COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# SENATE

## COMMUNITY AFFAIRS LEGISLATION COMMITTEE

**Reference: Health Legislation Amendment (Private Health Insurance Reform) Bill 2003**

THURSDAY, 15 MAY 2003

C A N B E R R A

BY AUTHORITY OF THE SENATE

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## WITNESSES


**GALE, Mr Andrew Peter, Chief Actuary, Medibank Private Ltd..................................... 1**

**GODDARD, Mr Martyn, Senior Health Policy Officer, Australian Consumers Association................................................................................................................. 11**

**JOHNSON, Mr Andrew, Senior Legal Adviser, Department of Health and Ageing ...... 23**

**MACKEY, Mr Paul, Director, Policy and Research, Australian Private Hospitals Association................................................................................................................. 20**

**MASKELL-KNIGHT, Mr Charles Andrew, Principal Adviser, Acute Care Division, Department of Health and Ageing........................................................................... 23**

**MIDDLEWEEK, Miss Katherine Ann, Public Officer and Corporate Lawyer, Medical Benefits Fund of Australia Ltd ................................................................... 1**

**MIHM, Ms Uta, Content Producer, *Choice*, Australian Consumers Association............ 11**

**MORAUTA, Dr Louise Helen Margaret, First Assistant Secretary, Acute Care Division, Department of Health and Ageing......................................................... 23**

**POWLAY, Mr John Frederick, Private Health Insurance Ombudsman......................... 17**

**ROFF, Mr Michael, Executive Director, Australian Private Hospitals Association ....... 20**

**SCHNEIDER, Mr Russell, Chief Executive Officer, Australian Health Insurance Association................................................................................................................. 1**

**WALLACE, Mr John Gerard, Health Policy and Economic Manager, Medibank Private........................................................................................................................ 1**

**SENATE**

**COMMUNITY AFFAIRS LEGISLATION COMMITTEE**

**Thursday, 15 May 2003**

**Members:** Senator Knowles *(Chair)*, Senator Greig *(Deputy Chair)*, Senators Denman, Heffernan, Humphries and Hutchins

**Participating members:** Senators Abetz, Bishop, Boswell, Buckland, Carr, Chapman, Jacinta Collins, Coonan, Crossin, Eggleston, Chris Evans, Faulkner, Ferguson, Ferris, Forshaw, Harradine, Harris, Hogg, Lees, Lightfoot, Ludwig, McGauran, McLucas, Moore, Murphy, Nettle, Payne, Tierney, Watson and Webber

**Senators in attendance:** Senators Allison, Denman, Heffernan, Humphries, Hutchins and Knowles

**Terms of reference for the inquiry:**

Health Legislation Amendment (Private Health Insurance Reform) Bill 2003

**Committee met at 3.39 p.m.**

**MIDDLEWEEK, Miss Katherine Ann, Public Officer and Corporate Lawyer, Medical Benefits Fund of Australia Ltd**

**SCHNEIDER, Mr Russell, Chief Executive Officer, Australian Health Insurance Association**

**GALE, Mr Andrew Peter, Chief Actuary, Medibank Private Ltd**

**WALLACE, Mr John Gerard, Health Policy and Economic Manager, Medibank Private**

**CHAIR**—I call the meeting to order. The committee is taking evidence on the Health Legislation Amendment (Private Health Insurance Reform) Bill 2003. I welcome representatives from Medibank Private, MBF and the Australian Health Insurance Association. Witnesses are reminded that the giving of evidence to the committee is protected by parliamentary privilege. However, the giving of false or misleading evidence may constitute a contempt of the Senate. The committee has before it your submissions. Do you wish to make any alterations to those submissions?

**Mr Wallace**—No.

**CHAIR**—In reading some of the submissions, I notice that some of them do go beyond the terms of reference. I encourage witnesses to keep their comments to the terms of reference; that would certainly assist the committee. I now invite any or all of you to make an opening statement. Mr Schneider, would you like to kick off?

**Mr Schneider**—Firstly, let me thank the committee for giving us an opportunity to give evidence on this legislation, which we believe is quite an important piece of legislation aimed at reducing the regulation on the private health insurance industry and with safeguards attached thereto. I do not believe this committee is the appropriate forum to resolve what might be termed commercial disputes. However, in some of the submissions, arguments have been put, particularly by the Australian Private Hospitals Association, which do have a

commercial bent to them and I think do need to be corrected, or at least have our point of view expressed about them.

In its submission, APHA claimed that health funds are offering between a minus 10 to plus two per cent increase in negotiations over benefits this year. Equally, private health funds report that private hospitals are seeking increases ranging from the CPI to 20 per cent or more and are threatening to impose co-payments on patients if funds do not respond appropriately. I think the committee should see these allegations as very much part of a negotiating environment in which both sides make ambit claims and pay little heed to the protests. But it is unfortunate that they have chosen to intrude them into these hearings.

The true situation as far as the utilisation of hospitals is concerned is as follows. Between the years ended December 2001 and 2002, the total accommodation benefits health funds paid private hospitals actually increased by seven per cent, an increase of $211 million. Total admissions to private hospitals, combining overnight and same day services, increased by four per cent, up 73,400 admissions. Overnight admissions decreased by 2.3 per cent, and total benefits increased by $136 million, up by 5.3 per cent. So even though overnight admissions were down, income was up very substantially. Same day admissions increased by nine per cent, which is an increase of 91,000 admissions. The total benefits for same day admissions increased by $75 million, which is up by 16 per cent. The average benefit per bed day for an overnight admission increased by six per cent from $617 to $655 per bed day. Total overnight benefits per episode increased by eight per cent from $3,482 to $3,754, which is up by almost $300 an episode. I could go on, but I think I have made my point. Neither space nor time would allow me to go through every assertion the APHA has made in its submission. But if the committee wishes us to provide a paper which details what we believe is every inaccurate fact or assertion, we will do so.

The most important point to make, though, is that if we take the year before the 30 per cent rebate was introduced, total private hospital accommodation benefits, excluding prostheses and medical gaps, increased from $2.3 billion to $3.2 billion, a 40 per cent increase. So unlike what APHA says, the revenue stream has not been stopped. It has not even been squeezed. Some would say it is flowing very strongly—almost a river of gold.

APHA has put a graph to you which shows bundled benefits paid for episodes involving overnight admissions with same day stays. That is very important because if you combine them, you get quite a different picture from the picture you get if you unbundle them, which we have done. With the committee’s permission, I will present a graph which shows the unbundled situation.

**CHAIR**—Is leave granted? There being no objection, leave is granted.

**Mr Schneider**—Thank you. It is also of concern to us that there seems to be a view that health funds have to provide ‘cost plus’ coverage for health care facilities regardless of their efficiency. This would not be in the interests of contributors, taxpayers or patients. Even in the areas of alleged uncontrollable costs, such as wages and indemnity insurance, the hospitals have overlooked the potential for well-run hospitals to secure cost savings via productivity arrangements and improved patient safety.

I note with some sadness that, in their argument, the hospitals do not say that the indemnity insurers have failed to acknowledge their presumably demonstrable safety record via lower indemnity premiums. If that were the case, the hospitals would have a very legitimate argument to come here, and we would support them, in seeking legislative action to require indemnity insurers to provide those hospitals with lower premiums.

The proposals that APHA makes for performance indicators are, in our view, similarly intended to improve the commercial position of hospitals as distinct from the welfare of health fund contributors and their patients. While it may be a legitimate commercial tactic for them to adopt, we submit it is not appropriate for this parliament to be seduced into providing such support.

I hope you will treat the suggestion that funds should be required to pay 55 per cent of total benefits to private hospitals and day hospitals with the contempt it deserves. The fact is that the size of the benefit pie is constantly changing, depending very much on decisions made by this parliament itself, by medical technology and by evolving care patterns and pathways which influence the sort of care that is provided. Indeed, hospital care may not always be the most appropriate solution for a patient. The reality is that since the rebate came in, the private hospital sector has received twice as much of the additional revenue stream. I would like your leave, if I may, to table another graph which shows the relative increases in benefits paid to the various provider groups, which will give an interesting picture of what has happened since the rebate came in.

We are also concerned about the suggestion that health funds should consult with the private hospitals prior to lodging applications for premium increases. Apart from the obvious offence under the Trade Practices Act of such collusion, the hospitals would know that individual funds and hospitals are continually discussing cost pressures et cetera as part of ongoing contract negotiations. I draw to your attention that if the APHA is referring to the recent nursing cost pressures, which began with increased pay to nurses in New South Wales, AHIA last year provided the New South Wales government with detailed information about the impact of an award application which was agreed to. We provided that to the New South Wales Treasury, which passed it on to the Industrial Relations Commission. We are not aware of the hospitals taking any similar action, so for them to now be complaining about the impact on them of increased nursing costs is hypocritical in the least.

In relation to eligibility verification, we are working with the private hospitals to provide 24 hours by seven days electronic eligibility checking. We hope that if the hospitals can conform to the necessary technology, this problem will soon be solved. But that will require hospitals to commit to the necessary technology. I do not believe that it would be appropriate to impose performance indicators in this respect.

Finally, in relation to any sanctions, we believe that the act and the current legislation provide more than adequate sanctions to ensure health funds behave according to the requirements of the parliament, the department and the government. I would add that under portability provisions this parliament introduced quite some years ago, which I had the honour of putting forward, people are able to move from one health fund to another without any penalty, so there is free transfer between funds. Any health fund that does attempt to do

something that is inappropriate in the marketplace faces the possibility of its members moving elsewhere. That is a very real sanction.

But we do note that there are no similar sanctions imposed on private hospitals or other providers who may breach their obligations and cause problems for insured patients. As pointed out in our submission, the Commonwealth has considerable potential power, if it wishes to use it, to deal with those matters because it can issue hospitals with provider numbers and it can issue them conditionally or for a limited time. This sanction should be more widely used, particularly in relation to any activity which may compromise the Ombudsman in the performance of his powers.

I am sorry to have gone on for so long about that, Madam Chair. The allegations made do tend to cast discredit on the health insurance industry. I thank you for your indulgence in allowing us to respond.

**CHAIR**—Thank you. Mr Wallace, do you have anything to add?

**Mr Wallace**—I will add two short points. First of all, Medibank Private strongly supports the thrust of the bill and all the main lines of the content in the bill. You will see from our submission that we raised a number of issues of detail. Generally, both on our own part and in working with AHIA, we are seeking to move them forward. In particular, we support the manner in which the bill provides for the establishment of a set of performance indicators to monitor fund activity. Certainly we accept the need for such indicators. We support the reference in the department of health's submission to working with the industry to develop a reporting format and framework and look forward to moving forward with that in the short-term future.

With respect to enforcement and sanctions, which make up another large part of the bill, again, we support the consolidation and clarification of this quite complex area. There is an amount of detail that needs to be worked through in terms of how that is put in place. Again, we look forward to working with the department of health, in particular, to achieve those outcomes.

**ACTING CHAIR (Senator Heffernan)**—Mr Gale and Miss Middleweek, do you have anything to add?

**Mr Gale**—I have nothing further to add at this stage.

**Miss Middleweek**—I would like to thank the Senate committee for allowing us to speak. MBF, like Medibank Private, welcomes the reforms that have been commenced by this bill. We think that deregulation of the industry will enhance efficiency, which will ultimately benefit members. However, this first stage of the bill does not do a lot in terms of taking down the regulations surrounding private health insurance. We see this occurring in phase 2 of the legislation process, with the changes to reinsurance and prostheses. We would like to see this go even further to allow health funds to develop innovative funding models and to reward preventative behaviour. We think that this will enable health funds to be as efficient as possible, which will ultimately benefit members.

We understand that, in moving towards deregulation, it is necessary to have protections such as those afforded by the monitoring and compliance provisions of the bill. We believe

that it is correct for the minister to develop performance indicators in consultation with the industry. That is in fact what has happened around community rating indicators. We do, however, wish to ensure that there are safeguards around the use of any powers by the minister, so that health funds can act with certainty and know that, when they are operating within the bounds of the act, they are doing the right thing. This will enable funds to be as efficient as possible. MBF also looks forward to close, ongoing consultation with the department on these issues. Thank you.

**Senator ALLISON**—I would like to ask about some of the recommendations made by the Australian Consumers Association. I am not sure whether you have seen their submission. The first of them goes to the question of mandatory reporting. They argue that, rather than being abolished, mandatory reporting should be replaced with an independent process supervised by PHIAC at arms length from political involvement with the minister, with transparent guidelines developed against which proposed rule changes are evaluated. In your view, is this a reasonable recommendation? Can you advise the committee how you regard the government's proposals with regard to mandatory reporting?

**Mr Schneider**—I do not recall the precise proposals made by the Consumers Association. The point we would make would be that there is already considerable mandatory reporting imposed on health funds. We should remember that the whole purpose of this legislation is to try to reduce the cost pressures on health funds that are involved in mandatory reporting. That imposes costs on the agency to which the reports are made, because it has to employ staff to consider the mandatory reports; otherwise there is no point in making them. It means that 42 health funds would be subject to the cost of that reporting as well. So, in our view, the controls that the department and minister have under the current legislation preclude the need for any form of mandatory reporting as such.

Indeed, the department has very extensive powers to seek information. It is looking at requiring funds to report to it in relation to any breach of community rating. The idea of mandatory reporting of rule changes seems somewhat inappropriate in the current environment. After all, it is supposed to lead to lower costs to consumers rather than higher costs.

**Senator ALLISON**—Could you clarify for my assistance the current regime with regard to reporting. Is this bill not making any changes to it?

**Mr Schneider**—As I understand it—and I hope we are not talking at cross-purposes, but I do not believe we are—at the moment a health fund must submit a rule change 60 days in advance of the rule change being agreed to. During that time, it is looked at by the department, discussed with the fund and, ultimately, approved or disapproved. That involves considerable cost to both the fund and the department. My understanding is that the proposals in the legislation would remove the requirement for that and replace it with a system by which the department and its officers maintain constant vigilance of health fund marketplace activities. The funds would report to them on various what might be termed performance indicators in relation to community rating so that the department itself can maintain an oversight of whether the policy objectives behind community rating are being breached or not. We think that that provides more than adequate safeguards, particularly when combined

with very extensive powers for the minister and his or her delegates to ensure that there is no misbehaviour or inappropriate action on the part of health funds.

**Miss Middleweek**—Under the current system, we do a lot of financial reporting to PHIAC. Three of the key regulators that we deal with—PHIO, PHIAC and the department of health—all have copies of our rules. Even in the new system, we will still have to notify what our rules are to the department. This will be done through a new system that the department is putting in place, an electronic by-laws processing system. So the only thing that the bill changes in terms of diminishing our obligations to report is that we do not have to give 60 days notice because the department does not go through an approval process. But they still have full access to our rules. In fact, with community rating indicators and the state of the health funds report that will be produced annually by PHIO, I would say that on balance this bill will increase the amount of reporting that health funds currently do.

**Senator ALLISON**—Typically, what sort of time do you need for rule changes? Is it unlikely that there would be 60 days between you making a decision about a rule or wishing to change a rule and having to implement it? I am a bit unclear about why it is such an onerous matter.

**Mr Schneider**—Let us look at it in terms of products, for example. A health fund may develop a new benefit proposal for its members, which it would currently have to submit to the department 60 days in advance of approval. It does not know at that stage whether it is going to be approved or not. It may have spent three months, six months or nine months investment in developing that. It then has to wait another two months to find out whether or not it can put it into the marketplace.

The market may have changed quite significantly in that time, so it makes it difficult for funds to respond quickly. It also means that any other fund that may wish to introduce similar products is put to a significant disadvantage by having to wait for that period. Its members may be denied access to that product unless they move to another fund. So in terms of the consumer interest, there is an argument to shorten the period, quite apart from the cost involved.

**Miss Middleweek**—I concur with everything that Russell said on that and add that health funds are mindful of their obligations to give notice to consumers in the event that rule changes might not be viewed as favourable. It can only be in consumers' best interests, if it is a rule change that might be beneficial to members, that there should not be any extra waiting time, as has just been pointed out by Russell.

**Senator ALLISON**—The Medibank Private submission contains a number of points of clarification and concern about the bill, which you did mention in your opening statement. I invite you to tell us what you think is the most significant issue. In particular, I want to ask about your comment that you are concerned about the ramifications of the process, investigatory powers and sanctions set down in the bill.

**Mr Wallace**—In terms of the process, we do refer to a desire to be dialoguing with the department of health. That process did commence after the minister made her first announcements on these changes, and we are progressing. Prior to Christmas, there was a series of major changes in the department in terms of structure and organisation. Through that

time and then into January, the discussions that had started to occur ceased for what turned out to be quite a critical period, knowing how this legislation had to go forward. So from the point of view of how we are going forward now, those discussions have resumed and will continue on at a further pace.

In terms of the enforcement and sanctions side of things, we recognise that a series of enforcement arrangements were in place which were loosely set out in the current bill. They need to be brought together in one place. It is the case that there is a process clearly specified, starting with the minister making an inquiry of a fund, progressing potentially to investigation, and a number of sanctions that can be commenced either at that point or further down the line after the investigation process. These do open up a number of sanctions to the minister. We feel that that range of sanctions, in terms of the points at which they can be actioned, are exposing us to a lack of clarity in terms of what action might be taken at which point. That is what we are very keen to resolve and clearly understand.

**Senator ALLISON**—You expect that to be resolved in the current talks with the government; is that what you are saying?

**Mr Wallace**—In terms of talks with the department, we have taken the approach of moving in that direction. Because of the stage that the bill has reached, we appreciate that that is a complex procedure, but that is how we would like to go forward.

**Senator ALLISON**—Rather than work through all of your points of concern, would you like to indicate to the committee which are still of concern and which are not.

**Mr Wallace**—The clarification of the sanctions is a point of concern. The one other area that I would raise is the one I mentioned in my introduction—performance indicators. Again, we have had a range of discussions. The department has signalled a desire to move forward in terms of finalising that framework. We appreciate that performance indicators are being talked about in a number of forums within private health that have an impact on us. We are keen to work with other stakeholders to ensure that the right indicators are put in place at the end of the day and that they are the indicators that in fact measure the outcomes that we are seeking to measure through this process.

**Senator ALLISON**—Do you think these performance indicators should be settled before the legislation is dealt with?

**Mr Wallace**—We think the actual content of those indicators needs to be settled in the way that is proposed. They need to be settled through regulation so that they are not dependent on the finalisation of the legislation itself.

**Senator ALLISON**—Do you have any comments to make about the administrative sanctions that have been introduced? A suggestion in one submission was that there was very little by way of discussion about those sanctions.

**Mr Schneider**—Like any industry, we would prefer that there be no sanctions for any activity at all. That is a practical fact that applies to all business. On the other hand, the health insurance industry does accept the reality that health insurance is a matter of particular significance to the Australian community and that in their interests there must be a level of regulation which must be supported by sanctions of one form or another. While there is

naturally a feeling of discomfort about the possibility of sanctions involving substantial financial penalties on individuals, the reality is that the industry accepts them as being a necessary concomitant of the function they play.

I think it would be very rare for any person to appear before this committee from any organisation and say that they welcomed the imposition of sanctions. The practical reality is that I do not believe any health fund will ever be subject to the sanctions because I do not believe anyone would perform in a way that justified their imposition. But to say that anyone openly volunteers for sanctions to be imposed on them I think is stretching human nature a bit far. But we accept the sanctions without comment and qualification.

**Senator ALLISON**—Miss Middleweek, you indicated that appropriate safeguards should be put in place to ensure that due process is followed at all times. Are you satisfied that due process will be followed?

**Miss Middleweek**—Not on the current wording of the act. There is a very good dialogue with the current department of health. It may go some way towards any practical implementation of the provisions. But on the face of the act there needs to be safeguards. Going back to your consultation point, I think part of the reason this has happened, that we have more concerns at this point about some of these sanctions, is that we did not have detailed discussions. I think that was due partly to departmental restructuring and partly to Canberra being terribly affected by fires at the time this legislation was coming through.

What we would like to see in the legislation—I think it could be quite easily altered to reflect this—are powers to act when the act has been breached. The purpose of the performance indicators is to highlight to the minister if there are concerns that the act has been breached. Once that has occurred, we agree that there is a need, especially when we are moving more to a self-regulatory framework, which health funds welcome, to know what our obligations are to comply with. So the safeguard would be that the minister needs to be satisfied that there is a breach of the act. I think the sanctions need to be proportionate to the breach. In the event that strong sanctions are put in place, health funds should be able to have time to have discussion and to remedy that sanction. It is a matter of having a process if you have done something wrong, so that you have a chance to remedy it. I think health funds need to have breached the act for the very onerous sanctions to be put in place. We understand the need for them.

**Senator DENMAN**—What alternatives would you suggest to the minister, then, in investigating breaches to the act? Do you have any suggestions?

**Miss Middleweek**—We are quite comfortable that the minister should have the power to investigate breaches of the act.

**Senator DENMAN**—I know that. But have you got any other alternative suggestions as well?

**Miss Middleweek**—No. I think that the act sets out a wide amount of things that the minister can do.

**Mr Schneider**—Another point that is always important in these matters is to ensure that the act does provide appropriate appeals provisions so that due process may not only be done

but be seen to be done and that there is a feeling of comfort that if action is taken capriciously or inappropriately, the organisation alleged to have transgressed does have a capacity to appeal through the appropriate court mechanisms. My understanding of the legislation is that there are those provisions there. It would comfort us, I believe, if we could receive some assurances, perhaps from later evidence, that those provisions are in existence in the draft bill.

**Senator HUMPHRIES**—In paragraph 12 of your submission, you argue for the withdrawal of the amendment to section 66 of the National Health Act, the argument being that the outlawing of discrimination based on place of residence would prevent the funds from providing different benefits regimes—I assume you are saying this—in different states. Does this happen already on a wide scale?

**Mr Schneider**—In fact there is a difference in contribution rates by state which is brought about by the demographic factors in the state or, very largely in fact, different mixes of public and private hospital provision. So in a state where there may be a larger number of private hospitals than another, the cost structure of that state is quite different. Probably the shining example, from memory, is South Australia, where there is a very large number of private hospitals. That means that the price per member in South Australia is much higher than it is in other states. The purpose of doing these things by states is at this stage because of those differences. We are saying that, rather than imposing an absolute requirement in the bill, that provision would probably be better left for discussion between the industry and the department because it could have quite significant ramifications, depending on how it was applied. It would not be appropriate, I do not believe, for it to automatically result in people in one state paying higher premiums than those in another state unless the other things were taken into account. On the face of it, the legislation could allow that to happen.

**Senator HUMPHRIES**—The regimes within states are all consistent, I assume. You don’t have different rules for different parts of a state?

**Mr Schneider**—Within states the rates are identical. It does not matter whether you live in Sydney or Broken Hill; you pay the same rate. It could be Perth or Albany or whatever it might be; within a state the rates are the same.

**Senator HUMPHRIES**—I have a question for Medibank Private. On page 2 of your submission you say that you are concerned about the regulatory burden being lifted because of a higher PHIO levy. You say that this is at odds with everything positive about the regulatory changes under discussion. Isn’t it the case at the moment that the total collected from the levy is under $1 million across the whole country and that the amount this represents to the funds in terms of their income is about 0.2 per cent of the total funds’ income? If you doubled that amount, it would still be a very small burden in terms of the individual members of your funds.

**Mr Wallace**—I accept your figures and, I guess, the mathematics of what you are explaining. You might be aware of the continuing cost pressure that health funds are under to, as well as seeking efficiency, make sure that any premium increases are minimised. An individual extra cost like that will make the sort of difference you have mentioned. With respect to paying expenses generally, we are conscious that they should be kept to a

minimum. The PHIO expense is of the order that you have mentioned, but we remain sensitive to increases in it or in other such fees.

**Senator HUMPHRIES**—But you are arguing that that very minimal additional cost, even if it were doubled, for argument's sake, would not be worth the benefit?

**Mr Wallace**—That in itself would not lead to a need for a premium increase. We are also concerned that our internal costs, if there are further reporting requirements and system changes, would also be impacted. I think it would be fair to say that, in our case, we would be more concerned with that in terms of total dollars than in terms of the dollars on the PHIO levy. But we are very conscious of that all the same.

**CHAIR**—There being no further questions, I thank Miss Middleweek and gentlemen for their attendance this afternoon. Thank you very much.

[4.15 p.m.]

**GODDARD, Mr Martyn, Senior Health Policy Officer, Australian Consumers Association**

**MIHM, Ms Uta, Content Producer, *Choice*, Australian Consumers Association**

**CHAIR**—I welcome the witnesses representing the Australian Consumers Association, who are giving evidence via a teleconference. I remind you as witnesses that the evidence given to the committee is protected by parliamentary privilege. However, the giving of any false or misleading evidence may constitute a contempt of the Senate. The committee has before it your submission. Do you want to make any alterations to that submission?

**Mr Goddard**—No, thank you.

**CHAIR**—I invite you to make any additional comments that you would like to make. Following that, I will invite honourable senators to ask you questions.

**Mr Goddard**—Thank you. There is no point in going over again the material you already have. That would be a waste of time for everybody. Basically, our central concern as it affects the background to this legislation is that we have some concerns about the declining consumer value in private health products. We have seen good public discussion of one half of that. We have seen a good public discussion of increases in premiums. But the other side of the equation is the changes in conditions, such as increases in excesses, increases in co-payments, items or benefits being taken off or reduced and things like discounts for direct payment being discontinued. We do not have much of a handle on the value of those things to consumers. We do not have as a community an informed discussion about them. So that is part of the background to our concern.

The legislation seeks to remove some of the requirements to justify those sorts of changes, and we think this is of some concern to consumers. On the other hand, we support the strengthening of the powers of the Ombudsman and the potential for the Ombudsman's state of the funds report to provide the community with a rather better understanding of the broader issues surrounding value.

**CHAIR**—Thank you. Senator Allison, do you have any questions?

**Senator ALLISON**—Yes, I do. Could you expand on the point you make in your submission that the notional Lifetime Health Cover birthday would disadvantage stakeholders; presumably, by that you mean consumers . Could you explain what you mean by this?

**Mr Goddard**—It is interesting to look at some modelling work that has been done by Ian McAuley, an economist specialising in public finance economics at Canberra University. Ian based his modelling on a reasonably typical product, which is the premium New South Wales Medibank Smart Choice single new excess. What he looked at was the point in somebody's life, on average, at which they do better out of health cover—in other words, they get more back in the average year than they put in. Unless you are planning to have children, that does not happen. The numbers do not cross until you are 65. That is basically the same for men and women. That is taking into account both the effect of the 30 per cent rebate and Lifetime Health Cover. There are reasons for that when you look at the broad industry. But taken from

the point of view of the individual customer aged, say, 30 or in their late 20s, who would be the people targeted by the marketing campaigns which we could expect to surround the national birthday on each year—

**CHAIR**—Could I interrupt you there, Mr Goddard. Are you on a speakerphone?

**Mr Goddard**—Yes, I am.

**CHAIR**—It is very difficult to hear you.

**Mr Goddard**—Is that better now?

**CHAIR**—That is wonderful.

**Mr Goddard**—I am not on the speakerphone any more. From the point of view of the individual who is aged 28, 29 or 30, looking at those campaigns that we would reasonably expect every year and being convinced that it was a good idea for them to join a fund, on average they would be looking at another 35 years before, from their point of view, it became worthwhile. Now that is an awfully long time. We really have some concerns about the use of this measure to redress the imbalance that is starting to develop in health fund membership between younger healthier people and somewhat older people. As I understand it, the number of people in their 20s and 30s has been declining and the number of people in their late 40s and 50s has actually been increasing, even since Lifetime Health Cover. Our task is to look at this not only from the broad industry point of view—you can see why they would want to get as many younger people in as possible—but also from the point of view of those younger people.

**Senator ALLISON**—I go to your complaint about the changes to mandatory reporting of rule changes. Medibank Private and MBF have just indicated to us that they believe consumers might be disadvantaged if they had to wait 60 days with notice. Can you explain from a consumer’s point of view why you think it is important to hold to the 60 days?

**Mr Goddard**—Again, we have a broad concern with the nature of the contracts that consumers have with health funds. These can be varied unilaterally without the consumer having a say in the matter. At the moment, consumers get maybe a couple of weeks notice every year that their premiums have gone up. There is not much they can do about it apart from trying to seek another provider or dropping out of health cover altogether. Therefore, we think that the least the industry can do is to give people a bit of decent notice so that if they want to find another provider, they have a bit of time to do so. Uta would like to add to that.

**Ms Mihm**—We have anecdotal evidence from consumers who have come to us. The health funds have sent them letters giving them less than a few weeks notice. The letters were received in the middle of March and the premiums went up by 1 April. The premiums went up 17 per cent. For example, for one couple that contacted us, their premium was $39 a fortnight. From 1 April, it was $50 a fortnight. They had been members of that fund for 13 years and they were happy with the product. But obviously when their premiums rose by so much, they wanted to change. They then tried to find out about that product and to compare it with other products, to review their product and to change over to a different product. They found it was absolutely impossible for them to do that in that short period of time.

**CHAIR**—You are talking about premiums having risen sharply since large numbers of new members have joined insurance. Since Lifetime Health Cover was introduced, premiums have risen by an average of less than four per cent. That is much less than for the previous period under this government, when premiums rose by about six per cent, and it is much less than during the last years of the previous government, when there was an average 7.6 per cent increase. What did you have in mind in your submission when you were referring to the sharp increases?

**Mr Goddard**—I was speaking of what has perhaps happened in the past two years. In the three years since the new measures have been in and people went through the waiting periods, there was stability for that 12 months . Since then, we have had average increases of around six and then 7.4 per cent. Our belief—I hope we are proved wrong—is that because the industry has so little control over the structure of its own costs, particularly over costs within private hospitals, there is no reason to believe that that trend will not continue.

**CHAIR**—I accept that it has gone up more in the last couple of years. But let's face it: we also have a situation where the premiums after the 30 per cent rebate are now at about the same level that they were in 1996. I am not sure what you are saying to me, but would the ACA like to see premiums rise by 42 per cent if the 30 per cent rebate was removed? How would that benefit the nine million consumers that have health insurance?

**Mr Goddard**—This is a more complicated question than the brief in front of us at the moment. The bill is not proposing to remove the 30 per cent rebate. The ACA has a position on that. It is a considered position. If you wish, I can go into that. However, I would suggest that it is not related to the bill that is before us.

**CHAIR**—Quite frankly, I think there is much in the submissions before us that is not particularly related to the terms of reference. That is why we are trying to keep it on track.

**Senator ALLISON**—I would like to follow up on your complaint about PHIAC's public reporting of premium changes, which you say should be greatly improved. You also point out that the reasons given to you as to why it was not possible for more detailed reporting related to the number of funds and the number of products et cetera, but that the ACA itself is able to annually review most of these products. If the ACA is able to do this, why do you feel it is necessary for PHIAC to do it? What problems does the ACA have in compiling this information, if any?

**Mr Goddard**—I will answer that broadly and then pass over to Uta, who is actually the person who does that job. First of all, it takes one person doing it some weeks to do that after the announcement and after 1 April, when people actually have to start paying. It would be much more satisfactory from the consumer's point of view if much more detail was available to the consumer so that they can make their choices at that point. The ACA is happy to do that job, but we feel that the realities of resourcing mean that we are much less equipped to do it than the advisory council is.

We agree with the criticisms that have been made by a number of people, including the ACCC, that the simple weighted average figure, the one weighted average figure, is misleading because almost no funds go up by that amount. Most of them are either less or more. We need to see something of that range. The more information they can give us, other

than one bald figure, the better. But it would be ideal if, at the time they are doing their assessments, they could get that sort of list together. If we had a reasonable waiting period of 30 to 60 days between the time of the announcement and notification to consumers and the actual introduction of new conditions, and if during that period people had the information, they could make some much better choices.

**Ms Mihm**—I will expand on that. At the moment, we have a rather large number of people phoning us and being really desperate to get that information that we are compiling at the moment. But as the announcement was only made on 17 March , we only received information from the funds on that date. As it is a very complicated job to analyse all of that complicated information, we are not able to publish that before 1 April. At that point, people really want to have that information to be able to review their policies and to make a choice as to whether they want to keep that policy or change over to a different product.

**Senator HUMPHRIES**—I am always interested in what *Choice* does in the way of reviewing issues like this, including health fund providers. I note that in a recent edition of the magazine you recommended to readers that they go to Goldfields Medical Fund and the Independent Order of Rechabites. Can you tell me how these funds have fared in recent years?

**Ms Mihm**—Those funds have gone into administration. I understand where your question comes from, but we do not have the capacity to review funds' records or papers and to review their financial situation. That is not our standing. We are just looking at their products and whether they actually offer good products or good prices. If they do that, we recommend them. If the product is actually not financially viable, we cannot do anything about that, unfortunately.

**Senator HUMPHRIES**—So that is an argument for a higher level of overview by bodies like the ones outlined in the legislation, presumably?

**Mr Goddard**—It is certainly an issue of prudential requirement. Certainly normal, reasonable prudential requirements are in the interests of consumers.

**CHAIR**—Doesn't it illustrate that there is a potential pitfall for the ACA to be offering such clear-cut, black and white recommendations to people with a lot of fanfare attached that can have ultimate downfalls? The Goldfields and the Rechabites are two classic examples where people could have easily relied on your advice as opposed to relying on more official advice, but that advice gets less coverage because they do not make such a song and dance about it.

**Mr Goddard**—What official advice, Senator? If any officials had serious doubts about the financial capability of a fund to meet its requirements and commitments and they did not say anything, they did not move to change that situation, if they did not move to warn consumers, then are they doing their job? The ACA is not a regulator.

**CHAIR**—That is exactly right. I think the point that Senator Humphries and I are trying to make is that the recommendation that the ACA made about GMF and Rechabites was taken by a lot of people. Both funds failed. I just think that there are certain areas that the ACA might be involved in that are not necessarily helpful to the situation. You also mention in your submission that public hospital waiting lists have not benefited from government policy on

private health insurance. You say that the decrease in public hospital admissions is not a vindication of the policy on private health. However, under this government, total growth in public hospital admissions has been around six per cent. Under the previous government it was 22 per cent. So how can you say to the public that public hospital waiting lists have not benefited when the figure under the previous government was 22 per cent?

**Mr Goddard**—I am simply not going to get into a political argument on one side or the other, I am afraid. We have, as I said, a considered position on what we regard as the best way of using the health money that is going into the rebate. It is our position as an organisation that it is not being used in the most efficient way at the moment. Again, we are not arguing for that change in the context of this submission or this bill.

We accept and say constantly that any move away from the 30 per cent rebate is going to be complex and would have to be handled intelligently; otherwise consumers could suffer. Clearly that is the case. However, as I said before, we can discuss this and we would be here all night. I am happy to discuss it, but it is really not part of what we were called in here to talk about.

**CHAIR**—I happen to be referring to page 9 of your submission, in which you say that public hospital waiting lists have not benefited. For an organisation that gets as much coverage and airplay as the ACA does, for you to be able to say in your public submission to this committee that public hospital waiting lists have not benefited when in fact it is quite the reverse reflects a lack of responsibility for the information that is being fed to the public.

**Mr Goddard**—What I actually say is that public hospital waiting lists have not benefited as the government promised. I draw simply on the work that we are well aware of, particularly from Professor Deeble, analysing that. I am aware that that is a controversial point and is always going to be controversial. It is a political point. But that is our position.

**CHAIR**—But it is not just a political point, Mr Goddard. I am trying to say to you that it is a factual point that I think is a very difficult one for people to be able to understand if on the one hand they are being told something by ACA but on the other hand quite the opposite is true.

**Mr Goddard**—I disagree with you, Senator.

**CHAIR**—So you do not think the ACA has a responsibility to reflect the truth of the situation? You are quite happy to have ACA going out and saying that public hospitals have not benefited by the number of people being taken off the public hospital waiting lists and put into private hospitals?

**Mr Goddard**—If you wish, we can talk about this. We are not going to agree. We are drawing on work done by some pretty good health economists which leads us to these conclusions. We believe that those conclusions are justified. We believe that our statements on this matter have been justified.

**Senator HUMPHRIES**—You mentioned Professor Deeble's work. You refer on page 5 to his comments about the effect on public hospital waiting lists. You make the point that public hospital waiting lists are almost entirely unaffected by the changes in private health insurance. I might say there is some justification for that comment. But isn't it also the case that

separations in private hospitals during the period since these changes have been quite significantly larger? In the past two years, there have been more than 450,000 additional separations in private hospitals in a range of quite complicated fields. Doesn't this indicate that really there is a very large amount of activity going on in private hospitals which we cannot afford as a community to have transferred into the public hospital system because it would not be able to cope?

**Mr Goddard**—We have been making the point quite consistently, and I have made it personally many times, that our argument against this means of funding health is not an argument against private hospitals. It is certainly an argument in favour of getting better cost control and better value for money out of private hospitals, but that is something which the minister herself is recognising with the move towards justifying cost effectiveness, for instance, in prostheses. Our point is that there is reasonable evidence to believe that looking at a more direct funding from the health system of facilities in private hospitals might be a more effective way of going about it. Quite clearly, the community, the health system and the government cannot afford to ignore the immense capital investment in the very large and often very good facilities in the private hospital system.

**Senator HUMPHRIES**—Can you properly get the level of throughput we are seeing today through those private hospitals if you do not have the sort of incentives for people to use them that we have created with devices like the 30 per cent rebate and other measures to encourage the use of private health insurance?

**Mr Goddard**—Again, we are arguing about the broader issues, about the merits or demerits of the government's broad policies on private health.

**Senator HUMPHRIES**—With respect, I think what we are doing—

**Mr Goddard**—It is a matter of funding. Our point is that we believe there are reasonable arguments to say that we should be exploring other and more efficient ways of funding the purchase of facilities from private hospitals. We do not have a developed model on that. We are suggesting that we should be looking at that as a community as an alternative.

**Senator HUMPHRIES**—I suppose I was making the point that you have made some assertions in your submission which, with respect, I do not think are backed up by the facts available on the public record. Perhaps at some other stage you might like to outline what those alternative means of purchasing services from private hospitals are. I do not think you go into that in your submission, do you?

**Mr Goddard**—No.

**CHAIR**—Thank you very much, Mr Goddard and Ms Mihm. We do not have any further questions for you. We thank you for your time.

**Mr Goddard**—Thank you very much.

[4.46 p.m.]

**POWLAY, Mr John Frederick, Private Health Insurance Ombudsman**

**CHAIR**—Welcome, Mr Powlay. I remind you about the privilege side of things, the possibility of contempt and all of those things. We have before us your submission. If you would like to make any further comments, we would be pleased to hear them. We will then ask you a few questions.

**Mr Powlay**—I will make some brief comments. I am conscious of your warnings earlier, Chair, about sticking to the terms of reference. I guess the most relevant aspects of what is covered in my submission regarding the terms of reference are my comments relating to changes in the arrangements for the approval of fund rule changes. I would have to say—and I did not say this specifically in my submission—that I share some of the concerns indicated by the Australian Consumers Association about the nature of some of the changes we have seen to health insurance products, particularly the introduction of excesses, co-payments, restrictions on certain types of treatment, exclusions of certain types of treatment and the tendency to introduce these into products where they were not previously and with a very small amount of notice.

In my view, these sorts of conditions within health insurance products adds significantly to the complexity of health insurance products. They are very difficult for consumers to understand. We find that very many of them in fact have not grasped what they have meant until the time comes when they feel their impact. Having said that, though, I recognise that there is inevitably a trade-off for the funds between considering these types of measures and further increasing the premium costs. In the end, funds can only operate on two sides of the equation—the benefits and the contributions. My most serious concern relates to the notification that consumers have of these changes. As Mr Schneider mentioned, consumers now do have significant rights to transfer between funds. In a private sector market situation, I guess the ultimate right of the consumer is to take their business elsewhere. If they do not receive adequate notice of some of these things, as pointed out by the Australian Consumers Association, their chances of taking their business elsewhere are effectively reduced.

On that issue of notification, I have indicated in my submission—and I am still of the view—that I prefer to pursue an approach of self-regulation with the funds on that issue rather than legislation. This legislation does not impose any additional requirements in that regard. On that point, I have received good feedback on proposals that I have put to the funds from both AHIA and the other main health fund organisations. So it does give me some confidence. My view is that a better result can be achieved for consumers through self-regulation rather than picking on some arbitrary period of notification to include in the legislation.

Finally, a little away from the terms of reference, this is a significant piece of legislation for the role of the Private Health Insurance Ombudsman. It sets out for the first time some specific authority and requirements relating to the Ombudsman's ability to obtain information and documents. It also prescribes a new additional function for the Private Health Insurance Ombudsman, the production of the state of the health funds report. It is important that these changes are being made at a time when there is less direct oversight of some of the health funds' activities. In my view, the changes in the provisions that support the operation of the

Private Health Insurance Ombudsman will bring my office into line with provisions that support government appointed ombudsmen elsewhere throughout Australia.

**CHAIR**—Thank you, Mr Powlay.

**Senator ALLISON**—I return to the notification process. You acknowledge that consumers will be somewhat disadvantaged if it comes to making a choice between funds. Would you go so far as saying that the 60-day notice should be in place? Do you suggest that as a way of dealing with this problem?

**Mr Powlay**—The 60 days at the moment applies to the period of notice that the funds are required to give the department. Certainly for some changes I would like to see the funds effectively use that 60 days to advise their contributors particularly of detrimental changes rather than use the time to advise the department.

**Senator ALLISON**—So at present there is no requirement for the funds to notify their members at all?

**Mr Powlay**—This bill does not change anything in terms of the formal requirements on funds to notify contributors of changes. There is a slight wording change in that provision, but it is still basically the same. The effect is that funds have to do their best to notify contributors before the change takes effect, which is a fairly minimal requirement.

**Senator ALLISON**—Would it make your job easier if it were more stringent?

**Mr Powlay**—I do not think so. As I said, certainly at this stage I would prefer to work with the funds on a self-regulation basis in terms of notification for contributors. My concern is that if we did put a mandatory period within the legislation, the period of notification that is required or appropriate depends on the nature of the change. There are some fund rule changes that are very minor and do not affect many fund members or are unlikely to affect them immediately. I would have no difficulty with funds advising members of those changes just before they occur. Similarly, with changes that are to the advantage of contributors, I have no difficulty with funds only telling them the day before if it is an increase in benefits or something of that nature.

When you get to significant changes to benefits, to excesses, as I said in some of those cases, I would like to see 60 days notice. Other minor changes in benefits may require 30 days. Whatever period you insert in the legislation, my experience is that if you put a requirement for, say, 30 days in the legislation, the funds will give 30 days, but they will not give any more in cases where it is appropriate to do so. So I would prefer to work on a more flexible basis at the moment and attempt to achieve the best result for consumers through self-regulation.

**Senator ALLISON**—What percentage of the complaints made to your office are related to notice about rule changes?

**Mr Powlay**—I am sorry, but I do not have that here. It is a relatively small percentage. It would be somewhere between five and 10 per cent. But it has been a growing area of complaint over recent years, even with the previous 60-day requirement in place.

**Senator ALLISON**—The ACA suggests that as well as increasing your powers there should be a higher level of resourcing available to you. How did you score in the budget? How will you deal with this extra workload?

**Mr Powlay**—I did not receive any additional funding for the office in the last budget. I notice that a couple of the submissions raised the issue of concern about the impact of the levy. I should explain that the funding for the office of the Private Health Insurance Ombudsman as it is now was fixed in the year 2000 at $950,000 per annum. It has remained at exactly that level in each of the three years since. It is not subject to any indexation. Obviously, my costs have not stayed static over that period of three years. Regardless of this bill, at some stage I would be looking for increased funding.

I do not believe any of the changes in this bill in relation to my powers should have any significant effect on the requirement of funding, but I do consider that the new function of the state of the health funds report will require, if it is to be done properly, some additional resourcing. So I will be going to the minister at some stage in the near future to talk about prospects for additional funding. That will inevitably mean an increase in the levy, which currently stands at about 3c per single health fund contributor and 6c per family. I would not envisage it going to any more than 4c or 5c per contributor.

**Senator ALLISON**—We could pursue this in estimates, but what does that levy raise on an annual basis?

**Mr Powlay**—The levy raises $950,000 on an annual basis at present.

**Senator ALLISON**—I have no further questions.

**Senator DENMAN**—At point 10 of your submission, you state that you are concerned about the ministerial authority to conduct investigations. In what way is it inadequate currently?

**Mr Powlay**—I cannot recall exactly what I said in my submission. I did not intend to indicate inadequacy in terms of the ministerial power to conduct investigations. My understanding of the situation now would be that there would be nothing to prevent the minister from conducting an investigation into a health fund. There just would not be anything specific in the legislation authorising how she would go about it. My concern was more about the inadequacy of the sanctions available to the minister. It was basically an all-or-nothing situation. If the minister found a health fund to be in breach of the act, basically under the existing arrangements she has two options. One is to deregister the fund. The other is to impose an additional condition on the fund, which in effect is the same thing. If the fund does not meet that condition, her only fall-back is to deregister the fund. So you had this, if you like, huge stick for whatever the breach was. In my view, what the bill puts in place is an appropriate range of sanctions that the minister can look to that may better match the particular situation than deregistration and with less disruption to the health fund members.

**Senator DENMAN**—Thank you.

**CHAIR**—Thank you very much, Mr Powlay, for your time.

[5.00 p.m.]

**MACKEY, Mr Paul, Director, Policy and Research, Australian Private Hospitals Association**

**ROFF, Mr Michael, Executive Director, Australian Private Hospitals Association**

**CHAIR**—I welcome representatives of the Australian Private Hospitals Association. As usual, I remind witnesses that the giving of evidence is protected by parliamentary privilege. However, the giving of any false or misleading evidence may constitute a contempt of the Senate. We have before us your submission. Do you wish to make any alterations to it?

**Mr Roff**—No.

**CHAIR**—Do you wish to make any comments?

**Mr Roff**—Yes, please. On behalf of the APHA, I would like to thank the committee for the invitation to appear today. As you are aware, we are the peak national body representing Australia's private hospitals. We have a very diverse membership, including large and small hospitals and day surgeries covering both the for-profit and not-for-profit sector groups and independents and hospitals located in metropolitan, rural and regional areas. We strongly support reforms to private health insurance adopted in recent years via the Commonwealth government, including the 30 per cent rebate and Lifetime Health Cover. We believe these measures have assisted in restoring balance to the Australian health care system and have empowered consumers by enhancing choice with regard to hospital services.

For the record, Australia's private hospitals provide a wide range of procedures for a very diverse cross-section of the community. By way of example, almost 20 per cent of patients treated in private hospitals are aged 75 and over. That is higher than the proportion in public hospitals. Private hospitals also now perform the majority of all surgery in Australia, providing, for example, 50 per cent of chemotherapy procedures, 50 per cent of major procedures for malignant breast conditions, 60 per cent of same-day mental health treatment and 75 per cent of knee procedures. In 2000-01, private hospitals treated 2.2 million patients.

As we mentioned in our submission, despite the fact that health funds received premium increases averaging 6.9 per cent in 2002 and 7.4 per cent this year, private hospital organisations are experiencing great difficulty in obtaining viable benefit flow-throughs from health funds through hospital purchaser-provider negotiations. Once again, as we have mentioned, hospital operators are now reporting offers from health funds for benefit payments in 2003 in the range of minus 10 to plus two per cent. That plus two per cent is definitely the upper range. These levels of changes are clearly not sustainable, particularly when private hospitals are faced with increasing non-discretionary costs far in excess of the CPI, including nursing wage increases and professional indemnity insurance.

With these points in mind, we were very concerned to learn last month via a media release that the government intends to abolish a vital protection for private hospitals in the second-tier default benefit. We understand that this is to be achieved via regulation. The proposal to abolish the second-tier benefit is an excellent example of why we have argued in this submission that this bill provides too much ministerial discretion. Major changes that impact significantly on particular elements of the health care system should be subject to the full

scrutiny of the parliament and should require the minister and her department to clearly set out a case for change rather than quietly dealing with the matter via a change to the regulation.

I will turn now to our submission on the bill. APHA and our members have a central stake in reforms to private health insurance. We are concerned that any reforms work to the benefit of all stakeholders, including hospitals and their patients. In this regard, we have argued that the bill proposes to give the Minister for Health and Ageing too much discretion, particularly with regard to performance indicators for health insurance funds. While we do not support unnecessary regulation, we do believe it is important that the parliament has the opportunity to scrutinise fully any performance indicators that may be developed as well as a regime of sanctions to enforce compliance. In fact, it is a weakness of the current regulatory arrangements that an effective regime of sanctions is not in place.

APHA is not implying that this or any future minister would not act in the best interests of all stakeholders if permitted the discretion envisaged by the bill. However, scrutiny by the parliament is a key feature of our democracy and, in APHA's view, should generally be preferred over ministerial discretion on issues of significance such as these.

We believe the proposals contained in this bill are tantamount to the parliament resolving that crimes should be punished but then leaving it up to the relevant minister to determine what constitutes a crime. Accordingly, we are concerned to ensure that appropriate performance indicators are explicitly within the National Health Act rather than established by ministerial discretion. We are aware of many instances of health insurance funds flaunting their existing conditions of registration and, therefore, we are not confident of any change in this situation unless the performance measures are explicitly included in the act, together with a regime of appropriate sanctions.

This situation partly occurs because a range of conditions of registrations have been promulgated by way of ministerial determination. Despite repeated requests to the Department of Health and Ageing, APHA has been unable to obtain a consolidated list of these conditions. If a major industry stakeholder is unable to access a list of all the conditions of registration for health funds, this raises serious questions about whether the parliament, or anyone for that matter, can be confident that funds are actually complying with the conditions of registration.

In our submission, we propose a range of performance indicators that could be included in the act. These cover crucial areas of health fund operation, including service quality and accreditation, benefit benchmarks, consultation with stakeholders and eligibility verification. The bill proposes the removal of the capacity to offer the 30 per cent rebate as a direct discount as a sanction that may be imposed on health funds breaching their community rating obligations. We argue this sanction should be widened to encompass any condition of registration breached by a health fund. We also propose an additional sanction whereby the government would ban a health fund from accepting new members for a specified period of time in cases where the fund had breached any of its conditions of registration.

The regulation of private health insurance is a vital responsibility of the Commonwealth government. APHA believes that the private health insurance industry has shown itself unable

to meet the high levels of self-discipline that are essential for the protection of its nine million contributors in a less regulated environment. APHA therefore does not support the wide discretion accorded to the minister for health by this bill. We call on the committee to recommend to the Senate that specific and binding performance indicators, together with accompanying sanctions, be established explicitly in the National Health Act to ensure the appropriate and enforceable monitoring of health insurance funds.

Finally, I note that Mr Schneider devoted much of his opening statement to providing a critique on APHA's submission. While I do not intend to take up the committee's time this afternoon by responding to that, I would be happy to review the *Hansard* and provide written comments at a later date. I do note, however, that one proposal from APHA that Mr Schneider did not specifically comment on relates to service quality and accreditation. Therefore, I assume the health insurance industry agrees it should be subject to independent quality accreditation. Once again, thank you for the opportunity to appear.

**CHAIR**—Thank you, Mr Roff. Mr Mackey?

**Mr Mackey**—I have nothing further to add, thank you.

**Senator ALLISON**—I want to ask you about the recommendation on performance indicators and about registered health benefit organisations providing a facility for private hospitals to verify the eligibility of patients 24 hours a day, seven days a week. What is the current arrangement? How reasonable is that for private health funds to provide?

**Mr Roff**—I think it is a reasonable ask for private health funds. The majority of complaints that relate to hospitals have to do with the inability to obtain eligibility verification, particularly outside business hours. I think Mr Schneider indicated in his evidence that it was something that the health funds were working towards. That is a good thing. The introduction of a performance indicator detailing this as a goal would provide added impetus to achieve that goal.

**Senator ALLISON**—Thank you. They are the only questions I have.

**CHAIR**—Mr Roff, I just make the observation that the performance indicators are, of course, to be imposed by regulation, which are disallowable.

**Mr Roff**—They are disallowable, but there is no opportunity for the parliament to debate and amend them as they see fit.

**CHAIR**—The parliament can in fact look at the regulations. That is the whole part of having disallowable regulations.

**Mr Roff**—Yes. But at the end of the day, if the performance indicators put up are disallowed, then we end up with no performance indicators.

**CHAIR**—We would probably see them in another form, I imagine.

**Mr Roff**—Possibly.

**CHAIR**—Thank you very much, Mr Roff and Mr Mackey.

[5.13 p.m.]

**JOHNSON, Mr Andrew, Senior Legal Adviser, Department of Health and Ageing**

**MASKELL-KNIGHT, Mr Charles Andrew, Principal Adviser, Acute Care Division, Department of Health and Ageing**

**MORAUTA, Dr Louise Helen Margaret, First Assistant Secretary, Acute Care Division, Department of Health and Ageing**

**CHAIR**—I welcome officers of the Department of Health and Ageing. I remind officers, as they have heard me say so many times, about the issue of evidence being protected by privilege and the possibility of any misleading evidence constituting a contempt of the Senate. You will not be required to answer questions on the advice you may have given in the formulation of policy or to express a personal opinion on matters of policy. We have before us your submission. Do you wish to make any alterations or additions to that submission?

**Dr Morauta**—No.

**CHAIR**—Would you like to make any comments?

**Dr Morauta**—Yes. As senators may recall, the Minister for Health and Ageing announced on 2 April 2002 that the federal government would reform the regulation of the private health insurance industry. A review was established to consider if the current rules and regulations delivered the best outcomes for fund members. On 11 September 2002, the minister announced a series of government decisions arising from stage 1 of the review. The amendments to health legislation required to implement a range of these recommendations are set out in the bill presently before this committee.

Before turning to the first term of reference, dealing with the minister's powers, it may be helpful to explain the context in which these powers may be exercised. A key finding of the review was that the current legislative framework for consideration of changes to health fund rules limits the ability of health funds to respond expeditiously to changes in the market, adds a level of uncertainty in health funds' planning processes and risk management, is administratively cumbersome for both the funds and the department, has the potential to stifle innovation in product design and tends to hinder the efficiency of the private health insurance industry.

The government thus decided to amend the rules assessment process to reduce the regulatory burden on funds. However, it decided to ensure that deregulation was counterbalanced by the introduction of measures to ensure health funds comply with their obligations, including a new enforcement and sanctions regime. Previously the powers under the act in relation to monitoring and enforcement did not enable a range of actions proportionate to the issue of concern. The amendments, including those increasing the minister's discretion, will allow timely, flexible and proportional responses to responsible breaches of the act. As is shown in detail in the department's submission, many of the items in the bill relocate existing provisions to provide a cohesive framework that will make the new system more readily understandable to industry. The only new powers provided to the minister are to request a health fund to enter into an enforceable undertaking, the ability to

remove the 30 per cent rebate as a premium reduction and the ability to apply to the Federal Court for an order to address a breach of the National Health Act.

The option to revoke a fund's capacity to claim the 30 per cent rebate is limited to cases where a fund is in breach of the principles of community rating. While this would never be used lightly, the power of revocation is a very important deterrent to health funds. If a health fund were ever to lose its right to offer the 30 per cent rebate as a premium reduction, contributors could still access the rebate either by receiving a direct payment through their local Medicare office or by claiming it back via their tax return. Health fund members can also vote with their feet and join another health fund without any loss of rights.

Turning to the second term of reference, the bill proposes amendments to Lifetime Health Cover. When Lifetime Health Cover was introduced on 1 July 2000, the government conducted an advertising campaign to ensure that Australians were advised of the changed regime. It believed it was important for people to understand the change and make an informed decision whether or not to join private health insurance without facing increased premiums. The government is now concerned that people approaching 31 years of age may not be aware of or may forget about Lifetime Health Cover. They may not be aware of the benefits of making a decision on whether to take out private health insurance at that time. Therefore, the bill introduces a fixed annual date, a horse's birthday, for the purposes of Lifetime Health Cover. This will enable health funds to concentrate advertising endeavours to inform people about the potential impact of Lifetime Health Cover and should assist in recruiting members of each annual cohort of 30-year-olds to private health insurance. This will help maintain a balanced age profile across the membership and contribute to the ongoing viability of the sector.

Other amendments proposed in the bill address minor anomalies that only became apparent after the introduction and implementation of Lifetime Health Cover. These anomalies primarily relate to the grace period allowed by Lifetime Health Cover for veterans, new migrants and Australians living overseas. The government does not expect that there will be any immediate fiscal implications from this amendment as it will probably lead to a concentration of health fund advertising rather than increased advertising and increased health fund costs. In relation to participation rates, the forward estimates for the 30 per cent rebate assume a stable participation rate. The amendments in the bill will assist in maintaining a stable rate by encouraging the recruitment of 30-year-olds to replace older members who die, with no fiscal implications relative to the forward estimates.

Finally, in relation to the third term of reference, I emphasise that the bill does not alter the community rating obligation of funds. It clarifies existing provisions of the act and, as such, is not expected to have any fiscal implications for the funds or the government.

**Senator ALLISON**—A number of suggestions have been made to the committee through submissions that go to performance indicators, with some recommended, I guess, additional performance indicators. Has the department had a chance to look at them? Can it comment?

**Mr Maskell-Knight**—We have read the submissions. I am not sure we are in a position to make any particular comments on them. I believe that some of them are probably, on a fairly cursory glance, not particularly helpful. There was a suggestion that funds should have to pay

55 per cent of benefits to private hospitals. I do not think that is at all a desirable indicator to have. The allocation of benefits across different classes of benefits should be driven by members' claims rather than an arbitrary allocation that so much has to go to a particular sector.

**Senator ALLISON**—What about the question of private health insurance companies providing private hospitals with verification of the eligibility of patients 24 hours a day, seven days a week? What do you think of that?

**Mr Maskell-Knight**—I think that the desirability of that would need to be considered in the light of the need for that. I think the government would need to be convinced that there was a significant issue with people being admitted after hours where their eligibility could not be verified. I am not aware that there is any evidence around about that.

**Senator ALLISON**—So the department hasn't collected any evidence or sought any about it?

**Mr Maskell-Knight**—Well, I am not sure that the evidence exists in the databases at the moment.

**Senator ALLISON**—What about sanctions? A number of submissions have suggested that the sanctions available to the minister are blunt, to say the least, in terms of deregistration. There is a suggestion that perhaps other sanctions might be a ban on accepting new members or a ban on premium discounts. Did you consider them as possible sanctions?

**Mr Maskell-Knight**—We have not considered them. I think the idea of a ban on premium discounts is actually, as I read it, removing eligibility to receive the 30 per cent rebate as a premium reduction. So that is already included in the legislation that is before the committee.

**Mr Johnson**—Deregistration is already something that is available under the National Health Act, so we are not doing anything new in relation to that aspect.

**Senator ALLISON**—I understand that, but a suggestion has been made here today that there ought to be some other options by way of sanctions for the minister.

**Mr Maskell-Knight**—I think the issue is that it is difficult to imagine sanctions on funds which do not ultimately hurt the contributors in some way. For example, removing the funds' right to obtain the 30 per cent rebate as a premium discount would undoubtedly hurt the fund but it would cause a considerable amount of angst to the members.

**Senator ALLISON**—What about the ban on new members?

**Mr Maskell-Knight**—That is a possibility, yes, but it is not one considered by the government at the time. I think the important thing about the new regime is that at the moment, as someone pointed out, under the existing legislation, the sanctions are effectively deregistration, imposing a new condition of registration. The legislation before you seeks to put in some intermediate steps, if you like, requiring the health fund to explain to the minister their behaviour, allowing the minister to require a fund to enter into an enforceable undertaking to change their behaviour in some way. The government believes certainly that it is better to address possible breaches of community rating by requiring funds to change their ways rather than by imposing punitive sanctions on them.

**Senator ALLISON**—Mr Powlay suggested, as did the Consumers Association, that some members of health funds were disadvantaged by not receiving information about changes to rules and changes that might adversely affect them. What is the department's comment on that? How much evidence is there? Do you think funds are not doing as well as they might do in terms of informing members?

**Mr Maskell-Knight**—I think you are starting to get me to speculate. I think Mr Powlay is in the best position to tell you about the level of complaints that he has received about those issues. They would primarily go to him rather than us.

**Senator ALLISON**—You were here. Mr Powlay said—

**Mr Maskell-Knight**—He mentioned five to 10 per cent.

**Senator ALLISON**—There was not a lot, but they were increasing. But the department is not especially concerned about that?

**Mr Maskell-Knight**—I do not know whether it is a matter that we are not particularly concerned about. John is in a much better position to judge how significant those complaints are.

**Senator ALLISON**—He is not in a position to propose legislation to change anything, though.

**Mr Maskell-Knight**—I am sure he could write to the minister and make proposals.

**Senator ALLISON**—Indeed.

**CHAIR**—Thank you very much. I declare the hearing concluded and thank everyone for their attendance.

**Committee adjourned at 5.25 p.m.**