations. Whilst the HIC was unable to state how many such offices would be opened, and that the matter was still under discussion, the Community and Public Sector Union indicated that their understanding was that 70 offices would be established. This was not refuted by the HIC.

Thus, the net result of the government's changes will mean that the number of Medibank Private outlets will be reduced from around 269 to approximately 70. Given that reduction and the fact that Medicare Offices will no longer provide the facility members of Medibank Private will no doubt suffer a significant diminution in the availability of over the counter service. We do not accept that such a change can be simply overcome by greater use of telephone or electronic lodgement facilities.

Customers of Medibank Private have enjoyed the availability of co-location with Medicare and from their own evidence the other funds have not found this to be a difficulty for their fund members. In an era when the virtues of the "one-stop shop", especially in respect of government business enterprises and services, are being recognised it seems incongruous that customers of Medibank Private and Medicare should be affected by such disruption.

Further, these changes will have a significant impact in rural and regional areas as customers will be unable to use their local Medicare office and may have to travel long distances to any new Medibank Private office.

Secondly, whilst the Government says that this legislation has no financial impact on the Commonwealth, and the HIC claims that it can manage the separation so as there is no increase in costs, we are concerned that ultimately there could be increased costs to the fund members.

It has been acknowledged that the establishment and success of Medibank Private has had a beneficial impact upon the private health insurance industry. It has increased competition. It has reached number 1 and this has been achieved under its present structure. Nothing has been put forward to suggest that this would not continue or that the proposal to separate and corporative will dramatically improve it.

The establishment of new offices will inevitably involve costs. In answers provided after the hearing the HIC estimated that the fit out cost of an office will be around $80,000. If 70 new offices are opened that is a total cost of $5.6 million. Additional establishment costs can be expected for new computer systems, rentals or purchase of property, advertising, administration, etc.

Such costs together with the loss of economies of scale and reduced competitive force may lead to increases for members of Medibank Private and across the industry generally. Even if such establishment costs are ultimately absorbed by closures or transfers it still seems unnecessary to implement such changes for no real public benefit.

Privatisation

This legislation will, if enacted, make it much easier for Medibank Private to be privatised.

The private health funds, who strongly support this bill, have in the past advocated that Medibank Private should be privatised. In its submission to the Industry Commission in 1996 the AHIA expressed the view that "the Commonwealth has no more role in operating a private health insurance organisation than in running an airline". (Industry Commission, Report No. 57, February 1997, p. 92)

The Industry Commission's Report also noted that National Mutual Health Insurance "considered that Medibank Private should be de-linked from Medicare and privatised" and that Australian Unity "considered that Medibank Private could first be corporatised and then ultimately privatised". (Industry Commission, Report No. 57, February 1997, p. 92)

The Government has stated that it does not intend to privatise Medibank Private and that the legislation will ensure that it remains in government ownership. During the hearing the Chairman of the Committee also stated on a number of occasions that the Government intended to tighten the provisions to prevent future privatisation in the absence of parliamentary approval. However despite these assurances the Government is no longer proposing to amend the bill to this effect.

Given such an about-face this bill must increase the prospects of privatisation.

Impact on Employees

The CPSU gave evidence of the concerns of the Union and its members employed by the HIC particularly in Medicare/Medibank Private offices.

These were outlined by Mr McKenna as follows:

> Of considerable concern to our members has been that section of the legislation which deals with the forcible transfer power of the minister, or his or her delegate, to transfer someone against their will to Medibank Private Ltd. Staff turnover in the Health Insurance Commission is not high and there has always been a very enjoyable mix of work between the government program work and the Medibank Private work. It is fair to say, for example, that someone who may have only just joined the Medibank Private operations of the Health Insurance Commission will be forcibly transferred against their will, if they do not wish to transfer, by virtue of the section in the legislation which gives that binding power to the minister or his or her delegate.
>
> The second major concern we have in relation to the industrial aspects of the legislation is the 12-month mobility right. There is a standard, if you like, in the Australian Public Service of three years mobility for someone who has left the Public Service to be employed by a Commonwealth owned statutory authority; they have what is called a three-year mobility right back into the service. We cannot see any real reason why that standard does not apply in relation to the separation of Medibank Private from the Health Insurance Commission. We would specifically point you to section 28(4) of the bill which we would seek to be changed from a 12-month mobility right to a 36-month mobility right.
>
> In conclusion, we would say that this legislation is unnecessary. There is nothing here to be fixed. The Commonwealth ownership of the Health Insurance Commission and, thereby, Medibank Private Ltd has been a very

> positive development in the private health insurance industry over the past couple of decades. (Hansard *Transcript of Evidence*, p 8)

The CPSU also expressed concern that, whilst they did not expect big job losses as a result of this legislation, eventual privatisation could lead to redundancies.

Mr McKenna summed up the concerns in the following comments:

> **Senator Forshaw** – Mr McKenna, can you see any advantages in this proposal at all for either Medibank Private or the Health Insurance Commission generally or the public?
>
> **Mr McKenna** – Frankly, no, for all those three parties. This is going to be a very disruptive exercise over the next 12 months to separate 1,200 staff and establish them, not only in a different business entity but also physically move them. In some states, they even have to go to the expense of physically relocating staff into new Medibank Private buildings, and that seems to be an unnecessary cost and an unnecessary change on the working lives of our members. We are still looking for the rationale that underpins this legislation.
>
> I point to the minister's original media release from 10 April and, again, the second reading speech just recently where he uses the word `perception' repetitively, that there is a perception of competitive advantage through co-location. That might be the perception of the private health insurance industry, but if you go through the quite rigorous statutory cost apportionment guidelines and the minister's own cost apportionment guidelines which must go through Treasury, above and beyond the statutory ones, there is no real basis for that perception. It seems an unnecessary piece of legislation in response to a perception. (Hansard *Transcript of Evidence*, p 10)

The ALP Senators agree with this analysis. Medibank Private has proved over the years to be a successful health insurance fund. Its current structure as part of the HIC is adequate and appropriate. We do not believe that separating it from the HIC and establishing it as a separate corporate entity will advance either the public interest generally or the interests of the fund members. **The legislation is unnecessary and should be rejected.**

Senator Michael Forshaw
(ALP, New South Wales)

Senator Kay Denman
(ALP, Tasmania)

Senator Sue West
(ALP, New South Wales)

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

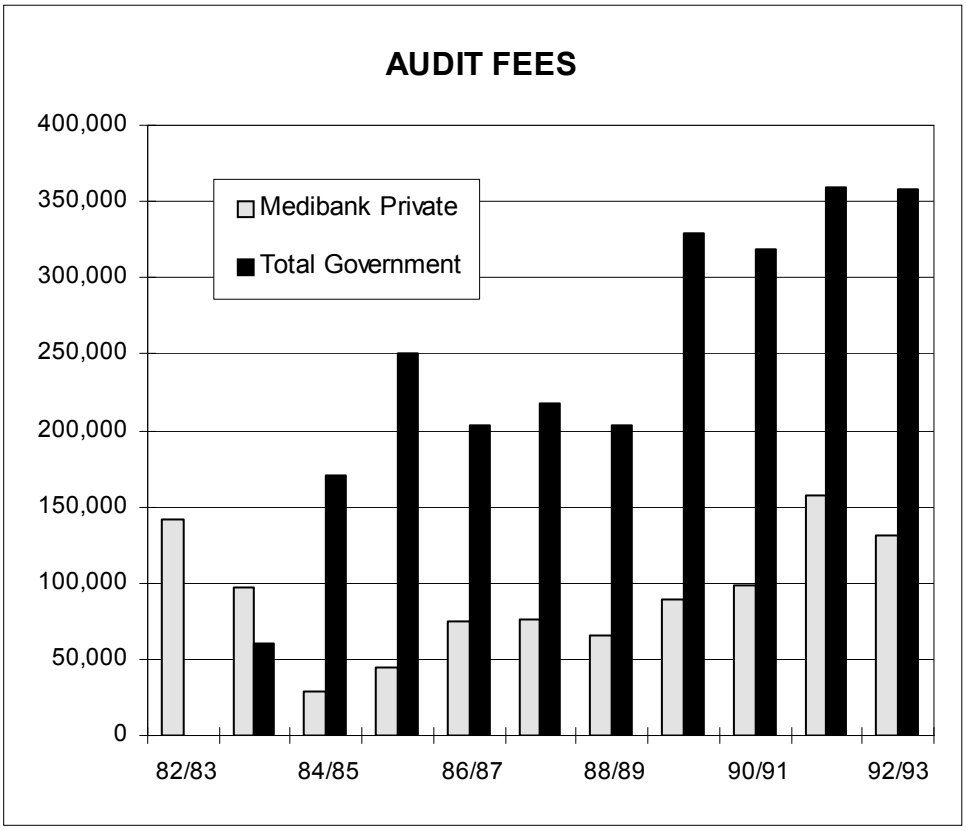
accounts have consistently shown that most assets which yield income are held in the name of Medibank Private.

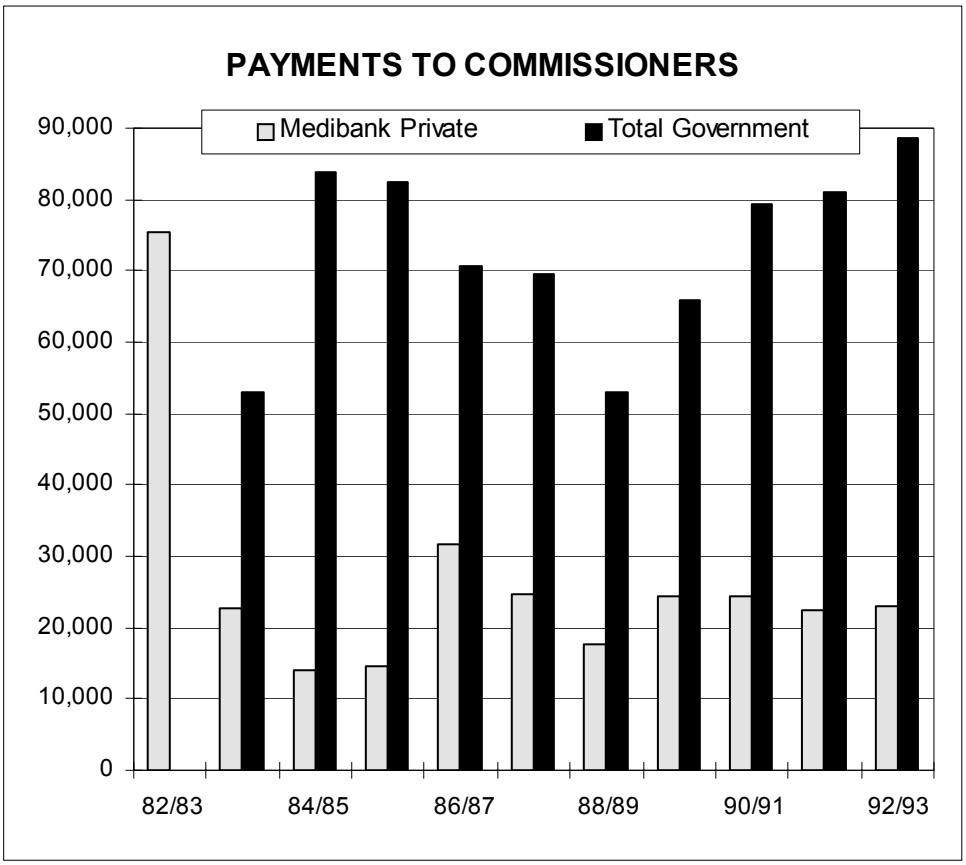
4. AHIA asserts that joint operation has allowed Medibank Private over the years to have generated surpluses which, in real terms, may not exist if they are based on a false allocation of salary and other costs to Medicare. Certainly they do not reflect the surpluses that would have been generated had 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.

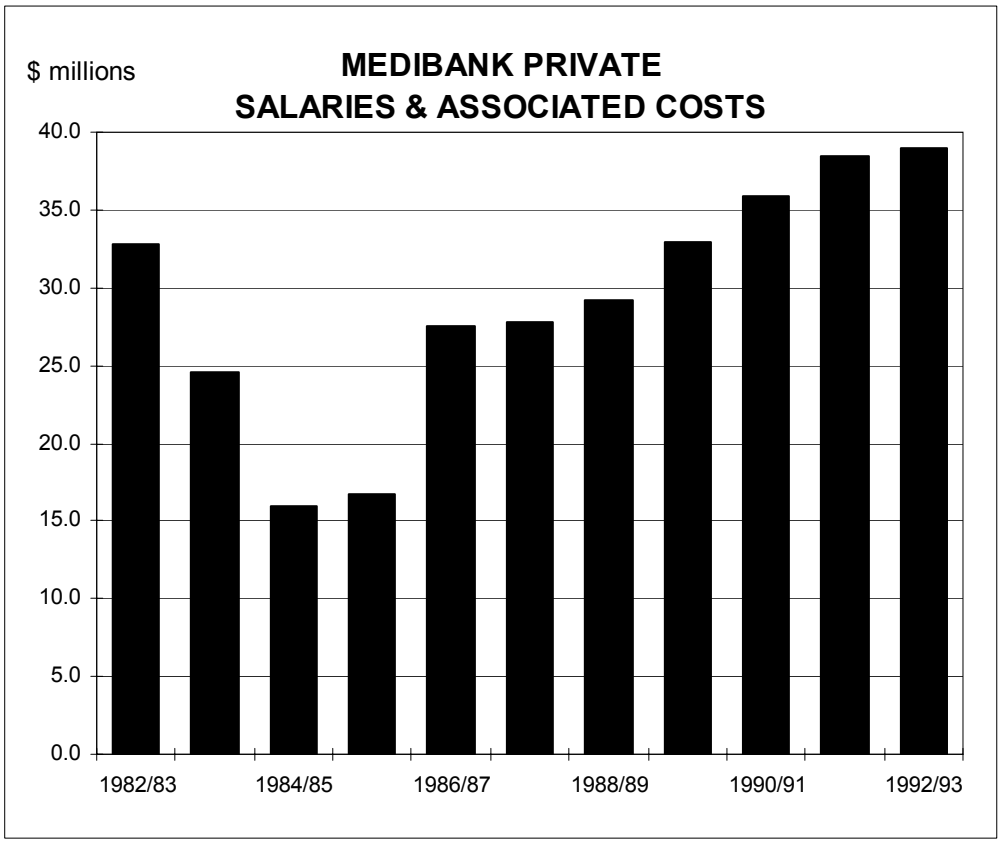




SALARIES

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.



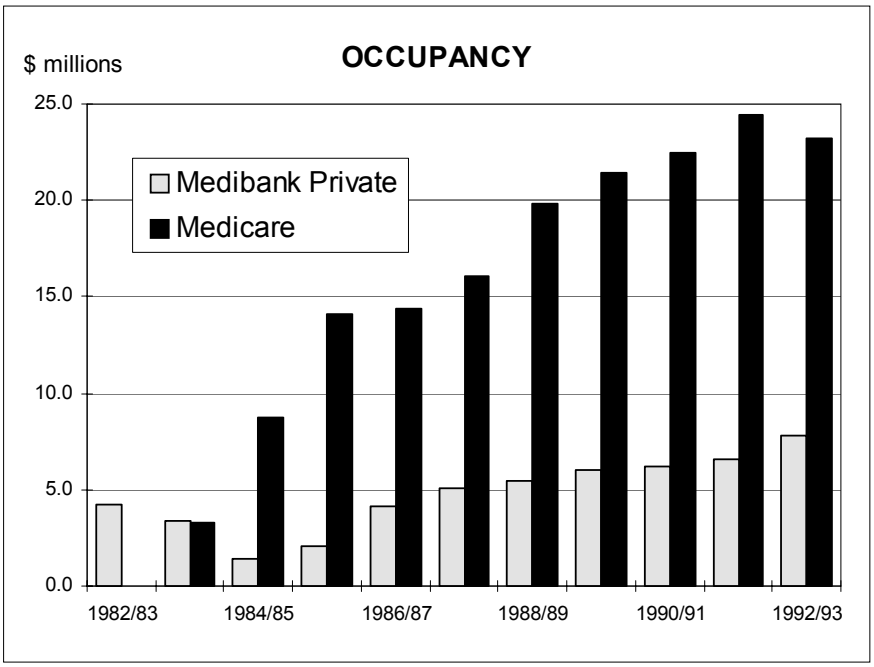
10. Had Medibank Private's salaries increased at CPI from 1982-83 it would have paid $293 million more in salaries.

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.

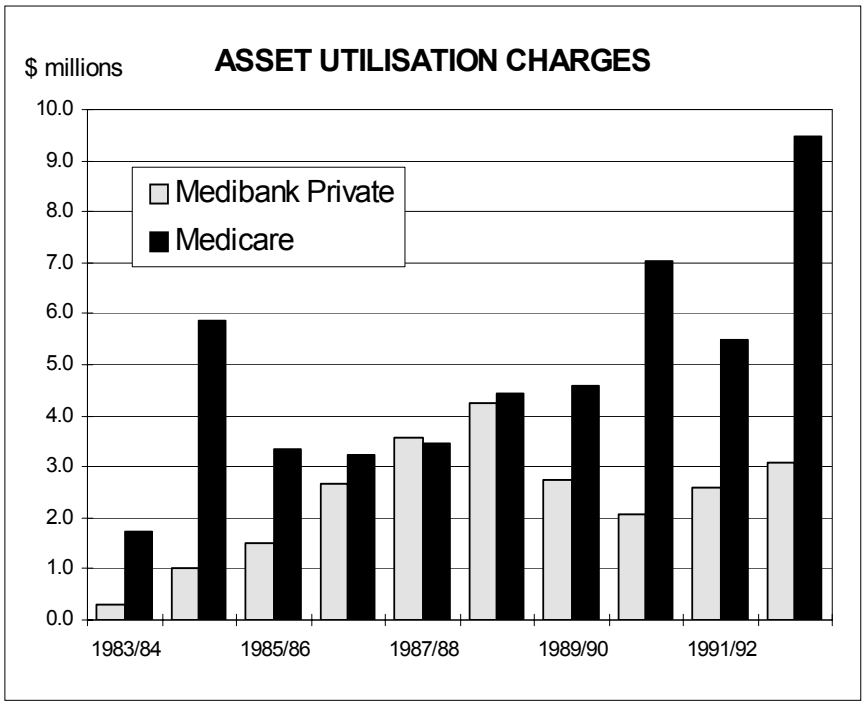


ASSET UTILISATION

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)

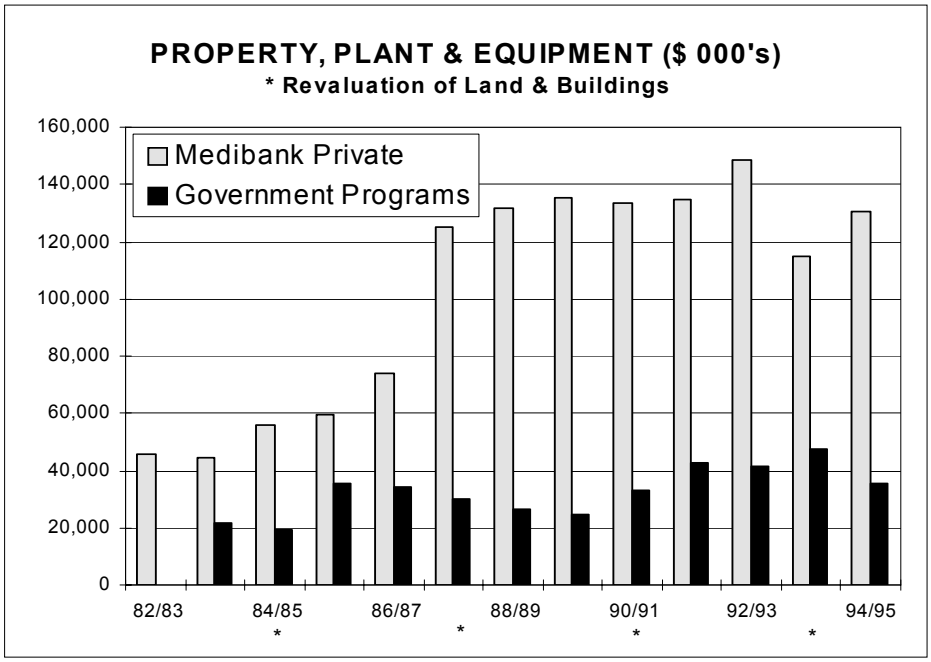
15. If all assets other than land and buildings were classified as belonging to Medicare, then Medibank Private would have paid an additional $73 million since the introduction of Medicare.

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



PROPERTY, PLANT & EQUIPMENT

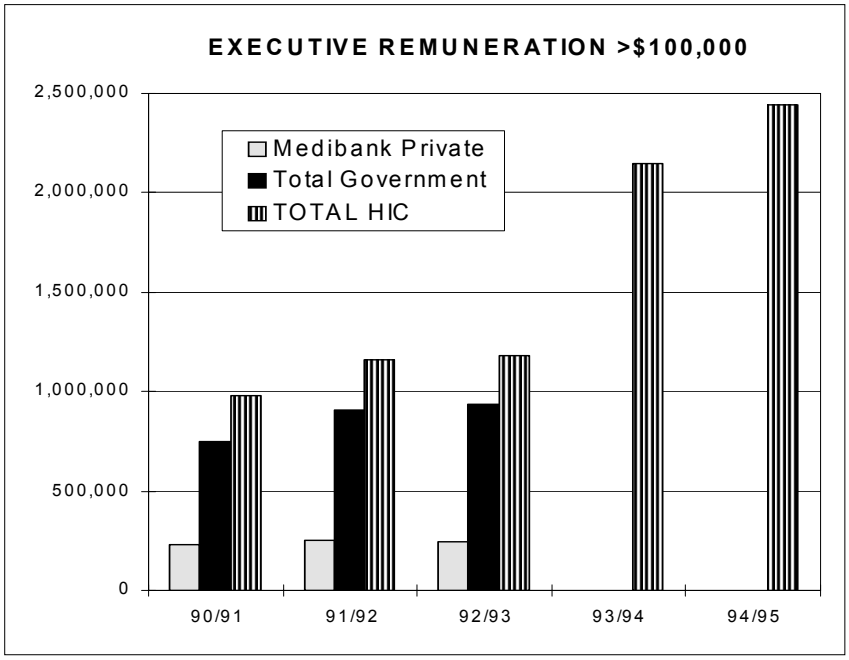
17. The allocation of property, plant and equipment to Medibank Private has grown considerably since conjoint operation with Medicare. Since 1982-83 property, plant and equipment has increased by $85 million - from $46 million to $130 million - an increase of 186 %. Given the nature of the HIC apportionment 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

APPENDIX 2

PUBLIC HEARING

A public hearing was held on the Bill on 4 September 1997 in Senate Committee Room 2S1.

Committee Members in attendance

Senator Sue Knowles (Chairman)
Senator Meg Lees (Deputy Chair)
Senator Kay Denman
Senator Alan Eggleston
Senator Michael Forshaw

Witnesses

Australian Health Insurance Association

Mr Russell Schneider, Chief Executive Officer

Community and Public Sector Union

Mr David McKenna, National Industrial Officer

Medibank Private

Mr Ken MacDougall, General Manager, Medibank Private

Health Insurance Commission

Ms Jackie Wood, General Manager, Government Programs
Mr Adrian Kelly, Manager, Industrial Relations
Ms Donna Moody, Manager, Accounting Branch
Ms Ann Stumpf, Principal Legal Adviser, Legal Services

Department of Health and Family Services

Dr John Loy, First Assistant Secretary
Ms Gail Batman, Assistant Secretary