Submission to the Senate Standing Committee on Finance and Public Administration on the proposed sale of Medibank Private Limited

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I have been invited to make to make this submission to the Standing Committee in relation to the proposed sale of Medibank Private Limited. As some of the members may know, I was involved in the original establishment of Medibank Private in 1976. I was also a Commissioner of the Health Insurance Commission (HIC) from 1984 to 1999 and for the 14 years (to 1997) that the Commission managed Medibank Private, I had a particular interest in that area.

This submission is mainly concerned with the policy arguments for and against the sale of Medibank Private Limited (MPL). There has certainly been widespread public concern about the sale and the perceived appropriation of 'contributors funds' which is implicit in it. That has no doubt influenced some of the processes proposed. Not surprisingly, the government has relied on its internal advice and a very literal interpretation of the legislation governing Medibank Private Limited included in the Blake Dawson Waldron opinion circulated by the Minister for Finance and Administration, namely that the Australian Government is the legal and beneficial owner of the company and its assets, which it can transfer through a sale of shares on any terms. It is at present restrained from doing so by a provision in the relevant act preventing any transfer but that could be remedied by the Parliament simply repealing that section.

I cannot comment on the legal issues except to say that, while I would expect a right to sell to be upheld, I do not believe that all the consequences of a sale can be so easily ignored. Medibank Private Limited is currently registered as a non-

profit insurer under the National Health Act. A necessary condition for commercial sale is that it be converted to for-profit status and the government has signalled its intention to do so. However that would fundamentally change the way in which its assets could be used. As the Parliamentary Library Digest of Bills paper points out, the National Health Act specifies that a registered non-profit organisation may not distribute profits and must retain, in a specific account, all of the assets of its health insurance 'fund'. Furthermore, it requires the management to 'give priority to the interests of members in any dealing with fund assets". A for-profit organisation, on the other hand, can use its assets in any way it chooses, including the payment of dividends and the transfer of assets to other business activities, subject only to its health insurance fund retaining sufficient money to pay benefits and maintain the prudential solvency ratio required by the Private Health Insurance Administration Council. Medibank Private's assets substantially exceed those requirements. All are currently used for the benefit of members through the investment income that they generate. If, through privatisation, part of those funds were to be transferred to another use, its contributors would clearly suffer a loss.

That is a much more convincing reading of the legislators' intentions than the simplistic interpretation on which the government relies. However the legalities are less important than the policy. The question is whether it would be in the public interest for MPL to be sold and whether the arguments in favour of its sale are valid.

Background

Medibank Private was established in 1976 under the first health insurance changes of the Fraser government. They provided for universal insurance coverage to be retained but an income-related levy was introduced to fund the government scheme (then called Medibank). However, people were exempted from that levy if they joined an approved private health insurance fund. The levy rate was set to

achieve about 50% of the population 'opting-out' and that was ultimately achieved. But there was considerable resistance to people being 'forced' to join a private organisation, culminating in a national strike. The strike was not particularly effective but Mr Fraser and Mr Hawke, then ACTU President, reached an agreement which resulted in Medibank Private. It was intended mainly to accommodate Medibank supporters (the name was deliberately included in its title) but that was not the only reason. The Government was having considerable difficulties with the private health funds proposing premiums which were far too high to make its scheme attractive and Medibank Private was seen as a way to guarantee a standard private cover at affordable premiums.

That was how the HIC always interpreted its task. Medibank Private soon became the largest single fund and its approximately 30% share of the national market has not changed much for 25 years. It operated under the same rules as any other private fund. It never made a loss but it never maintained a surplus which would raise its 'free' reserves (ie, those not covered by provisions for future outlays) beyond 3-4 months of expected outlays. The minimum prudential level is 2 months. Any excess accumulation was adjusted by lower premiums for the next year. Earnings from the investment of its reserves were included in operating income to offset expenses. Medibank Private's products were competitive but they were not always the same as its competitors', particularly in relation to those 'deductible' and 'exclusion' products which could have threatened the community rating rule. No subsidies were received from government and no dividends were ever paid. We were never directed in relation to any of these matters.

I do not know the policies of Medibank Private Limited since 1997, but its financial results have been much more variable since then, particularly in relation to a loss of $175 million in 2001-02 (which resulted in a subsequent injection of Commonwealth funding through a share issue) followed by surpluses of $131 million and $203 million in 2004-05 and 2005-06 respectively. That has more than

made up for the loss. MPL's total equity, including the $85 million which the government provided in 2005, is now above the 'free reserve' level with which it started.

The stated case for sale

1 There is no policy reason for the government to run a private insurance fund.

That is simply a statement of the present government's position. 'Private insurance" does not mean 'privately-owned insurance' or even 'insurance against the cost of privately-provided health care' - otherwise, there would be no insurance for private patients in public hospitals. In fact it simply means insurance against the cost of health services which neither the Australian government nor the State /Territory governments insure or provide through Medicare. The government is clearly concerned with this function. It closely regulates the scope and content of non-government insurance, supports it financially through both the Private Health Insurance Rebate and the conditions under which the Medicare Levy surcharge can be avoided and has, of recent years, assumed responsibility for approving any premium increases which are other than routine.

In fact, the policy interest in private health insurance is now far greater than ever before. Why would this not include a public presence in the private insurance market? There are at least two major arguments for that presence. The first is the conventional one that it that it would not only be a competitor in financial terms but could also lead in developing products of benefit to its members in terms of healthcare outcomes, not simply money. The present government has actually gone much further in controlling the financial affairs of private insurers than was ever contemplated through Medibank Private's presence. However, its proposals

have still placed great emphasis on the competitive advantages of a privatised, profit seeking MPL, although that seems to reflect more ideology than evidence.

The second and in my view much more important argument, is that MPL's presence affirms the broader public interest in private health insurance. I have always believed that Medicare is a national system of health care financing which includes the private sector and its insurers, not just a Commonwealth scheme of benefits for medical care and public hospital treatment. The two parts are complementary in ways which go beyond the market place, although there are vested interests with a reason to argue otherwise.

Poor co-ordination between the public and private provision of health care is a major, and justified, criticism of the Australian system and I see the continuing emphasis on separating them even further as our major policy mistake. Health insurance is not the same as life insurance or home insurance or motor car insurance. It gives access to a range of technically sophisticated services and supports a network of professional providers. It is, in many ways, the agent for its members and its operations affect the type of services they get. But the whole thrust of these proposals is to move Medibank Private Limited further away from the health service sector and into the more general finance industry. If the largest fund does so, others would probably follow. Integration would then be even less likely.

2 There is a conflict of interest in the government being both the regulator of private health insurance and the owner of a fund

Superficially, this statement is nonsense. MPL is subject to exactly the same rules as any other private insurer, endorsed by Parliament and administered through the Department of Health and Ageing. They state quite precisely what the organisation

can and cannot do. With whom could they conflict? Departmental objectives may vary but the government cannot have a conflict of interest with itself.

What it might be obliquely referring to though, is the possibility that the rules themselves might be either framed or administered in a way which favoured the government fund over its competitors. The non-government funds have routinely made this claim about Medibank Private for years.. That would imply either mal-administration, even corruption, or that the Parliament had enacted laws which might be seen as discriminatory. But what would the conflict of interest be? The government is not a trading enterprise. As long as the rules are legal, any remedy must surely be political. People see the public interest in different ways.

3 Selling MPL would increase competition in the private health insurance industry.

Under the government's current proposals, no. The initial suggestions for a trade sale to competitors raised significant issues of potential market dominance but the current proposal for a public float of the existing MPL would avoid those difficulties and maintain the organisation intact. According to Senator Minchin's media release of 17 October 2006, the legislation would;

- Repeal Section 35 of the National Health Act 1953 to enable the Government to sell Medibank Private,
- Prevent any takeover, foreign or otherwise, of Medibank Private for a period of five years after the sale. No single shareholder, whether foreign or domestic, will be able to own more than 15% of the company and this shareholder cap will remain in place for 5 years…….
- Put in place provisions for five years to ensure that Medibank Private remains an Australian company, including a requirement

that it remains incorporated in Australia and that a majority of its directors and its head office be Australian for the first five years after sale.

Medibank Private's status would be changed from non-profit to for-profit. In other statements, the Government has signalled that present contributors "will be recognised through an entitlement as part of the public offer structure', although the nature of that entitlement has not been clarified.

Under these conditions, the present Directors and management of Medibank Private would almost certainly remain in place, at least initially, and in the absence of any major controlling interest they would probably continue for some time. The only changes would be to the company's profit-making status and its ownership. Curiously, there is no formal requirement for it to continue to provide health insurance during the 5 year period.

It is very hard to see how this could increase competition in the health insurance industry. Nothing in the market structure would change. The government claims that "Independent economic analysis has highlighted the potential efficiency benefits that may result from a privatised Medibank Private", but that is entirely hypothetical. Privatisation and the search for profits is simply assumed to automatically yield these benefits, as would the opportunity for Medibank Private to diversify into other areas such as life insurance. But it is not clear exactly what efficiency gains are anticipated or to whom the benefits might accrue.

The current evidence is not particularly supportive. Outside the United States, there are very few profit-seeking health insurers with which a privatised MPL might be compared and the US environment is entirely different. Australia has five for-profit funds (out of 38 funds in total) although only one is of a scale large enough to be competitive with MPL - British United Provident Association Pty Limited which

acquired the for-profit business previously operated by AXA in 2002. It is also one of the six large insurers which dominate the market, cover 77% of the privately insured population and hold 69% of the net equity in the industry ('free' reserves plus subscribed capital).[1]

Tables 1 and 2 (attached) show the statistics for these six insurers in 2004-05, as reported by the Private Health Insurance Administration Council. They cover all the essential features of health insurance. Coverage figures are for both hospital and ancillary insurance at 30 June 2005, transactions are for both categories in 2004-05. Assets include both financial investments and real assets (buildings, equipment etc). Liabilities include provisions for unpresented claims, contributions paid in advance and other outlays which would have to be met in the event of a winding-up. Other reserves are categorised as 'free' but PHIAC requires a minimum prudential holding of at least two months benefit payment above provisions and most insurers hold somewhat more. Surpluses are shown before tax and after tax. BUPA, as a profit making company, is liable for tax which the others are not. The data for Medibank Private and BUPA are highlighted because that is the comparison on which the government must be presumed to base its case.

The statistics are somewhat complex but so are the issues. Table A summarises the main results. As can be seen:

- the three largest insurers – MPL, MBF and BUPA – had very similar contribution and benefit structures. The other, slightly smaller organisations were also very similar, though at somewhat lower premium levels. Operating results varied but not in any systematic way. In dollar terms, BUPA's gross operating margin (the difference between revenues and benefits paid) was around the average in the other two big funds but about 25% higher than in HCF and HBF, two of the longest established and more

regional organisations. However it was less than in both MBF and NIB, an organisation with a particularly expansionist profile

- BUPA spent the lowest proportion of revenue on administrative expenses but the share in HBF was almost the same. Except for NIB, none of the differences were large.

- pre-tax, MBF had by far the highest surplus. The BUPA result was only slightly lower but all the other funds were well behind. The post-tax profit for BUPA was even further below the MBF outcome. However it was almost exactly the average for other insurers. MPL earned slightly less.

- BUPA showed the highest return on funds employed, even after tax, largely because its retained earnings were relatively low. MPL earned about the average.

Table A Operating and equity ratios, six largest private health insurers, 2004-05

		MPL	MBF	HCF	HBF	NIB		**BUPA**
Operating								
Revenue ($)	Per person	**966**	1,035	901	868	885		**1,050**
Benefits ($)	Per person	**830**	857	776	730	731		**890**
Gross profit margin ($)	Per person	**136**	178	125	138	154		**160**
Gross profit margin (%)	% revenue.	**13.8**	17.7	13.7	12.2	16.7		**15.4**
Expenses	% revenue	**8.9**	9.4	8.3	7.7	11.3		**7.6**
Net profit margin								
Pre tax	% revenue	**4.9**	8.3	5.4	4.5	5.4		**7.8**
After tax	% revenue	**4.9**	8.3	5.4	4.5	5.4		**5.1**
Equity								
Return on funds								
Pre tax	% pa	**9.5**	11.7	8.1	9.9	8.2		**16.6**
Post tax	% pa	**9.5**	11.7	8.1	9.9	8.2		**11.6**

Source Private Health Insurance Administration Council, Annual Report 2004-05, Part C tables

Comparing BUPA's results to MPL, why would the BUPA outcomes be preferred? BUPA is an efficient organisation and a commercially successful one, although if profitability as measured by 'net margin' is the test, MBF was even better. **However maximising size, profits or return on funds are surely not the major public interest criteria for a publicly-supported health insurance fund. Value-for-money must count more**. BUPA charges higher premiums and pays a lower proportion of its revenue as benefits than MPL. Its administrative expenses are a little lower but they have to be because BUPA has a tax liability which MPL does not. Its pre-tax profit margin was therefore nearly 60% higher than that for MPL, for a very similar post-tax result. How could this outcome be seen as more in the public interest than the present? The Treasury would certainly gain from the privatisation of MPL but the customer would not. In fact, the import of these figures is actually the opposite of what is often claimed. **The only logical conclusion is that it is the tax-exempt status of the non-profit funds which has held premiums down, not the incentives of for-profit operation.**

3. *Premiums will not increase as a result of the sale*

That is impossible to promise but equally hard to reject with certainty. The details of the proposed sale have not been released and are probably not finalised. Nor have the bases for the various estimates of value been made public. There may nevertheless be some guidelines.

Medibank Private would be floated as a going concern, with assets of about $1.5 billion and net equity of (probably) about $850 million at present. Estimates of value between $1.5 billion and $2 billion have been publicly discussed, based on the 2005 position outlined in Table 2. A figure of, say, $1.7 billion might well be realistic. To meet the various prudential requirements, about $1.2 billion would

have to remain in the health insurance business but about $300 million in liquid assets could be withdrawn and the new company could use these and any other funds to diversify into other, potentially more profitable areas. Its overall return on capital would therefore not depend entirely on profits of the health insurance arm but for the $1.2 billion which would have to be retained, what return would the 2004-05 net surplus of $131 million equate to ? The answer is, about 11% pre-tax and about 8% post-tax.

By any measure that seems to a grossly inadequate return, even for a relatively low-risk business whose market is heavily supported by government. The only indicator would be BUPA's purchase of the AXA business in 2002 but there are no public details of that transaction. However on the same basis as the calculation above – the return on the funds needed to continue the business as a going concern – BUPA's 2004-05 surplus of $78 million represented a yield of 16.8% pre-tax and 11.6% post-tax. Those are much more realistic figures.

Applying that standard to Medibank Private Limited would have required 'profits' of $200 million in 2004-05, 52% more than the $131 million achieved. **But that was exactly what the surplus was in 2005-06**. The necessary adjustment had thus been made already, which means that the promise of no premium increases beyond the present level might have been achievable in 2006-07. It may or may not be so in 2008. However the latest surplus was itself an extraordinary result which may or may not be sustainable It will have taken MPL's free reserves way beyond the solvency ratio range required by PHIAC. In a non-profit environment an increase of that size would have been factored into a premium reduction, or at least a significant moderation, this year. But a profit-making MPL could never afford to do so. That would be the major long term difference.

And there could be some unintended flow-on effects as well. With two of the biggest funds now operating for profit, there would inevitably be calls for a 'level

playing field' in terms of tax liability. It would be impossible to exempt MPL and BUPA specifically, but it would be just as hard to tax the others. Alternatively, some of the other large funds might find the diversification route attractive and so convert to for-profit status, with an almost certain increase in the profits that they would then have to make. One never knows.

Summary

The main conclusions of this submission are as follows:

- legal restrictions are unlikely to prevent the sale of Medibank Private Limited but the yield might not be as attractive as the government hopes,

- the conventional arguments for retaining Medibank Private Limited in public hands relate to its size, importance for competition and potential to act in relation to health care outcomes rather than purely financial considerations. However, there is an equal, and in my view , more important argument for retaining a public MPL as a commitment to private insurance as part of an integrated financing system, not one where Medicare and private insurance are seen as separate and competing schemes,

- earlier discussions of a trade sale for MPL raised serious questions of an unacceptable reduction in competition. Under the present proposals for a float, nothing significant would change. Despite conventional wisdom and convictions, <u>there is no Australian evidence that private ownership and for-profit status has produced any efficiency gains sufficient to offset the higher</u>

cost of private capital; and good reason to believe that non-profit status, not the incentives of private ownership, has been the largest controlling influence on premiums. If the public interest is seen as consumer value for money, there is no demonstrated case for Medibank Private's sale,

- because the nature and policies of any privatised MPL cannot be known now, it is impossible to say with certainty that premiums would or would not rise if a sale took place in 2008. The very large increase in MPL's surplus for 2005-06 would probably have avoided an increase in 2006-07, but in the longer run higher contributor costs are much more likely than reductions.

Note

(1) Medibank Private Limited, British United Provident Association Pty Ltd, Medical Benefits Fund of Australia Limited, The Hospital Contribution Fund of Australia Limited, HBF Health Funds Inc. (WA), NIB Health Funds Limited.

Medibank Private operates actively in every State and Territory. The other organisations had regional origins and although most have some members in most jurisdictions (mainly through interstate migration) their active operation is limited. States/Territories of most active operation are:

MBF	NSW/ACT, Victoria, Qld, Tasmania, NT
BUPA	NSW/ACT, Victoria, SA,
HCF	NSW/ACT, Victoria, Qld.
HBF	WA, NT
NIB	NSW/ACT, Victoria, Qld.

Table 1 Operating statistics, six largest private health insurers, 2004-05

		MPL	MBF	HCF	HBF	NIB		BUPA
Item								
Persons	(mil)	**2.76**	1.65	.94	.79	.66		**.96**
Revenue	($mil)							
Premiums		**2,599**	1,609	803	643	531		**989**
Other		**63**	100	41	42	20		**21**
Total		**2,667**	1,708	844	685	551		**1,010**
Benefits	($mil)	**2,298**	1,414	727	577	459		**855**
Expenses	($mil)	**238**	161	70	53	62		**77**
Surplus	($mil)							
Pre tax		**131**	133	47	49	29		**78**
After tax		**131**	133	47	49	29		**54**

Source Private Health Insurance Administration Council, Annual Report 2004-05, Part C tables

Table 2 Assets and Liabilities, six largest private health insurers, 2004-05

		MPL	MBF	HCF	HBF	NIB		BUPA
Item								
Assets	($mil)							
Financial		**1,334**	1,113	508	475	295		**450**
Other		**59**	21	72	24	57		**19**
Total		**1,393**	1,134	580	494	352		**469**
Provisions	($mil)							
o/s claims		**304**	156	75	65	42		**117**
Contrib. in advance		**308**	194	120	121	39		**139**
Total		**639**	260	207	191	84		**265**
Creditors	($mil)	**58**	50	43	37	39		**5**
Equity	($mil)							
Capital		**85**						**96**
Reserves		**568**	724	331	228	224		**104**
Total		**653**	724	331	228	224		**200**

Source Private Health Insurance Administration Council, Annual Report 2004-05, Part C tables