



The proposed sale of Medibank Private: historical, legal and policy perspectives

The privatisation of Medibank Private, Australia’s largest and only national private health insurer, has been discussed frequently since not long after the fund was established by the Fraser government in 1976. The latest debate commenced in April 2006, when the government announced its intention to sell. This Brief considers the historical development of Medibank Private, some legal issues relating to ownership of the fund and some policy arguments for and against the sale.

Luke Buckmaster
Social Policy Section

Jerome Davidson
Law and Bills Digests Section

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Executive summary

In April 2006 the Commonwealth Government announced its intention to sell Medibank Private. The reasons given for the sale include that there is ‘no good public policy reason’ for the government to own a health fund, and that ‘a privately-owned fund would be able to be more efficient’, with the possibility that this may lead to lower premiums for members.

This Research Brief examines the historical development of Medibank Private, and the questions of who ‘owns’ or enjoys other rights in the fund, and whether there are public policy reasons for the government to maintain the current Medibank Private ownership structure.

The main conclusions of the paper are:

- Medibank Private was initially established in 1976 by the Fraser government for a combination of reasons, including bringing greater competition to the private health insurance sector
- while the government clearly ‘owns’ Medibank Private Limited (the managing organisation of the Medibank Private *fund*) the fund itself is best characterised as a government controlled not-for-profit entity (not strictly *owned* by either the Commonwealth or the fund members)
- members of the fund nevertheless have certain rights to the benefit of the fund and associated assets and these rights need to be considered in any scheme for the sale of Medibank Private
- whether or not Medibank Private should, from a policy perspective, be sold depends on answers to a range of questions related to the mode of sale, its likely impact on the private health insurance market and the impact of any future changes to the regulation of private health insurance
- in the absence of further information about the details of the sale, there is little evidence to support assertions that a privatised Medibank Private would be more efficient, competitive and less expensive for consumers. Similarly, there is little evidence that a privatised Medibank Private would be less competitive or less able to contain costs.

1. Introduction

The idea that Medibank Private, Australia's largest and only national private health insurer, should be privatised, has been discussed for years—indeed, probably since not long after the fund commenced operations in October 1976. Debate about the ownership of the fund reached a new phase in March 2006, when the government announced its intention to sell.

According to the Minister for Finance and Administration, Senator Nick Minchin, the decision to sell is based on the view that there is 'no good public policy reason' for the government to own a health fund and that selling will remove the perceived conflict of interest in the government being both the regulator of the industry and owner of the main health fund.¹ He also suggested that, on the basis of the recent scoping study into the sale by Carnegie Wylie, 'a privately-owned fund would be able to be more efficient', with the possibility that this may lead to lower premiums for members.²

The government has nominated the following as its 'objectives' for the sale:

- to contribute to an efficient, competitive and viable private health insurance industry
- to maintain service and quality levels for Medibank Private contributors
- to ensure the sale treats Medibank Private employees in a fair manner
- to minimise any post sale residual risk and liabilities to the Australian government, and
- having regard to the above objectives, to maximise the net proceeds from the sale.³

At the time of publication, while the government had not announced whether the sale will be in the form of a trade sale or a share market float, it has made very clear that it will not be in the form of a demutualisation. According to Senator Minchin, the sale is 'not in any sense of the word a demutualisation ... [t]his is not a mutual health fund in any sense of the word. It is a government-owned business'.⁴ This issue is considered below, under the heading 'ownership of Medibank Private'.

The decision to sell Medibank Private has been particularly controversial. While welcomed by some, including operators of rival health funds, others have questioned whether a sale would involve a Commonwealth abrogation of the rights of the members of Medibank Private, and whether the sale would be in the interests of the Australian public.

This Research Brief examines the debate surrounding the sale of Medibank Private through a discussion of the origins of the fund, the question of ownership and other rights in the fund, and arguments for and against the sale.

In discussing the likely impact of the sale, this Research Brief seeks to clarify key aspects of the debate and highlight a number of areas for consideration by the government and others when approaching the sale of Medibank Private.

2. Medibank Private—history and current status

Origins of Medibank Private

Historically, the Commonwealth Government has been closely involved in the private health insurance industry through high levels of subsidisation (the \$3 billion annual expenditure on the Private Health Insurance Rebate is the most recent example), promotion and regulation. Nevertheless, some, especially those involved in privately-operated health funds, have argued that public ownership of a private health insurance fund presents, at best, an incongruity and, at worst, an illegitimate intervention in the private sector.

This section explains how the Commonwealth became involved in the operation of a private health insurance fund and provides an overview of the development of Medibank Private to the present day.

Brief history of health insurance in Australia

The ‘transfer burden’ in healthcare

The Australian health system, with its complex division of responsibilities between the Commonwealth and states and public and private sources of financing, is widely recognised as unique. It has been described as ‘one of the more mixed, disintegrated and confusing systems on earth’.⁵ Nevertheless, while unique, the system has also been subject to the same types of structural forces as have shaped health systems throughout the developed world during the past century.

The most significant of these forces have been:

- *supply*: continuous advances in medical knowledge (including technology, making available an ever-increasing range of medical services)
- *demand*: growing acceptance that equitable access to quality healthcare is a central aspect of the standard of living in society, and
- *cost*: the increasing cost of providing healthcare as a result of such things as expensive new medical technologies, capacity to treat new conditions and demographic change (such as the ageing of the population in developed countries).

The combined effect of these forces has been a progressive increase in what has been called the ‘transfer burden’ in healthcare—that is, ‘the cost of healthcare provided to the non-

wealthy sick which has to be met by others ... if the equity, and indeed public health goals of the society are to be met'.⁶

The evolution of Australia's health financing arrangements, particularly the various efforts at refining the mix between public and private health insurance, can be seen as a series of attempts to respond to the continuous increase in the transfer burden.

Early developments in health insurance

The tension between private and public sources of funding in response to the transfer burden in healthcare has been a feature of health care in Australia for more than a hundred years. In the latter half of the nineteenth century friendly societies, valued for their emphasis on thrift and self-help, were the main sources of funding of health services to the non-wealthy ill.⁷ Charitable hospitals provided free outpatient and dispensary services to the poor.

From the early twentieth century, rising demand for health services led state governments to increasingly intervene in the charitable hospitals through higher subsidies, leading them to play a greater role in regulating access and staffing.⁸ This led to the development of the current public hospital system. While the friendly societies achieved significant market power as purchasers of medical services on behalf of members, this power waned considerably as they lost members as a result of the depression of the 1930s.⁹ The depression also led to significant strain on public hospitals as unprecedented numbers of people from across the social spectrum sought public medical care.

Over the succeeding decades, in response to these pressures, the health system was shaped by two forces working in opposing directions. First, various Commonwealth governments attempted to extend the role of government in financing healthcare. Second, the private fee-for-service sector of medical practice expanded significantly—to a large degree as a result of the efforts of medical practitioners, primarily led by the then British Medical Association (BMA) in Australia; now the Australian Medical Association (AMA).¹⁰

The first significant efforts by the Commonwealth Government to expand its role in healthcare financing were made by the Chifley Government shortly after World War II, with attempts to establish a subsidised medical benefits scheme and a scheme for the provision of free medicines. Neither of these programs was implemented (primarily due to political and legal challenges from opponents such as the BMA).¹¹ However, the Chifley government was able to implement a hospital benefits scheme, under which the states agreed to provide free, non-means-tested healthcare in public hospitals. In return, the Commonwealth paid the states a subsidy of six shillings per occupied bed day.

Voluntary health insurance

Following its election in 1949, the Menzies government established a series of health system reforms of its own, including a national health insurance scheme (known as voluntary health insurance) and a limited version of the current Pharmaceutical Benefits Scheme

(implemented under Chifley's *Pharmaceutical Benefits Act 1947*). Under the voluntary health insurance scheme, doctors were able to determine their own fees. Broadly, the cost of these fees was met by a combination of one-third government benefit, one-third private health fund benefit and one-third out-of-pocket payment by the patient.¹² The level of direct expense to the patient depended largely on the level of fee charged by the doctor.

Under this scheme, private health insurance funds were heavily subsidised by the Commonwealth. This meant that premiums could be kept low and allowed coverage to expand from around 40 per cent of the population in 1953–54 to around 70 per cent in 1960.¹³ The private health insurance sector was also heavily regulated. As health economist Dick Scotton has noted, by the mid-1960s, 'funds were obliged to adhere to a policy of "uniformity", under which they were obliged to offer identical tables, providing identical benefits, at identical contribution rates'.¹⁴ As a result, the funds were effectively protected from competition.

While apparently fragmented (in 1965 there were 81 medical funds and 94 hospital funds), the private health insurance sector was relatively highly concentrated at this time: five (provider-dominated) Blue Cross funds insured more than two-thirds of all contributors and dominated the market in every state.¹⁵ However, the Blue Cross funds do not appear to have used their market power to attempt to contain the costs of health services (through, for example, intervening in the setting of medical fees).

By the mid-1960s, the capacity of the voluntary health insurance system to cope with the demands of the Australian population for health services was increasingly a matter of public debate. There was growing concern about such issues as:

- the persistence of high numbers of uninsured people (particularly among those on low incomes)
- the absence of adequate restraints on medical fees and rising out-of-pocket costs for patients as a result of inflation, and
- high medical fees and rapidly increasing premiums (the impact of which was felt disproportionately by people on low incomes and by the chronically ill).

The Government responded to these concerns by establishing the Committee of Inquiry into Health Insurance, chaired by Mr Justice Nimmo of the Australian Industrial Court. In 1969, the Nimmo Committee reported, causing both sides of politics to commit themselves to reform of the health system. Among Nimmo's conclusions were:

- operation of the health insurance scheme was unnecessarily complex and beyond the comprehension of many
- benefits received by contributors were frequently much less than the cost of hospital and medical treatment

- member contributions had increased to such an extent that they were beyond the capacity of some members of the community and involved considerable hardship for others
- rules of many registered organisations permitted disallowance or reduction of claims for particular conditions, causing, in many instances, serious hardship
- an unduly high proportion of member contributions was absorbed in operating expenses
- the level of reserves held by some organisations was unnecessarily high.¹⁶

Nimmo recommended a range of changes to health insurance administration but stopped short of recommending a scheme for compulsory universal insurance. Later in 1969, a Senate Select Committee into medical and hospital costs handed down its report, with the majority (government members) adopting conclusions similar to those of Nimmo and the minority recommending a scheme for universal compulsory insurance.

Subsequently, both major parties went into the 1969 election with promises of health reform. Labor's policy, under the leadership of Gough Whitlam, included a proposal for compulsory universal insurance. The Coalition, led by Prime Minister John Gorton, proposed a series of changes aimed at improving the existing system, including reducing the gap between medical benefits and fees. The latter would win the 1969 election, but with a substantially reduced majority.

The birth of Medibank—from voluntary to compulsory health insurance

Labor's policy for health sector reform drew specifically on the proposal for a universal, compulsory, publicly-administered and funded health insurance scheme developed by health economists Dick Scotton and John Deeble.¹⁷ According to Scotton and Deeble the voluntary health insurance system had proved incapable of raising the necessary funding to meet the transfer burden in healthcare. Compulsory insurance, they argued, while controversial, would be much more effective:

Proposals for widespread changes in health care financing are bound to become political issues, since they bear upon institutional and professional interests as well as on deeply held convictions about the merits of voluntarism and compulsion and the role of public and private activity. We are not concerned with the ideological issues; a compulsory and public-administered scheme is simply the most efficient and equitable method of achieving universally acknowledged objectives.¹⁸

The Whitlam government was formed after the 1972 election. After considerable resistance from the Liberal-Country Party opposition, the voluntary health insurance sector and the AMA, the bill to implement Labor's compulsory health insurance scheme was finally passed, following a double dissolution election and joint sitting of parliament on 7 August 1974. Known as Medibank, the scheme provided for universal coverage of the population for medical expenses.¹⁹ This meant that all Australians were to be entitled to a standard rebate

(of 85 per cent of the ‘scheduled fee’ or that fee less \$5—whichever was greater) from Medibank for any medical expenses incurred.

Medibank commenced on 1 July 1975 under the administration of the newly established Health Insurance Commission (HIC). Demand for the new scheme was substantial—in the first few months the HIC was processing well in excess of the expected 90,000 claims per day.²⁰ However, the future of Medibank became unclear following the dismissal of the Whitlam government on 11 November 1975 and the establishment of a caretaker Liberal-Country Party government under Malcolm Fraser. In the December 1975 election campaign Fraser had promised to ‘maintain Medibank’. However, his election platform also included a commitment to significantly reduce public expenditure, suggesting that a Fraser government would seek to somehow reduce prospective outlays on Medibank.

The Fraser government sought to balance these priorities through a complex series of changes over the next few years that ultimately ended in the abandonment of Medibank. Initially, though, the government sought to maintain Medibank but as a non-compulsory *alternative* to private health insurance. Significantly, the changes (widely known as Medibank Mark II) included giving the HIC the opportunity to compete with the existing health funds to provide private insurance to those who chose to opt out of Medibank.

The creation of Medibank Private

Medibank Private commenced operations on 1 October 1976. This followed the announcement by the Fraser government on 8 June 1976 that the HIC would be authorised to offer private medical and hospital insurance in all states in competition with existing registered health funds.²¹ The HIC, as the operator of Medibank Private, would assume the same rights and obligations under the *National Health Act 1953* as other registered health funds.

The establishment of Medibank Private is best understood within the context of the complex and shifting health financing debates occurring in Australia at that time. In early 1976, the Fraser government, with the support of the AMA and a significant segment of the private health insurance sector, had begun to examine options for making changes to Medibank, necessary for controlling the costs of the program (principally, through the Medibank Review Committee (MRC)). This process took place against a backdrop of strong opposition to the idea of making changes to Medibank from the Labor Party, the union movement and those in the community who had come to support the program. The fact that the government had given the assurance during the 1975 election campaign that it would ‘maintain Medibank’ added a further layer of complexity to the debate.²² Nevertheless, the government announced a series of proposed changes to Medibank on 20 May 1976, the most significant of which were the establishment of a 2.5 per cent levy on users of Medibank and the possibility of opting out of the program in favour of private health insurance.

Deeble and Scotton argued strongly in submissions to the MRC and following the government’s announced changes to Medibank, for the HIC to be given the opportunity to

offer private health insurance in competition with the existing funds.²³ On the one hand, they were concerned that people on higher incomes would opt out of Medibank, leaving it with a high proportion of people contributing little or nothing to the scheme.²⁴ On the other, they argued that allowing Medibank Private to operate a private health fund, would increase competition in the private health insurance sector and strengthen the government's capacity to reform and regulate the industry.²⁵

The government's decision to establish Medibank Private came as a surprise to many, given that it initially appeared to lack enthusiasm for the idea. Scotton has described the decision as both a 'sensational ... example of the Fraser decision-making style' and 'another of those near-accidental but decisive events on which the course of future events hung'.²⁶

Why Medibank Private?

There is no general agreement over a single cause for this change in policy. Rather, most accounts of the government's decision to establish Medibank Private tend to emphasise a combination of motivations, each reflecting some combination of political exigency, ideology and rational policy-making (the latter based around the notion that Medibank Private could play an important role in reforming the private health insurance system).

First, it is likely that the government conceived of Medibank Private as providing a way of overcoming the lack of cooperation from existing funds with its proposed changes to Medibank. In particular, the funds were disappointed that the government would not abolish Medibank and was planning to introduce new regulatory controls. The new requirements on health funds included the provision of a specified basic insurance package, entry into the reinsurance pool, new data collection and reporting standards, and coverage for all applicants irrespective of risk status.²⁷ Representatives of the funds signalled to the government that they would have difficulty in complying with the new requirements by the proposed commencement for the new scheme on 1 October 1976.²⁸ This caused both the Prime Minister and the Minister for Health, Ralph Hunt, to threaten the health funds with competition from Medibank.²⁹

Second, the establishment of Medibank Private was probably a response to intense pressure from the union movement (most specifically the Australian Council of Trade Unions (ACTU)). According to health policy commentator, Sidney Sax, the government was keen to avoid a protracted dispute with the unions because it:

... had arranged for formal discussions with the [ACTU] to begin in Canberra on 11 June 1976. The economy was to be reviewed, the impact of recently announced fiscal measures was to be assessed, and the unions were to be asked to moderate wage claims. While wage-earners had reason to be pleased about the newly introduced indexation of personal taxes and the payment of family allowances, the cost burdens of the Medibank levy and private insurance offset those gains, and the unions were angry about the Medibank changes.³⁰

Sax argues, the decision to establish Medibank Private was, in part, ‘influenced by a wish to defuse union attacks over the Medibank changes’.³¹ There is also some evidence of more direct union involvement in the planning of Medibank Private. According to one media report at the time, it was ‘understood that a major input for the change came from the Combined Association of Government Employees Organisations, who had done considerable work in the area since the original Medibank changes were first announced’.³²

Finally, the establishment of Medibank Private could also be seen as an attempt to rebalance the scheme in favour of private enterprise, while strengthening the Prime Minister’s claim to have maintained Medibank. As Fraser and Hunt stated following the announcement of Medibank Private, ‘the Government by this measure, is giving the widest possible area of choice and nobody is being forced out of Medibank’.³³ Further, the decision could also be seen as an attempt by the government to address the concerns of those who wanted to protect Medibank and/or remain within the public system. According to health policy commentator, Ron Hicks, the creation of Medibank Private helped overcome philosophical problems many people had with the proposed changes to Medibank:

Many people, particularly staunch Labor voters were philosophically opposed to private health insurance. But the very name Medibank Private was close enough to the original to encourage these people to join the fund (plus the fact that it was national). In fact, the Leader of the Opposition, Mr Hayden, and the President of the ACTU at the time, Mr Bob Hawke, were among the first to join.³⁴

In other words, the decision to establish Medibank Private made it possible to *both* support Medibank *and* take out private health insurance.

Initial responses

The main opponents of the government’s efforts to change Medibank—the Labor Party and the unions—were initially critical of the decision to establish Medibank Private on the grounds that it was still an erosion of key principles of Medibank such as equity and universality.³⁵ Nevertheless, as noted above, the existence of Medibank Private enabled supporters of the original scheme to take out private health insurance while remaining within the overall rubric of Medibank.

As may have been expected, many of those representing the existing private health funds reacted with hostility to the announcement of Medibank Private. For example, the national president of the Voluntary Health Insurance Association of Australia (VHIAA) suggested that Medibank Private would have unfair advantages over the existing funds by virtue of government ownership.³⁶ He added that he ‘wouldn’t have expected this kind of thing from a private enterprise government’ and that the ‘private funds would leave no stone unturned to remain viable’.³⁷

Mr Hunt responded to these criticisms in two main ways. First, he asserted the role to be played by Medibank Private in strengthening competition by stating that, depending on the

premium rates set by Medibank Private, the private funds may well have to reduce their premiums for health insurance (arguing that ‘that’s what competition is all about’).³⁸ Second, he denied that Medibank Private would be advantaged in relation to the existing funds, noting that he was:

... sure they [the funds] will be able to compete because we are not competing unfairly with the Voluntary Health Funds. We intend to operate the Medibank private insurance as a completely commercial operation, with no subsidies, no help at all. It will have to stand on its own feet entirely.³⁹

As announced on 8 June 1976, while making use of existing HIC facilities, costed and separate accounts under statutory requirements would be kept for both Medibank Private and Medicare.⁴⁰ Further, as noted above, Medibank Private would be required to comply fully with regulatory obligations under the National Health Act.⁴¹

Early period of operation

The HIC faced a number of challenges in the short time before Medibank Private commenced operations on 1 October 1976. These included the development of systems for premium collection, payment of benefits, registration and identification of private insurance contributors and their dependents, and the need for reserves. Given the HIC’s lack of experience in the private health insurance field, the impending announcement by Medibank Private of its contribution rates provided a further difficulty. The initial rates provided by the HIC were well above the government’s indicative figure of \$350 per annum and were rejected.⁴² A second calculation with lower rates (for example, \$332 per annum in Tasmania and \$398 per annum in New South Wales) was accepted and publicly announced on 22 July 1976.⁴³

The entry of Medibank Private also provided the government with early success in the form of greater competition. As it happened, the existing private funds waited for Medibank Private to introduce its contribution rates, and in almost all cases undercut the new fund. According to Sax, ‘in some cases, the private funds cut their rates below actuarially assessed levels to protect their share of the market and, as a result, had to eat into their reserves—a clear sign of vigorous price competition’.⁴⁴

At the time, some commentators suggested that this price competition would cause significant problems for Medibank Private in attempting to establish a position in the market. As *Choice* magazine argued at the time:

Medibank Private, in almost every State, has become the least attractive fund. Who will insure with Medibank Private?

Some, perhaps out of political conviction; others because for them payments to Medibank Private are more convenient. But the existing funds have done their best to ensure that Medibank Private will be too small in membership to be economic.

In the future, will the competitive struggle to offer low rates and high benefits continue—even if Medibank Private is driven out of the business? Or will we return to the days of high reserves and almost identical (and high) rates?⁴⁵

Despite concerns about its capacity to compete, as will be outlined in the next section, Medibank Private quickly developed a national profile and the largest membership base of any fund.

Medibank Private and the private health insurance sector—1976 to the present

Chronology of events

Medibank Private has consistently been Australia's largest (in terms of contribution income) and only national private health insurance fund for most of its period of operation. Nevertheless, while the general picture is one of relative stability, the past thirty years have also been characterised by flux, controversy and uncertainty in the private health insurance industry, including Medibank Private. This has been a result of a number of factors, primarily changes to government policy, reductions in consumer demand for private health insurance (particularly among those with lower-risk health profiles), and the rising costs of medical services.

Significant episodes in the history of Medibank Private include:

- the abolition of Medibank Standard in 1978 (as part of further changes to health financing arrangements by the Fraser government), making the operation of Medibank Private the sole function of the HIC
- by 1981 Medibank Private had grown to become the largest (and only national) health insurer in the country (enrolling over two million members)⁴⁶
- the introduction of Medicare in 1984 by the Hawke Labor government, thereby returning the task of operating a compulsory, universal, public health insurance scheme to the HIC
- a significant decline in the percentage of the population insured for hospital treatment across all private health insurance funds, primarily as a result of the introduction of Medicare (at 30 June 1984, just over 60 per cent of all Australians were covered for private hospital insurance but by 30 June 1998, this figure had fallen to 30.6 per cent)
- introduction of a range of government initiatives from 1997 designed to stem the decline in private health insurance coverage, including the 30 per cent private health insurance rebate (PHIR) for member contributions and Lifetime Health Cover (a major change to private health insurance arrangements that permitted health funds to charge different premiums depending on the age at which people take up private health insurance)
- separation of Medibank Private from the HIC and establishment of a new corporate entity Medibank Private Limited (with the Commonwealth government as shareholder) in 1998

- a steady increase in private health insurance cover across the funds since 1998 (reaching a high of 45.7 per cent in September 2000, before declining again to around 42–43 per cent from 2003)⁴⁷
- a loss of \$175.5 million by Medibank Private in 2001–02, primarily as a result of a 20 per cent increase in benefit outlays (resulting from increases both in utilisation and cost of healthcare services). This reflected similar trends throughout the private health insurance sector (for example, the rapid growth of membership from 2000 resulted in strong growth in claims as waiting periods expired),⁴⁸ and
- a net profit of \$130.8 million in 2004–05 (an increase of 192 per cent on the previous year and a further improvement on the loss in 2001–02).

Current performance and outlook

Private health insurance industry

The private health insurance sector in Australia comprises 38 operational funds and is, as has been the case for most of its history, subject to tight regulation, primarily through the National Health Act 1953. The main industry regulator is the Private Health Insurance Administration Council (PHIAC). A central pillar of the regulation of private health insurance in Australia is community rating—the principle that health funds may not discriminate on the basis of age (other than age at which health cover is first purchased), gender, sexuality, health status or claims history. Rather, they must charge the same premium to everyone, regardless of individual health risk.

Rating's agency Standard and Poor's regards the private health insurance environment in Australia as competitive and highly volatile.⁴⁹ According to PHIAC, by 2005 the private health insurance industry had improved its financial position on previous years.⁵⁰ This is supported by Standard and Poor's, which argues that the private health insurance industry 'enjoys the highest level of financial strength' since 2000.⁵¹ However, PHIAC notes that the 'buoyant economy' has contributed significantly to the industry surplus of \$626 million in 2004–05 and reserves of the private health insurance industry but that 'there is no guarantee that this will continue and investment income cannot be relied upon to fund future growth in benefits outlays'.⁵²

Benefits paid by private health insurance funds continued to grow at more than twice the rate of inflation (as measured by the consumer price index) in 2005, primarily as a result of increased hospital utilisation.⁵³ Significantly, PHIAC argues that the continuing growth in health costs 'can only result in ongoing pressure on premium rates'.⁵⁴ Private health insurance funds were granted permission by the Minister for Health and Ageing to increase premiums by an average of 5.7 per cent in January 2006, a decrease from the average increase of more than seven per cent per year since 2002 (7.9 per cent in 2005).

As noted above, membership numbers have remained stable since 2003. Hospital coverage at March 2006 was 43.1 per cent, with 8.829 million persons covered, a marginal increase over the previous year. While the number of members over the age of 65 years continued to increase in 2005, the growth in members under the age of 65 years was low.⁵⁵ This is a continuing concern for the industry given the greater use of hospital services by those over 65 years.

More fundamentally, in recent years, some commentators have questioned the sustainability of the private health insurance sector in Australia in its current form. For some, the problem is that private health insurance does not contain sufficient mechanisms to control the cost and utilisation of health services.⁵⁶ Others have pointed to the way in which increased premiums lead to a 'downward spiral' in which low-risk members leave because they contribute more than they claim, the proportion of high-risk members increases, premiums rise to make up the difference between income and benefits paid, in turn causing low-risk members to leave.⁵⁷ Still others have argued that the current stringent regulatory framework for private health insurance provides very little opportunity for enhanced competitiveness through administrative and product innovation.⁵⁸

The government has recently announced its intention to make a number of changes to the regulation of private health insurance.⁵⁹ These will include initiatives aimed at enabling health funds to develop more innovative products and services, such as:

- allowing funds to insure for out-of-hospital services that are part of an episode of hospital care or substitute for or prevent hospitalisation,⁶⁰ and
- engage in business other than offering benefits for healthcare services, such as financial services, life insurance and other general insurance products.⁶¹

These changes may provide greater scope for competition between funds and more viability for the private health insurance industry as a whole (particularly as a result of the ability to enter new areas of business). However, the complexity of the overall market for private health insurance means that it is difficult to provide a precise evaluation of their likely impact or significance. An important point to note is that the capacity to engage in product or service innovation will not necessarily address fundamental problems such as the absence of effective cost containment mechanisms.⁶²

Medibank Private

Medibank Private has a 'strong competitive position' as the largest fund in the Australian private health insurance sector.⁶³ The fund currently has around 29 per cent of the market, based on total contribution income. As can be seen from the table, it ranks either first or second in terms of market share in every state or territory. Total membership numbers have been stable at around 1.3 million for the last few years.

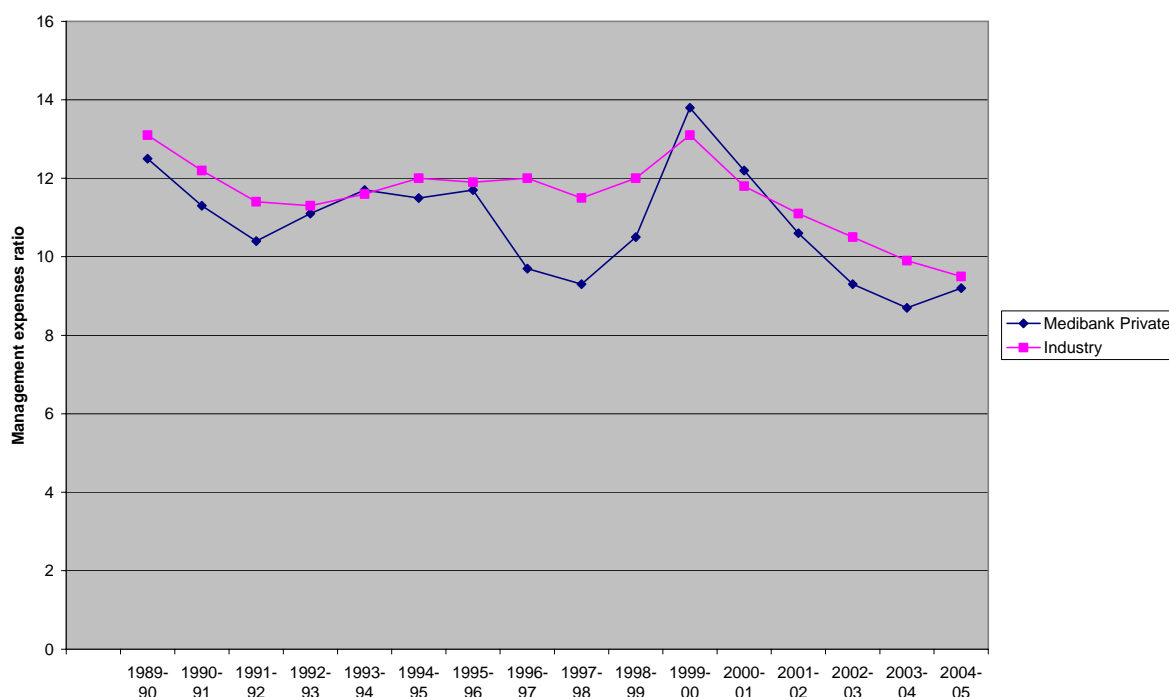
Table 1: Medibank Private, market share and ranking, 2004-05

State/territory	Market share (%)	Position
Australia	29	1
New South Wales/ACT	23	1
Victoria	38	1
Northern Territory	44	1
Queensland	36	2
Western Australia	20	2
South Australia	21	2
Tasmania	36	2

Source: Medibank Private Annual Report 2004–05, p. 13

Medibank Private’s administrative expenses continue to be below the industry average, with a management expense ratio (management expenses as a percentage of premium income) in 2004–05 of 9.2 per cent, compared with the industry average of 9.8 per cent. As can be seen from Figure 1, over the previous 15 years, Medibank Private’s management expenses as a percentage of premium income have been above the industry average only three times (1993–94, 1999–00 and 2000–01).⁶⁴

Figure 1: Management expense ratio, Medibank Private and industry, 1989–90 to 2004–05



Source: PHIAC, Operations of the Registered Health Benefits Organisations, various years

In 2005, Medibank Private's share of all complaints made to the Private Health Insurance Ombudsman was 28.8 per cent (that is, almost exactly in proportion with the fund's market share).⁶⁵ Of these, 26.5 per cent were complaints about benefits paid and 33.2 per cent were about service.⁶⁶

In 2004–05, Medibank Private recorded \$2.8 billion in total revenue (around \$2.6 billion of which was in the form of member contributions), with \$2.3 billion paid to members as benefits. The ratio of benefits paid compared with contribution income was 88.4 per cent, just above the industry average of 87.8 per cent.⁶⁷ In 2006, Medibank Private's premium has increased by an average of 5.9 per cent across the fund, compared with the industry average of 5.7 per cent.⁶⁸ In 2005, the average premium increase for Medibank Private was 7.9 per cent (about the same as the industry average).⁶⁹

As noted, Medibank Private has stabilised its financial position since the loss recorded in 2001–02. Standard and Poor's suggests that 'the considerable improvement in operating performance is due to a better product mix, competitive pricing strategy, favourable claim experience, and good investment returns'.⁷⁰ It adds that the stronger financial position also benefited from 'improved cost efficiency through better health care purchasing and business processes'.⁷¹

In its 2006 assessment of Medibank Private, Standard and Poor's notes that the fund's management 'focuses on developing strategies that deliver long-term profitability and efficiencies' but that its 'creditworthiness is constrained by the highly regulated private health insurance industry, with limited growth prospects, and restrictions on selecting and pricing risk'.⁷² This concern is consistent with broader concerns about the sustainability of the overall private health insurance sector discussed above.

3. Issues raised by the sale

There have been two main questions in the debates over the possible sale of Medibank Private since the possibility of the sale was raised during the late 1990s and the government announced its intentions to do so in early 2006:

- who owns or enjoys other rights in Medibank Private? and
- are there public policy reasons for the government to *maintain* the current Medibank Private ownership structure?

Ownership issues and Medibank Private

Whenever the sale of Medibank Private has been canvassed, debate has arisen as to the ownership of the organisation. According to some commentators, Medibank Private's members are the rightful owners of its assets. That seems to have been the view of Fred Millar AO CBE, who served as Chairman of the Health Insurance Commission for 15 years. Millar commented, in his Chairman's report for 1987-88:

Medibank Private is a non-profit organisation based solely on its contributors' funds. The Government has no financial interest in Medibank Private's assets and reserves. They are the property of its contributors.⁷³

According to a report in the (Canberra) *Sunday Times* in 2000, in documents canvassing a sale, the then Minister for Health referred to a risk of a campaign by members, possibly led by former employees, arguing that the assets of the Medibank Private fund belonged to the members.⁷⁴ The Minister, according to the report, asserted in a letter to the Finance Minister that 'this argument has no force'.⁷⁵ That opinion was said to have been based on an unpublished opinion of the Commonwealth Solicitor General some years before, on the basis that it would be impossible to work out the respective rights of short and long-term members of Medibank Private on any 'demutualisation'.⁷⁶ On the other hand, the founding Chief Executive of Medibank Private, Ray Williams,⁷⁷ has reportedly said that 'there is not one cent of Government money invested in Medibank Private, thus any attempt to make a profit out of the sale/privatisation of Medibank Private would be an act of theft'.⁷⁸

This section will consider these issues in more detail, but first it may be helpful to make some observations about the nature of the entities involved in what is often referred to collectively as 'Medibank Private'.

The fund, the commission, and the company

Significant entities that have, at different times, been relevant to the operation of 'Medibank Private' are:

- the Health Insurance Commission, a statutory body charged with establishing and operating the private health fund in question
- the Medibank Private fund itself, which exists as a registered business name and by virtue of the National Health Act and other legislation, and
- Medibank Private Limited, a company limited by shares incorporated in 1998.

These entities are depicted in figure 2. The relevant legislation distinguishes between health funds and the registered organisations that operate them. Part VIA of the National Health Act, for example, provides separate regimes for the winding up of funds themselves and for the winding up of registered organisations. Note in this regard that the Act clearly treats funds as being entities capable of ownership of assets.⁷⁹ The *Health Insurance Commission (Reform and Separation of Functions) Act 1997* defines 'Medibank Private fund' to mean 'the health benefits fund conducted by the Commission'.⁸⁰ Therefore, the Medibank Private fund can and should be, at least in some senses, treated as distinct from the registered organisation that operates it.

The registered organisations operating the fund were first, from October 1976, the Health Insurance Commission,⁸¹ and second, after corporatisation in 1998, Medibank Private Limited. The owner of these registered organisations is undoubtedly the Commonwealth, but

the source of controversy that arises when the Government speaks of selling ‘Medibank Private’ relates, in substance, to the ownership of the Medibank Private fund and assets held for its purposes—which we will call ‘associated assets’.

Figure 2: Medibank Private relevant entities

Commonwealth Government		
Owner of shares in Medibank Private Limited from May 1998		
Health Insurance Commission		Medibank Private Limited
Statutory body established in 1973 to operate Medibank and empowered in 1976 to enter private insurance market with Medibank Private, initial owner of shares in Medibank Private Limited		Company limited by shares established in 1998 to become registered organisation to replace HIC as conductor of Medibank Private fund
Medibank Private fund and associated assets		

Theory of ownership

The question about the ownership of Medibank Private assets is not answered simply by looking at the name entered on legal documents, share or land registries. Such inquiries might reveal the entity that is the ‘legal’ owner of a given asset, but that is not a satisfactory answer to the question of ownership. This is because ownership can be ‘legal, beneficial, joint, several, general or partial’ and ‘the precise meaning of the term may vary from case to case’.⁸² Rights of ownership can also be defined, and limited, by law. For our purposes, it is important to note that it is possible for the legal and beneficial ownership of something to be separated. This is the case where one entity holds something *on trust* for another. In the private health industry, assets of a fund are frequently held by registered organisations because those organisations hold a more readily identifiable legal status—such as company or association—than do the funds themselves, but this does not mean that the registered organisations necessarily hold the legal and beneficial interest in the fund assets, or indeed in the funds themselves. Whilst organisations such as Medibank Private Limited and before it, the Health Insurance Commission, hold or have held the legal interest in Medibank Private fund assets, whether they hold the *beneficial* interest in those assets, or whether their interest

is subject to the rights of others, are separate questions. These questions are the subject of our inquiry.

Determining the beneficial ownership of the fund and its assets is a matter of ascertaining who enjoys the substantial rights pertaining to those assets. The conventional definition of ownership of economic organisations, according to Yale law professor, Henry Hansmann, in *The ownership of enterprise*,⁸³ is associated with those who share two formal rights—the *right to control* the organisation and *entitlement to residual earnings* (profits or surpluses).⁸⁴

Some of the general categories of ownership structure for economic organisations referred to by Hansmann and others are:

- producer owned organisations (professional partnerships, employee and producer co-operatives)
- customer owned organisations (mutuals, retail co-operatives, friendly societies, industrial and provident societies, credit unions, mutual insurers, building societies); and
- investor owned (shareholder-owned companies, listed public companies, private companies).⁸⁵

Of particular relevance, for our purposes, is another category referred to by Hansmann—non-profit organisations—organisations effectively without owners.

Because some of the debate surrounding the sale of Medibank Private has centred on whether the organisation is a ‘mutual’ fund, that question will be considered in more detail below. We now turn to the question of Commonwealth ownership of the Medibank Private fund.

Commonwealth ownership of the Medibank Private fund

The question of formal ownership of the fund does not appear to have been given much attention prior to its establishment. The Fraser government chose to create a government controlled private health insurer simply by legislating to make operating a private health insurance fund a ‘function’ of the Health Insurance Commission. Government owned business enterprises often take the form of statutory bodies or registered companies, the shares of which are beneficially owned by the Commonwealth. Examples include (prior to its privatisation) the Commonwealth Bank, established as a body corporate by the *Commonwealth Bank Act 1911*. Nevertheless, the method chosen to establish Medibank Private was not unique. Trans Australia Airlines (TAA), for instance, was not established as an entity of itself, but was a ‘function’ of the Australian National Airlines Commission—the latter having the status of a body corporate.⁸⁶ Whilst there are parallels between the establishment of Medibank Private and TAA, there are also important differences. Purchasers of air tickets were simply contracting with TAA for air travel, they were not purchasing any form of membership that was associated with certain benefits. The Medibank Private fund, on

the other hand, was established as a not-for-profit entity and offered *membership* to those who paid contributions to it.

As mentioned above, both the Health Insurance Commission and Medibank Private Limited have at one time held assets for the purposes of the Medibank Private fund. Those entities—the Commission and the company—are properly described as government owned. The Commission was a statutory body and the shares in the company are owned, legally and beneficially, by the Commonwealth. In our view, however, the provisions of the relevant legislation have the effect that neither the Commonwealth, nor Medibank Private Limited or its predecessor, the HIC, hold the beneficial interest in the fund or associated assets. It seems difficult to attribute beneficial ownership of an asset to an entity that cannot sell the asset, cannot distribute profits generated by the asset and must give priority to the interests of others (i.e. members) when dealing with surplus earnings of the asset. All those restrictions are effectively imposed upon the Commonwealth and Medibank Private Limited in relation to the fund by the National Health Act, the *Health Insurance Commission (Reform and Separation of Functions) Act 1997* and by the fact of Medibank Private's status as a not-for-profit organisation.

This certainly seems to have been the view taken by the HIC, which has, on more than one occasion, expressed the view that neither it nor the Commonwealth is the beneficial owner of Medibank Private fund assets. For instance, in a submission to the 1992 Joint Committee of Public Accounts' inquiry into the administrative and financial relationships between Medicare and Medibank Private, the Commission stated:

While HIC is the legal owner of the assets, the benefits of ownership pass to that function of HIC which provided the funds to acquire the asset.⁸⁷

That position did not change, in our view, with the advent of corporatisation. On 1 March 1998 the Medibank Private fund and its assets were transferred to Medibank Private Limited. The transfer of assets was effected pursuant to the Health Insurance Commission (Reform and Separation of Functions) Act and instruments made thereunder. Shares in Medibank Private Limited were initially owned by the Commission, but later transferred to the Commonwealth. The transfer of shares to the Government occurred on 1 May 1998, and was achieved by instrument made by the Minister for Health pursuant to his powers under the Health Insurance Commission (Reform and Separation of Functions) Act. The Minister transferred the legal and beneficial interest in all of the shares in Medibank Private Limited to the Commonwealth.⁸⁸ There can be no doubt then, that the Commonwealth owns, both legally and beneficially, the shares in Medibank Private Limited, but it can be said that the effect of this was simply that Medibank Private Limited took the place of the HIC as holder of the legal, but not the beneficial interest, in the fund and associated assets.

This view is consistent with the expressed government intention at the time. The motivation for the change to the corporate structure came about not because of any government intention to substantially alter proprietary rights in the fund, but due to a perception in the industry that Medibank Private had an unfair advantage over its competitors by virtue of its association

with the Health Insurance Commission, at a time when the latter was also operating Medicare, and the two organisations shared offices. As the relevant Minister, Tony Abbott, explained on the second reading of the Health Insurance Commission (Reform and Separation of Functions) Bill 1997:

This bill provides for the separation of Medibank Private from the Health Insurance Commission, HIC, and the creation of a new Medibank Private corporation. Through the separation, the government will ensure that Medibank Private cannot be perceived to have any competitive advantage over other private health funds through its association with Medicare or other government program functions of the HIC. It reinforces the government's commitment to the principle of competitive neutrality.⁸⁹

Perhaps most conclusive in this regard though, is that fact that statutory requirements in place before and after corporatisation have the effect that Medibank Private Limited can not distribute profits to its shareholders and, in dealing with the assets of the fund, must give priority to the interests of the contributors.⁹⁰ The Commonwealth has, therefore, no entitlement to the residual earnings of the fund, and hence could not, on the definition of ownership outlined above, be described as the beneficial owner of the fund.

Finally, the language used by the board and management of the company since corporatisation can be said to be consistent with the view that the beneficial ownership of the fund and associated assets does not lie with the Commonwealth. Statements such as the following, found in Medibank Private annual reports, tend to reinforce the idea that the fund and associated assets are held for the benefit of the members:

Medibank Private is a not-for-profit Government Business Enterprise, with the sole purpose of providing high quality, excellent value private health insurance to our almost three million members. Medibank Private must earn sufficient returns to be financially sustainable, and build reserves to weather volatile, unforeseen circumstances that may adversely impact member claiming. *No dividends are paid and all of Medibank Private's financial resources are directed to member benefits.*⁹¹

*As a not-for-profit organisation, every dollar of profit is retained within the fund for the benefit of members.*⁹²

For the reasons expressed above, it seems clear that Medibank Private Limited, like the Health Insurance Commission before it, is the vehicle used to hold the legal interest in the Medibank Private fund and its assets, but neither the company nor the Commonwealth can be described, on the definition outlined above, as the true owner of the funds and associated assets. From here, we turn to the question of whether the members own the fund and associated assets.

Medibank Private as a mutual fund

As mentioned above, some have argued that the Medibank Private fund is owned by its members. This implies that it is a 'mutual' organisation. Exactly what constitutes a mutual

organisation is not easily determined. As has been noted by the New South Wales Supreme Court:

The Corporations Law does not anywhere refer to a mutual company. It makes no provision for the creation of such a company. Nor does it contain a definition of what a ‘mutual’ is, or articulate any principles for the management of the affairs of a mutual company ...⁹³

The question of what a mutual is has been considered, to some extent, in cases on taxation and in the recognition of a ‘mutuality principle’. The essence of that principle is that, where a number of people associate together for a common purpose and contribute to a fund in which they are all interested, any surplus remaining after the fund has been applied to the common purpose is in essence a return of their own moneys which they have overpaid and is not a profit.⁹⁴ More generally, a common attribute associated with a mutual organisation seems to be member or customer ownership. That certainly seems to be the sense in which some have applied the term ‘mutual’ to the Medibank Private debate.⁹⁵

In *Faulconbridge v National Mutual General Insurance Association*, Justice Upjohn considered that a ‘mutual’ existed in circumstances where contributors enjoyed rights along the lines of those outlined in Hansmann’s ownership test—where the contributors have some control over or voice in the organisation and where they are entitled, ultimately, to share in the profits of the organisation.⁹⁶ As the substance of the suggestions made have been that members own the fund, we will equate mutuality with member ownership here, and will consider the issue by reference to the test outlined by Hansmann, as applied to the members of the Medibank Private fund.

The foundation of claims that the Medibank Private fund is a mutual organisation appears to be the fact that comparatively little has been contributed, by the government, to the Medibank Private fund by way of capital. The position regarding government capital injection can be shortly summarised. The Commonwealth Government made a grant of \$10 million to the Medibank Private fund at the commencement of the fund.⁹⁷ On 4 December 1978 the Government decided to ‘capitalise’ the original grant of \$10 million (that is, change it to capital of the Health Insurance Commission).⁹⁸ The \$10 million was, however, eventually returned to the Commonwealth by Medibank Private apparently due to an administrative oversight in not giving the Government decision of 1978 appropriate legal standing.⁹⁹ At the same time as the purported capitalisation of the initial \$10 million, the Commonwealth made a further establishment grant of \$11 million. In relation to the latter grant, Medibank Private has explained:

A further grant of \$11 million was made in 1978 in recognition of the fact that Medibank Private had repaid \$13.3 million to the Commonwealth for benefits wrongly paid by Medibank Standard. An amount of \$9.4 million, which was owed by other private funds and which arose in a similar fashion, was written off. While other funds were relieved of liability for their debt, Medibank Private effectively repaid \$2.3 million of the total amount owed.¹⁰⁰

In 1978 Medibank Standard was abolished and apportionment and adjustment of assets and liabilities ‘between the Commonwealth (Medibank Standard) and the Commission

(Medibank Private)' occurred.¹⁰¹ No Commonwealth funding appears to have been provided from then until 2005, when the Commonwealth made an equity injection into Medibank Private Limited of \$85 million in return for 85 million \$1 shares. The explanation given for the cash injection is:

This year the Board obtained an equity injection of \$85 million from our shareholder, the Federal Government, to consolidate a capital structure more consistent with industry practice. Prior to this, Medibank Private had almost 30 per cent of the health insurance market risk, but only 16 per cent of its capital. Upon receiving these funds, the Board agreed to a range of financial and non-financial targets and a rigorous reporting regime, including rate of return on equity.¹⁰²

It is true then, that, since its inception, the Medibank Private fund's capital needs have been met, in large part, by contributions from members. It should be noted that, when the fund was operated by the HIC, Medibank Private's financial operations were always kept separate from those of the Commission and its other functions—that is, Medibank Standard then Medicare—so that the government did not subsidise the operation of Medibank Private, its administration was paid for from members' contributions.

The issue of capital input is, however, not determinative of the question of ownership. In the most common form of business enterprise—the company limited by shares—the investors of capital are also the owners of the company. That is the case, however, not so much because of the capital input in itself, but because the investors of capital in those companies also have both formal control of the company and entitlement to share in its residual earnings (profits). These rights are granted statutorily or as a result of the company's constitution, or both. But the Medibank Private fund (as opposed to the company) is not, and never has been, a company limited by shares, and in respect of organisations generally 'ownership need not, and frequently does not, attach to investment of capital'.¹⁰³ Financial institutions, for example, can lend funds to an organisation to be used as capital, without acquiring any control over the organisation. Rather than input of capital being the defining factor, as outlined above, ownership of economic organisations is conventionally associated with two rights—the *right to control* the organisation and *entitlement to residual earnings* (profits or surpluses).¹⁰⁴

If the members of the Medibank Private fund can properly be said to be the owners of the fund, the factors determining this will be not whether they have wholly supplied the fund's capital but rather, whether members have control of the fund, as well as some entitlement to the residual earnings of the fund. It will be argued below that members of the Medibank Private fund do enjoy statutory rights to the benefit of residual fund assets. We note here, however, that there is a difficulty for those that argue that the Medibank Private fund is a mutual organisation, so far as our theoretical framework is concerned, because there is nothing from which a conclusion can be drawn that members have any right to participate in, or exercise control rights over, the Medibank Private fund. On the contrary, those rights have always resided with the HIC and now, Medibank Private Limited and the Commonwealth. That seems to dispose of the argument that the Medibank Private fund can truly be described

as a mutual, as it can not be said to be an organisation owned by its members. The result is that members could not, in the event of a sale, claim entitlement to compensation on the basis that they were the owners of the fund. They would not, for instance, have an entitlement to share in any premium or goodwill paid by a purchaser for the organisation. That does not mean, however, that members could not claim compensation for loss of certain statutory rights over the fund and associated assets. See below for a discussion of members' entitlements in this regard.

Medibank Private as a Government controlled non-profit organisation

The critical characteristic of a not-for-profit firm, for Hansmann, is 'that it is barred from distributing any profits it earns to persons who exercise control over the firm, such as members, officers, directors, or trustees'.¹⁰⁵ On that definition, much of the Australian private health insurance industry can arguably be said to be made up of member controlled non-profit organisations. MBF for example, an organisation commonly referred to as a mutual, operates through a company limited by guarantee—MBF Australia Limited. The constitution of the company provides for contributors to the fund to be members of the company. Only a relatively small number of the members are entitled, under the constitution of MBF Limited, to vote on resolutions. It might be said though, that members have, ultimately, formal rights of control by virtue of the *Corporations Act 2001*. Entitlement to share in surplus earnings is present, but only in the same way as are members of Medibank Private—through rights to benefit from surplus assets. The fact that might preserve MBF's mutual status is that it is conceivable that the members, or at least those of them with voting rights, could resolve to seek to change the nature of the fund to a for-profit status, which could, ultimately, secure them the right to distribute residual earnings in the form of cash payments.

The members of Medibank Private, on the other hand, cannot be said to have any degree of control, and so the fund fits squarely within Hansmann's definition of a not-for-profit, or more specifically, a government controlled not-for-profit. A peculiar feature of such organisations, according to Hansmann, is that they are essentially, *without owners*, by reason of no entity sharing the two ownership factors of control and entitlement to residual earnings.¹⁰⁶ For the reasons outlined above, there is no entity that can claim full ownership of the Medibank Private fund, and hence it is properly described as a non-profit organisation.

Members' statutory rights to the benefit of the fund and associated assets

As the legal and beneficial owner of the shares in the company—Medibank Private Limited—the Commonwealth is free to sell that company. That does not necessarily mean, however, that the Commonwealth will not be liable in the event that the sale adversely affects the rights of members to benefit from the fund and associated assets. While the members cannot be said to be the owners of the fund, they nevertheless enjoy statutory rights in respect of the fund and associated assets. In this respect the view expressed herein differs, to some extent, with the pronouncement by Senator Nick Minchin that:

Medibank Private is a company owned by the Australian Government. It is not a mutual organisation and is not owned by its customers. The premiums paid by Medibank Private's customers buy health insurance—not a stake in the company.¹⁰⁷

For the reasons outlined above, we agree that the Medibank Private fund is not a mutual organisation, but Senator Minchin seems to be suggesting also that members of the Medibank Private fund are in no better position than purchasers of insurance from an insurance company. That suggestion is less sound. That is because members of the Medibank Private fund buy more than insurance—they buy *membership* of the fund, and that entails certain rights. Medibank Private, like other registered health funds, is subject to the provisions of the National Health Act.¹⁰⁸ That Act requires that the rules of a registered fund provide that 'the whole of the income' of a registered fund, arising out of the carrying on of its business as such, be credited to the fund, and that only specified amounts—essentially the costs of running the fund and payments to members—be debited to the fund.¹⁰⁹ At the time of the creation of Medibank Private, no allowance was made in the National Health Act for distribution of profits by a registered organisation. Currently, profits can be distributed only by organisations established on a for-profit basis. The National Health Act also requires that:

In making any decision, or taking any action, relating to the application, investment or management of the assets of the health benefits fund conducted by it, a registered organization must give priority to the interests of the contributors to the fund.¹¹⁰

The scheme of the legislation quite clearly seems to be that, at least in respect of not-for-profit organisations, members are to be entitled to the benefit, through their memberships, of the fund and associated assets. This view finds further support in provisions relating to the winding up of health funds. The National Health Act has, since 1976, required that funds be wound up only than under that Act. Between 1976 and 1999, the Act required that, unless a court considered that there were special reasons not to, schemes for the winding up of a fund include provision for the transfer of the business of the fund to another registered organisation which would agree to accept members of the wound up fund on terms substantially equivalent to those they previously enjoyed. Since corporatisation, Medibank Private Limited has a provision in its constitution for the transfer of any remaining assets, on winding up of the company, to another not-for-profit fund.

In 1983 section 82ZGA was inserted into the National Health Act. This section provided for the winding up of funds conducted by organisations which had not, by 1 February 1984, applied for registration as a combined 'health benefits' organisation (in that year the scheme of the Act changed from one registering separate 'medical benefits' and 'hospital benefits' organisations to one registering only 'health benefits' organisations). An interesting provision appeared in the form of subsection 82ZGA(3), which provided that, where a fund was to be wound up as a result of failure to apply for registration under the new regime, the scheme for the winding up of the fund must make provision:

for the refunding to each person who was a relevant contributor to the fund, in respect of the contributions paid to the fund by him, of an amount equal to so much of the excess as bears

to the amount of the excess the same proportion as the sum of the contributions made by the relevant contributor in respect of the relevant period bears to the sum of the contributions made by all relevant contributors in respect of the relevant period.¹¹¹

That provision was repealed in 1992, but it remains, for present purposes, of some interest. It appears to be an indication that, at least for a time, the Commonwealth recognised that, ultimately, the benefit of surplus fund assets was to be enjoyed by the members.

Whilst the fund remains operating, members' entitlements can be experienced only through incidents of membership such as lower rates and/or extra services. These are valuable rights. In its 2005 annual report Medibank Private Limited reported net assets of \$653.3 million. The effect of the current statutory requirements, in our view, is that the members are entitled to share in the benefit that this asset position will bring to the fund (less an adjustment for the government injection of \$85 million in 1985).

Members' rights to compensation

For reasons we have outlined above, membership of the Medibank Private fund, whilst not amounting to ownership of the fund, nevertheless gives to members a valuable right to the benefit of the fund and associated assets. This means little, however, unless that right is of a nature such that it has constitutional protection from unjust acquisition. The Commonwealth has broad power to acquire property, but that power is limited by the need to provide adequate compensation or 'just terms', to adopt the phrase used in section 51(xxxi) of the Constitution. As the scope of the power to acquire property is broadly defined, so is the scope of the requirement for just terms. The breadth of the constitutional guarantee has been outlined by the High Court in this way:

It is now well established that the plenary grant of legislative power contained in s. 51(xxxi) [to acquire property on just terms] enjoys the status of a constitutional guarantee of just terms and is to be given the liberal construction appropriate to such a constitutional provision. In the context of that guarantee, the word 'property', which has been said to be 'the most comprehensive term that can be used', must be construed as extending to every species of valuable right and interest including real and personal property, incorporeal hereditaments and choses in action. In the context of s. 51(xxxi), the word 'property' must also be construed as extending to money and the right to receive a payment of money.¹¹²

There is a considerable body of precedent that considers the extent of the rights compensable under section 51(xxxi). We do not intend to undertake an exhaustive analysis of that question here. For our purposes we merely note that it seems to us arguable that the right of members of Medibank Private to enjoy the benefit of fund surplus earnings could be one that is protected by the section. The Commonwealth would not, however, necessarily 'acquire' any such right on sale. Whether it did would depend upon the kind of sale and associated deal offered to members of the fund. As Medibank Private is a not-for-profit entity, the requirement in the Act limiting distributions of its income and profits would have to be specifically abrogated if any proposed sale was on terms that did not continue those conditions, or the organisation's status would have to be changed to for-profit.

A sale to another not-for-profit or to a mutual fund which undertook to comply with the existing requirements for not-for-profits under the National Health Act would have the result that they had not lost, and accordingly that the Commonwealth had not acquired, the rights associated with their membership status. That is, assuming existing members of the Medibank Private fund were offered continued membership on similar or better terms. Note in this regard that there are relatively few registered private health insurance organisations operating on a ‘for-profit’ basis, and all of those that do are ultimately owned by mutual organisations:¹¹³

At 30 June 2005, there were 40 registered health benefits organisations (RHBOs); 26 of which were available to the general public (open membership organisations) and 14 were restricted membership organisations.

Five organisations operated on a ‘for-profit’ basis. Organisations operating on a ‘for-profit’ basis may make distributions by way of dividends provided that they maintain sufficient capital to satisfy the requirements of the Solvency and Capital Adequacy Standards. Dividend payments totalling \$20 million were provided for or paid during 2004–05.¹¹⁴

If, however, the sale was to a for-profit, and the terms of sale had the effect of giving full ownership of the fund and associated assets to the purchaser, then the members might be said to have lost the rights attached to their Medibank Private fund membership and the question of compensation could arise. If the sale was to be by way of public float of shares in Medibank Private, as Senator Minchin has recently revealed as his preference,¹¹⁵ then the question would depend on whether Medibank Private Limited was to remain subject to the current requirements for the preservation of the fund. Presumably the organisation would, in that circumstance, be converted to a ‘for-profit’ one under the National Health Act. That would mean it would be entitled to distribute surplus profit to shareholders. Whether an entitlement to compensation would arise in these circumstances would depend on whether that right of distribution was prospective or retrospective. That is, whether it related to the existing assets or future profits.

Any sale of Medibank Private will probably be accompanied by amendments to the governing legislation. In the past, whenever there has been a perceived risk that property rights might be acquired, the government has included a ‘safety-net provision’ that provides for persons adversely affected to apply to a court for compensation.¹¹⁶ Such a provision is likely to be included in any amending legislation associated with the sale. These provisions pre-empt attacks on the legislation that might seek to have it declared invalid by reason of non-compliance with the constitutional requirement for ‘just terms’. On the views we have expressed herein, any action by members in relation to the sale would be likely to be brought pursuant to the compensation provision, rather than, for instance, in an application to prevent the sale from proceeding. Having drawn these conclusions on the legal aspects of the proposed sale, this paper proceeds now to consider broader public policy questions regarding the sale of Medibank Private.

Should the government sell Medibank Private?

In stating its case for the sale, the government has argued that ‘there is no policy reason for the government to continue to own a health fund’.¹¹⁷ The government has also suggested that a privatised Medibank Private is likely to be more efficient, enhance competition in the private health insurance sector and, as a result, reduce ‘upward pressure’ on premiums.¹¹⁸ On the other hand, opponents of the sale have suggested that there are important policy reasons for maintaining the current ownership arrangements for Medibank Private.¹¹⁹ For example, the Shadow Minister for Health, Julia Gillard, has stated that ‘Labor believes there is a role for a public, not-for-profit health insurer that can deliver quality and competing products, with its contributing members as the company’s main focus’.¹²⁰

The question of whether there are policy reasons for the government to maintain the current Medibank Private ownership structure will form the basis for the discussion in this section of the paper. While there is no general agreement about what might be said to constitute sufficient ‘policy reasons’, we examine this question in relation to categories drawn from the government’s sale objectives for the fund, the above discussion about the state of the private health insurance sector and the current debate about the sale.

The categories used in this paper are as follows:

- *relationship with members*—would the sale materially affect the interests of members of the fund?
- *public interest*—does Medibank Private currently play a role in promoting broader community interests? If so, would this role be altered by the sale?
- *competition*—does Medibank Private currently enhance or inhibit competition in the private health insurance sector? Would privatisation be more likely to promote or reduce competition?
- *cost containment*—does Medibank Private currently play a role in the containment of costs in the private health insurance sector? Would privatisation enhance or inhibit this role?

We conclude that there is no simple answer to the questions posed above. Indeed, we suggest that, at this stage, there is insufficient information available on the sale from which to develop a conclusive response. Any such response would be contingent on answers to a range of questions, including:

- what type of sale is proposed (trade sale or share float)?
- who is most likely to buy Medibank Private (a mutual, not-for-profit or a for-profit fund? A small or large fund)?

- what is the likely impact of the sale on other players in the market (will it lead to industry rationalisation and/or concentration)?
- what (if any) additional regulatory changes are planned for the private health insurance sector in future years (further expansion into out-of-hospital care or changes to the community rating framework)?

As such, the discussion in this section seeks to clarify key aspects of the debate and highlight those areas in which further information is required.

Relationship with members

As noted above, the government has stated that one of its sale objectives is ‘to maintain service and quality levels for Medibank Private contributors’.¹²¹ This raises the question of whether the sale is likely to materially affect the interests of members of Medibank Private.

Currently, Medibank Private could be considered to provide a reasonably good level of service and quality to its members. As noted above, complaints about Medibank Private are roughly proportional to its market share, it is slightly better than the industry standard in terms of the proportion of contributions returned to members as benefits, and it tends to raise premiums at around the same rate as the rest of the industry. The question is whether there is any risk that the sale of Medibank Private could make the fund any less focused on the interests of its members.

To some extent, this may depend on the type of organisation Medibank Private becomes following the sale. For example, it could be argued that, if it were to become a for-profit fund, Medibank Private would by definition be less focused on the interests of its members because it would now have to also focus on the interests of shareholders. This is one of the reasons that Medibank Private argued strongly for the maintenance of a predominately not-for-profit industry in its 1996 submission to the Productivity Commission’s inquiry into private health insurance. According to the Medibank Private submission, the interests of members are best served when funds ‘view their members as ‘shareholders’ for whom the delivery of lower prices is a dividend’.¹²² As outlined above, a defining feature of not-for-profit funds is the expectation that they return any operating surplus to members in the form of lower premiums and/or higher benefits.

Medibank Private argued in its submission that assuming that insurers are supposed to act in the best interests of members for the payment of healthcare services (given that members are least able to ‘shop around’ when in need of treatment), they would be ‘acting irresponsibly if they were to have as their motive the payment of a return to investors’.¹²³ Further, they argued that increasing the number of for-profit health funds potentially adds an additional layer of cost to the financing of healthcare:

A situation where a for-profit ‘middleman’ (health insurers) is also involved [in addition to private for-profit healthcare providers] will unnecessarily escalate the premium (price) for private health insurance’.¹²⁴

While competition with other funds might moderate any such increase, in practice many members (particularly older and/or long-term members) are likely to be ‘rusted on’ to a fund such as Medibank Private and hence unlikely to readily change funds despite above-average premium increases.¹²⁵

The small number of for-profit funds in the sector makes it difficult to find adequate comparative information from which to examine claims such as these. Of the five for-profit funds, the only one large enough from which reasonable comparisons can be drawn is BUPA, which has a market share of around 9.9 per cent. As can be seen from the table below, no clear pattern capable of illustrating a difference between the for-profit BUPA, the not-for-profit Medibank Private and the industry average can be discerned in a comparison of each across various criteria indicative of responsiveness to members. While in 2005 BUPA had lower management costs and premiums than Medibank Private and than the industry average, it had less success in retaining members, received a higher proportion of total complaints compared to market share and returned a lower percentage of benefits to members as a percentage of contributions.

Table 2: responsiveness to members, various criteria BUPA, Medibank Private and industry, 2005

Fund	Surplus from health insurance	Management expense ratio	Member retention	Market share	Complaints			Benefits as % contributions	Premium increase 2006
					Benefits	Service	All		
BUPA	5.8%	7.7%	83.7%	9.9%	12.8%	10.7%	11.7%	86.5%	4.9%
Medibank Private	2.4%	9.2%	86.8%	28.7	26.5%	33.2%	28.8%	88.4%	5.9%
Industry	2.7%	9.5%	na	na	na	na	na	87.8%	5.7%

Source: Private Health Insurance Ombudsman, *State of the Health Funds Report 2005*

As such, there may be some logic to the proposition that a predominately not-for-profit private health insurance *sector* is more likely to be more responsive to the interests of members. However, there is little available evidence from which to conclude that any one *individual fund* (such as a privatised Medibank Private) operating as a for-profit fund would necessarily reduce standards of service and quality.

Public interest

Some opponents of the sale of Medibank Private have suggested that such an action could place at risk the fund’s historical role in promoting broader community interests in addition to the interests of its members.¹²⁶ For example, according to Deeble, if the fund is sold:

... there will be bigger pressure on the government to deregulate and let them chase their good risk members and all that sort of thing if Medibank Private is sold, because Medibank

Private has always acted like the conscience of the industry, now selling that removes that pressure, that's what it was set up for that's what it's always done.¹²⁷

In other words, Deeble suggests that Medibank Private has, in general, tended to avoid actions that might be in its short term business interests if those actions conflict with broader community obligations.

There is evidence that historically Medibank Private *has* sought to play the public interest role suggested by Deeble and others. For example, an examination of Medibank Private's submissions (1996 and 1997) to the Productivity Commission's private health insurance inquiry reveals that Medibank Private was a strong advocate for regarding private healthcare as essentially complementary (rather than supplementary) to that available from the public sector. As such, according to Medibank Private's 1996 submission, private health insurance should be:

... subject to regulation which ensures social justice and community need are met. To achieve this, the universality principles applying to the public sector must be mirrored in private funding—private health insurance.¹²⁸

According to the submission, in the private health insurance sector, universality was and should continue to be embodied in the principle of 'community rating' (which, as outlined above, is the principle that everyone should pay the same premium for health insurance, regardless of health risk status).

This did not mean that Medibank Private was seeking a heavily-regulated sector. Rather, its submission argued for a regulatory framework in which community rating provided 'controlled entry' into a private health insurance market operating according to free market principles.

The key features of Medibank Private's preferred approach included:

- recognition of the 'social welfare element of private health insurance'
- 'controlled entry' into private health insurance 'based on community rating principles of equity of price, regardless of age, sex, or health'
- operation of a free market for private health insurance (following 'controlled entry' via community rating), and
- only minimal levels of regulation of the private health insurance market 'based on social imperatives of identified *community need*'.¹²⁹

This advocacy on behalf of community rating is significant for two main reasons. First, it was hardly in the immediate business interests of a private health insurer to actively promote community-rating (as opposed to risk-rating). Second, by emphasising social imperatives such as universality and equity, Medibank Private provided a source of informed analysis and

advocacy that could challenge the arguments of those who favoured a move from community rating to more risk-based approaches. This suggests that there is some evidence for assertions about Medibank Private's role in advocating the role of broader social imperatives in the regulation of the private health insurance industry.

One explanation for why Medibank Private has played this role is that for most of its existence, it was operated by the HIC and for much of this time in conjunction with Medibank (and later Medicare). Hence it was run according to the same ethos of universalism and equity as Medibank/Medicare and by the same people (including Deeble, a former Commissioner of HIC). The public sector as opposed to private enterprise focus of the HIC could provide a further explanation.

Nevertheless, it is unclear whether Medibank Private has continued to play this role since corporatisation. It does appear to continue to (publicly) support the principle of community rating. For example, in a report published in 2003 by Harper and Associates on behalf of Medibank Private, it was argued that government measures to arrest the decline in private health insurance coverage should be supported on the grounds that they could be seen as supporting community rating.¹³⁰ However, it is not clear that it is as active in this support as it was in the period prior to corporatisation. For example, there is little evidence in annual reports and other public statements from senior Medibank Private staff that anything other than the immediate corporate goals of the fund and its members are seen as important.

This is not intended as a criticism of Medibank Private. The era in which social imperatives were a key aspect of Medibank Private's approach may have been left behind since corporatisation. Nevertheless, it might still be argued that the current ownership arrangements mean that the government has some influence with Medibank Private and hence is able to restrain it from acting against the interests of consumers. For example, health policy commentator, Ken Harvey, has suggested that government control has probably tended to restrain Medibank Private from negotiating aggressively with service providers in marginal electorates. The flipside of this, as argued below, is that the insurer may have been restrained from gaining the best price from service providers on behalf of members.¹³¹

Competition

The government's sale objectives refer to contributing to an efficient and competitive private health insurance industry. Standard and Poor's has recently argued that any sale of Medibank Private is likely to 'materially affect the competitive dynamics of the industry'.¹³² While Standard and Poor's did not specify the precise nature of the effect on competitive dynamics, it appears to see the main impetus for change in the possibility that the sale may lead to rationalisation and greater concentration within the industry (depending upon the size of the newly privatised Medibank Private—a larger insurer being more likely to inspire others to seek to gain in size).¹³³ Again, this suggests the importance of issues such as the type of sale, the buyer and the type of organizational entity formed after the sale.

A common concern raised in commentary on the government's policy to sell Medibank Private is that privatisation would jeopardise the fund's role in providing competition to the private health insurance sector.¹³⁴ As indicated above, it is widely argued that one of the main objectives behind the creation of Medibank Private was the Fraser government's desire to create a more competitive private health insurance market. As noted above, Medibank Private almost immediately brought greater price competition to the private health insurance sector. More recently, the Industry Commission's 1997 report into the private health insurance industry noted that Medibank Private, appears to have 'played a catalytic role in intensifying competitive pressures in the industry'.¹³⁵ While not clear from its report, it appears that, on the basis of the Medibank Private submissions, the competitive pressures identified by the Industry Commission were mainly in the areas of innovation and efficiency.

In terms of innovation, Medibank Private has argued that its development of new products (such as those aimed at producing a lower priced entry point to private health insurance) have been integral to gaining and maintaining its current national market share.¹³⁶ More recently, Standard and Poor's has highlighted the way in which recent product rationalisation by Medibank Private has 'strengthened product popularity with younger members and increased membership in this segment'.¹³⁷

Other major funds also have a reasonably strong record in terms of administrative efficiency: as can be seen from Table 3 below, in 2004–05 most of the top six funds, measured in terms of market share, were relatively close to the industry average management expenses ratio of 9.5 per cent. Medibank Private's national coverage, however, is an important point of difference.¹³⁸ Other funds have varying degrees of influence in particular states but Medibank Private continues to be the only health fund with a strong presence in each state. As noted earlier, Medibank Private ranks either first or second in terms of market share in every state or territory.

Table 3: management expense ratio, top six health funds and industry, 2004–05

Fund	Market share	Management expenses as % of member contributions
MP	28.7%	9.2%
MBF	16.7%	10.0%
BUPA	9.9%	7.7%
HCF	8.8%	8.7%
HBF	7.9%	9.3%
NIB	6.2%	11.8%
Industry	100%	9.5%

Source: PHIAC, Operations of the Registered Health Benefits Organisations, 2004–05; PHIO, State of the health funds report, 2004–05

This strong national presence means that, to the extent that Medibank Private has helped to set the industry standard for low administration costs, current ownership structures ensure that such competitive pressures are able to be exerted in every private health insurance market in Australia. This could be considered to be an important role given that the private

health insurance market continues to be, for the most part state-based, with important differences in the private health insurance markets in different states (for example, differences in the age of the insured, the percentage of the insured population using public or private hospitals and the levels of service provided by particular health funds).¹³⁹ As such, the existence of a competitive health fund in each state could be considered as consistent with the ethos of community rating. This is where the type of sale envisaged by the government becomes particularly important. Any form of sale that had the effect of eroding Medibank Private's national presence could potentially jeopardise the level of competitive pressure in the private health insurance industry in Australia.

The importance of competition at the national level has recently been emphasised by consultants CRA International in a report prepared for health fund MBF. The report has not been made publicly available. According to a media report, however, CRA International argued that the government 'should consider selling Medibank Private in pieces to state-based health funds in an effort to create more national players'.¹⁴⁰ The objective of this would be to promote 'more head-to-head competition at a national level'.¹⁴¹ While it is unclear at this stage how the sale could be structured to achieve this effect it is reasonable to conclude that such an approach could potentially enhance competition in the private health insurance sector.

It is important to note that the private health insurance market in Australia is particularly complex and that the precise effect of changes in ownership among funds is difficult to predict. There are important differences in the private health insurance markets in different states. This could mean that changes that might enhance competition in one state might possibly also have the opposite effect in a different state. The complex nature of the private health insurance market has been highlighted by former Australian Competition and Consumer Commission (ACCC) Commissioner, Sitesh Bhojani, when he indicated in 2003 that the process of defining the market for private health insurance would be an important aspect of its consideration of any future mergers between health funds (including purchase of Medibank Private by an existing health fund). Mr Bhojani suggested, for example, that 'where local factors are the determining influence on prices, it is more likely that the market will be seen as narrower than a national one; much more likely to be state based or locally based' but that 'there are no clear answers to this'.¹⁴² He further noted that the ACCC:

... would be concerned in respect of merger proposals by any of the top five or six of the health funds, particularly amongst themselves ... It would require very close scrutiny. And in some instances, depending on whether the market is state or national, even one of the top five or six merging with one of the smaller funds may require us to have a look at it.¹⁴³

The key, though, he argued would be to properly define the market:

Depending on whether it's a state or national market will have a significant influence, obviously in terms of whether an arrangement is lessening competition or likely to lessen competition.¹⁴⁴

The difficulty in precisely defining the contours of the private health insurance market and hence the likely impact of changes of ownership on competition, again highlights the crucial nature of the precise plan of sale for Medibank Private to be used by the government.

Contrary to opponents of the sale of Medibank Private, others, including members of the government, have argued that this measure will provide opportunities for the fund to expand into new business areas, thereby *adding* to competitive pressures in the private health insurance sector.¹⁴⁵ The implication of this is that the current ownership arrangements limit Medibank Private in its expansion and innovation.

As noted above, Medibank Private has traditionally been particularly aggressive in pursuit of expansion, innovation and in competition with other funds. Nevertheless, while Medibank Private Chief Executive Officer, George Savvides, has recently argued that ‘there are no constraints [associated with the current ownership arrangements] about being a best practice organisation in the health sector today’, he has also argued that privatisation could ‘possibly’ allow the fund to ‘achieve greater goals’.¹⁴⁶

While Savvides did not provide details of where Medibank Private might expand under private ownership, as noted earlier, Ken Harvey, has suggested that privatisation could allow the fund to operate more aggressively:

It may be that government ownership (and sensitivity) hampers commercial negotiations, particularly high cost hospitals in marginal electorates. It is possible that a privatised Medibank Private could negotiate cost-effective services more aggressively if existing members were educated about what needs to be done and participated in the organisation’s transformation, for example, by being offered shares and greater involvement in return for past loyalty ... Finally, a privatised, freer, more innovative Medibank Private might stimulate a wave of demutualisation, amalgamation and increased efficiency of the remaining 42 health funds, many of whom are far too small to achieve economies of scale.¹⁴⁷

However, as Harvey goes on to argue, a change in the ownership arrangements of Medibank Private will not by itself create significant opportunities for innovation under current regulatory arrangements.¹⁴⁸ As McAuley has argued, ‘the industry is highly regulated (which limits the scope for innovation)’.¹⁴⁹ The extent to which the sale of Medibank Private would increase opportunities for expansion and innovation by the fund is therefore unknown given the absence of specific details from the government or the fund in relation to where such opportunities might arise. Any such opportunities are most likely to arise as a result of some kind of change to industry-wide regulation such as those recently proposed by the government (see discussion above), rather than a change in ownership for a particular fund.

Cost containment

In a previous section of this paper, we highlighted the importance of the capacity for insurers to contain the costs of healthcare as a particular concern of commentators who question the sustainability of the industry in its current form. Further, the government has nominated the

viability of the private health insurance industry as one of its sale objectives. Hence cost containment is an important issue for consideration when examining the potential impact of the sale of Medibank Private.

Some commentators have made the point that the size and national presence of Medibank Private (and other large funds) provide it with particular advantages in negotiating on cost and quality with providers of healthcare services through Hospital Purchaser-Provider Agreements (HPPAs). For example, McAuley argues that:

Service providers such as private hospitals and medical specialists themselves have strong market power, and they need to be confronted by strong insurers. (That is the case for a single national insurer, a case which the present Australian Government, after wasting at least \$25 billion on subsidies to private insurance, still does not understand.)¹⁵⁰

Leaving the case for a single national insurer to one side, it could be argued that the government is not unfamiliar with the advantages associated with confronting strong market power in the health system with a strong purchaser of healthcare. For example, the government's status as a bulk-purchaser of medicines through the Pharmaceutical Benefits Scheme (PBS) allows it to negotiate strongly with pharmaceutical companies over the price of medicines. Partly as a result, Australia spends less on pharmaceuticals than many other comparable countries.¹⁵¹

Medibank Private's development of a network of preferred hospitals (under the 'Member's Choice' framework) that have agreed to certain cost and quality criteria is an example of its use of strong bargaining power in negotiations with healthcare providers. As part of these negotiations, the fund insisted that hospitals would be required to provide pricing discounts when the number of Medibank Private members they treated rose above certain levels.¹⁵² According to media reports, Medibank Private also sought limits on which treatments it would pay for in intensive care, limits on how long it would pay for patients to be in hospital and for particular treatments, and sought to impose set payments for treatments from which hospitals must meet all costs.¹⁵³

During the negotiation process, Medibank Private was criticised strongly by healthcare providers and their representative bodies on various grounds, including interfering in clinical decision-making and potentially causing hospitals to limit numbers of patients treated or avoiding less profitable treatments.¹⁵⁴ The fund responded that its actions were necessary to reduce the costs of hospital services and through this, pressure on premiums. It argued that 'seventy per cent of our costs are related to what happens in a hospital, and increases in those costs then inevitably lead to people dropping out of health insurance and blocking up the public health system'.¹⁵⁵

It could be argued that any model of sale that had the potential to reduce the negotiating strength of Medibank Private (that is, through a reduction in its size or national presence) could be reasonably considered to put at risk the role played by the fund in containing costs by challenging the market power of healthcare providers. Conversely, it might equally be

argued that any form of sale that had the effect of increasing the size and/or national presence of Medibank Private, could well enhance the role played by the fund in containing costs by challenging the market power of healthcare providers.

Indeed, McAuley is of the view that the key factor is that there is a fund strong enough to negotiate with healthcare providers, and suggests that whether or not the fund is publicly owned is essentially irrelevant.¹⁵⁶ The question of whether public ownership makes any difference to cost containment is therefore particularly important in the context of this paper. It could be argued that some forms of ownership are better than others at containing costs. For example, the Blue Cross funds (funds that were dominated by healthcare providers) that dominated the private health insurance industry in the 1950s and 1960s were not noted for negotiating strongly with providers over cost.¹⁵⁷ The precise characteristics and intentions of any future buyer of the fund, obviously unknown at this stage, may well be an important factor in determining the impact on the capacity of Medibank Private to contain the costs of healthcare services.

4. Conclusion

This Research Brief has examined two key issues from the debate about the possible sale of Medibank Private:

- who owns or enjoys other rights in Medibank Private? and
- are there any policy reasons for the government to maintain the current Medibank Private ownership structure?

In relation to the first question, the conclusion reached is that, while the government clearly ‘owns’ Medibank Private Limited (the managing organisation of the Medibank Private *fund*) the fund itself is best characterised as a government controlled not-for-profit entity (not strictly *owned* by either the Commonwealth or the fund members). Members of the fund nevertheless have certain rights to the benefit of the fund and associated assets and these rights need to be considered in any scheme for the sale of Medibank Private

Medibank Private fund (as opposed to Medibank Private Limited) is best characterised as a government-controlled not-for-profit entity, an essential characteristic of which is that it is not strictly owned by anyone. While members do not own the fund, they enjoy certain rights over the fund and associated assets. If the terms of any sale continue those rights, at least over existing assets, then no issue arises. If, on the other hand, the terms of sale involved the loss of members rights to the benefit of fund assets, then the Commonwealth may be liable to compensate the members.

On the second question, while the sale of Medibank Private will most likely lead to changes for both members of the fund and the broader private health insurance sector, the precise nature of these changes is difficult to determine. For example:

- in the absence of a clearer understanding of the comparative virtues of not-for-profit and for-profit health funds in the Australian context, it is difficult to make any judgment on whether a for-profit Medibank Private would be more or less responsive to members
- it is unclear, in any event, whether Medibank Private is likely to change to for-profit status as a result of any sale
- in the absence of information about the likely size or geographical presence of Medibank Private after it is sold, it is difficult to gain a precise understanding of the impact of the sale on competition or the capacity of the fund to contain health costs; and
- while changes to the regulation of private health insurance in Australia could potentially change competitive dynamics in the sector, there is no clear evidence of the government's intentions in this area. The government has recently announced changes to aspects of private health insurance regulation, but it is not clear that these will directly address the kind of fundamental concerns in relation to industry sustainability discussed in this paper (for example, cost-containment). One example of a more fundamental change that some argue could address the issue of cost-containment is the adoption of a medical savings account model by insurers.¹⁵⁸

There is little evidence to support assertions that a privatised Medibank Private would be likely to be more efficient, competitive and (potentially) less expensive for consumers. Similarly, there is little evidence that a privatised Medibank Private would be less competitive or less able to contain costs.

This Research Brief has highlighted several key areas for the government and others to consider in their approach to the sale of Medibank Private. In particular, it has highlighted the importance of competition between funds, *and* the need for funds with sufficient strength to negotiate effectively with service providers and hence control costs. Failure to account for the likely impact of the sale on these factors would leave open the possibility that while the ghost of premium increases might be chased out the front door, there is every possibility that it will return via a side window.

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58. P. Gross, 'Radical reform of Medicare and private health insurance inevitable, says Gross', op. cit., p. 41; I. McAuley, 'Behind the smokescreen—here comes the nanny corporation to manage our bodies', *New Matilda*, 3 May 2006, p. 1; K. Harvey, 'The sale of Medibank Private', *New Matilda*, 1 March 2006, p. 3; Standard and Poor's, *Australian Health Insurance Report 2006*, op. cit., p. 9.

59. T. Abbott and N. Minchin, *Changes to the Private Health Industry and sale of Medibank Private*, op. cit.; T. Abbott and N. Minchin, *More innovation, greater choice in private health*, op. cit.
60. Department of Health and Ageing (DoHA), *Discussion paper—Private health insurance: cover innovation and regulatory reform*, Private Health Insurance Circular, PHI 34/06, DoHA, 15 June 2006, p. 7.
61. *ibid.*, p. 11.
62. I. McAuley, 'Behind the smokescreen—here comes the nanny corporation to manage our bodies', op. cit., p. 2.
63. *ibid.*, p. 24.
64. Management expenses are the costs of administering the fund and include rent, staff salaries and marketing costs.
65. Private Health Insurance Ombudsman (PHIO), *State of the health funds report 2005—Individual funds summary (Medibank Private)*, PHIO, 2005, at <http://www.phio.org.au/documents/Medibank.pdf>, accessed 31 July 2006.
66. *ibid.*
67. *ibid.*
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70. Standard and Poor's, *Australian Health Insurance Report 2006*, op. cit., p. 24.
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73. Health Insurance Commission (HIC), *Annual Report 1987–88*, Commonwealth of Australia, Canberra, 1988, p. 5.
74. *Sunday Times* [Canberra], 'Medibank sale a bad policy and politics', 2 January 2000.
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76. *ibid.*
77. *Not* Ray Williams, the former Chief Executive Officer of HIH Insurance Limited.

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81. Health Insurance Commission, Annual Report 1976–1977, p. 1.
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92. *ibid.*, p. 6 (emphasis added).
93. *Re NRMA Ltd; Re NRMA Insurance Ltd* [2000] NSWSC 82.
94. *Social Credit Savings and Loans Society Ltd v. Federal Commissioner of Taxation* (1971) 125 CLR 560, per Gibbs J at 570–71.
95. See, for example, the statement of Senator Minchin, cited herein, that equates a mutual organisation with members having a stakeholding.
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101. Health Insurance Commission, *Sixth Annual Report 1979–80*, Commonwealth of Australia, Canberra, 1980, p. 4
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104. *ibid.*, p. 11.
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110. *ibid.*, section 73AAC(1)
111. *ibid.*, section 82ZGA(3). The term 'relevant contributor' was restricted to those who had been members for 6 months or more prior to the making of the application for winding up: 82ZGA(5).
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113. Advice provided to the authors by the Private Health Insurance Administration Council, 14 June 2006.
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 121. *Sale of Medibank Private Limited: Government Sale Objectives*, op. cit.
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 134. See, for example, J. Odea, ‘Medibank Private: let’s wait and see’, *Australian Medicine*, 18:7, April 17 2006, p. 6; J. Gillard (Shadow Minister for Health and Aging), *Medibank Private sale sells out Australians*, op. cit.; John Deeble, quoted in *Medibank Private up for sale—the National Interest*, transcript, radio broadcast, ABC Radio National, 9 April 2006, p.1; Hon. John Hatzistergos, New South Wales Minister for Health, quoted in *Medibank sale details to be decided*, ABC New South Wales online, 27 April 2006.

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137. Standard and Poor's, *Australian Health Insurance Report 2006*, op. cit., p. 24.
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