SENATE COMMUNITY AFFAIRS COMMITTEE INQUIRY INTO THE PRIVATE HEALTH INSURANCE BILL 2006, AND RELATED BILLS

SUBMISSION FROM AUSTRALIAN UNITY

25 January 2007

1. Summary

Australian Unity supports the philosophy and intention of the reforms embodied in this Bill and through other related measures – greater competition leading to improved services for customers and clearer and simpler regulation for health insurers and services providers. We support the central role for Community Rating embodied in the Bill, and welcome the broader health reforms.

We do however have some specific concerns, relating to informed financial consent, broader health cover, directors' obligations and penalties, standard product information, electronic transactions and the requirement for health insurers to re-register under the new regime.

In addition, looking beyond the immediate reforms, we believe that more needs to be done to ensure that the health system continues to evolve and to achieve the sustainable health system that Australia needs. In particular we consider that: health insurers should have a role in helping coordinate members' healthcare; consumers should be able to access information about performance of hospitals and clinicians; a pay-for-performance model for doctors should be explored; consumers should be able to obtain information from health insurers about the billing practices of medical specialists; private health insurance brokers should be required to disclose commissions received; private health insurers should be able to access members' claims information to identify those who might benefit from participation in prevention programs; and the scope to pay private health insurance premiums from superannuation contributions should be explored.

2. Introduction

On behalf of Australian Unity, I wish to thank the Senate Community Affairs Committee for your invitation to make a submission to the Inquiry into the Private Health Insurance Bill 2006, and related bills.

We are pleased to have the opportunity to present our views on behalf of our health fund members.

3. Who we are

Australian Unity is a national health, financial services and retirement living organisation with more than 400,000 customers, including some 200,000 members, around $600 million in revenues and employing more than 1,300 people.

As a mutual organisation, Australian Unity has a heritage dating back more than 165 years. Australian Unity, as an entity, was formed with the merger of the Australian Natives Association and Manchester Unity Independent Order of Odd Fellows in Victoria in 1993. A further expansion took place in 2005 through a merger with Grand United Friendly Society Limited.

Today, Australian Unity provides health insurance cover for approximately 350,000 lives, through two health insurance companies: the Australian Unity retail health fund and the Grand United corporate fund.

Over the past decade, both Australian Unity and Grand United have pioneered services designed to help members protect and maintain their health and wellbeing, including providing information and personalised feedback on preventative health care.

The organisation also contributes to the community in a number of ways, particularly in the health and wellbeing areas. These include a partnership with Deakin University to produce the Australian Unity Wellbeing Index, now in its sixth year. The Index measures the life satisfaction of Australians in seven areas – standard of living, health, achieving in life, personal relationships, sense of safety, connection to the community and future security.

In 2006 Australian Unity also founded the Australian Centre for Health Research, a public policy research organisation to raise and consider health and ageing issues. The first two research papers released by the Centre focussed on the performance of prostheses and how Medicare might be improved.

4. Why we have a view

Private health insurers are a key part of the Australian health economy – the intricate mix of public and private organisations and individuals which, collectively, play their part to contribute to the better health of all Australians.

Together, private health insurers provide hospital cover for some 8.9 million people, or 43 percent of the Australian population[1]. Collectively these people paid premiums of $10.3 billion in 2005/06[2]. Without the large financial contribution of the private health insurers and their members, Government – which means the Australian taxpayer – and individuals would have to fund the entire health system, a system which already accounts for almost 10 percent of Gross Domestic Product[3].

Government support, particularly through the rebate, helps to ensure a vibrant private health sector, which is strongly placed to address the key challenges of the future, including chronic disease management, greater demand for health services as a result of the ageing of the population, and the increasing costs of medical technology.

While each member of this economy looks at health from their own perspective we are firmly of the view that, for the health industry to continue to be sustainable long-term, we must all try to see the big picture. Co-ordination and co-operation are essential for the system to work smoothly.

We commend the Federal Government for taking a broad approach in reviewing the private health insurance system and seeing the need for this co-operation.

As a mutual organisation representing more than 190,000 health members and their families, we are very conscious of our responsibility to represent and advocate on behalf of our members.

We typically have a long-term relationship with our members: our average member's tenure is 12 years, but many people have been with us for 40 or 50 years. We therefore have a longer-term association with many members than do individual clinicians who might treat them, which positions us uniquely to contribute to their health and wellbeing.

We come into regular contact with our members at crucial times of their lives. When they consult with us, ask for our advice and make claims, it is often when they are facing major health issues – planning to have a baby or having just had a child, about to have surgery, been diagnosed with a serious illness or reviewing how they might try to improve their health.

We recognise that it is a large responsibility our members trust us with – one we take very seriously. They trust us to advise them accurately and appropriately and to help them through, what can sometimes seem to the individual, a complicated health minefield. While they are focussed on the detail of their lives at that moment, it is our role to look beyond that and consider the bigger picture.

We believe part of that responsibility is to take stock of the environment, look ahead, advocate change as it needs to take place and work with other members of the health economy to develop solutions.

Some key trends are apparent to us, all of which will add to the cost of health care and therefore of private health insurance, including the following:

- The Australian population is ageing, and so is private health insurance membership. For example the proportion of persons covered by private health insurance who are at least 50 years of age has increased from 30.2% to 35.6% in the period from December 2000 to June 2006[4].

- Advances in technology mean the health of more people can be improved – at a cost. The number of joint replacements undertaken in Australia has more than doubled in the past 10 years, giving many people a better quality of life but costing well over $1 billion. And an estimated 20-25 percent of prosthesis surgery needs to be repeated because of failure or infection[5].

- The medical advances which enable people to live longer are very expensive. Health funds, including Australian Unity, regularly pay hospital bills of more than $100,000 during the last months of a member's life.

- Claims from people suffering from chronic diseases such as diabetes and coronary artery disease have increased significantly – diseases which are largely caused by lifestyle factors. For example, Australian Unity has experienced a significant increase in the benefits paid for coronary artery disease – up 8 percent per annum, diabetes – up 17 percent per annum, and arthritis – up 12 percent per annum, in the past five years.

These, and many other trends we have observed, are not isolated to Australian Unity's experience but are being felt in the broader Australian community. They indicate how our society, and its health, are changing.

It is important for those of us entrusted to a role of responsibility to recognise the changes and make the necessary modifications so that the health system works for the community it serves and that private health insurance continues to be affordable and offer value.

We are very conscious of the need to provide value for our members. They have chosen to pay for private health insurance for the many benefits it delivers – choice of doctor and hospital, many other ancillary benefits and, most importantly, peace of mind – but they do need to know that their premium dollar is being spent wisely. In this context we note that health insurers have reduced their management expenses, as measured by their Management Expense Ratios, significantly in recent years: to an average of 9.4 percent in 2005/06 from 13.1 percent in 1999/2000[6].

While we are prudently and efficiently managing our costs, part of our responsibility to our members is to co-operate with other parts of the industry to ensure that the system is as financially efficient as possible while maintaining and improving the health outcomes for our members.

5. Australian Unity's views on the proposed reforms

Australian Unity considers that the private health insurance industry must be appropriately regulated, given the public policy issues involved, and the public funds contributed via the Federal Government rebate. But some reform of that regulation is clearly necessary considering the changing environment we live in.

Australian Unity is supportive of the philosophy and intention of the reforms embodied in this Bill and through other related measures – greater competition leading to improved services for customers and clearer and simpler regulation for health insurers and services providers – as addressed by the Federal Minister for Health and Ageing in his Second Reading Speech in Parliament in December 2006.

We note that the Bill preserves the central role of Community Rating, which we strongly support, as by broadening the risk pool it helps to maintain the ability of private health insurance to fund older and less healthy members of the population. It also works to engage the entire private health insurance sector in investing in improving the health status of all lives insured.

Australian Unity welcomes the broader health cover reforms. We intend to build on the opportunities provided by the proposed changes to offer broader services to our members to help them achieve better health.

Health has changed in recent times. In the past, people tended to only think about their health when they were sick. Health was considered in terms of "ill health" or "sickness" and people went to their doctors looking for relief from an illness.

Now, many people are focussed on ways to stay well or improve their health by taking a more preventative approach. The boom in the fitness industry, vitamins, alternative therapies and numerous other ways of improving health are a reflection of Australians' focus on their wellbeing.

These reforms are consistent with Australian Unity's view that the role of private health insurers should be more than "bill payers". While this is an essential part of our business, we believe that we can and should make a much broader contribution.

Specifically, we believe that it is logical that health insurers have a role in helping to co-ordinate members' care, in conjunction with the medical profession. We consider that such a "coordinated care" model is important given the current lack of coordination, information gaps and information asymmetry in the healthcare sector. We consider that coordination is especially relevant given the increasing prevalence of chronic diseases, which typically require a number of specialists to treat, and which therefore call for more coordination than for many acute conditions. We believe

it essential that treatment continue to be clinician-led and are not proposing a form of "managed care", but we are confident that health insurers can play a valuable role in this more coordinated approach.

We consider that if all of the participants in the health economy work together we can improve the system further in areas such as preventative health where people are educated about how to make the lifestyle changes necessary to reduce their health risks.

This emphasis on preventative health results in individual Australians enjoying the benefits of healthier lives and also leads to less pressure on the health care system.

The health system must change to meet the evolving environment. We consider that the Government's proposed reforms will assist in addressing many of these issues.

6. Specific reforms – Australian Unity's perspective

Our comments below focus on the elements of the reforms which we believe are most significant and will have most impact on the health system.

6.1: Informed Financial Consent – all patients should be aware of, and agree to, the full cost of medical treatment before it occurs.

While this issue is currently not dealt with in the Bill, we consider it to be an important aspect of the overall reforms, which should be addressed in the Bill. This issue has also featured prominently in the Minister's statements on the reforms.

We strongly support all patients being given information prior to medical treatment in order for them to give Informed Financial Consent (IFC), in all but emergency cases.

We consider this to be essential in order to reduce the information asymmetry that pervades the health sector, to give consumers more control over their health costs and to improve cost efficiency.

Unexpected out of pocket costs, caused by lack of informed financial consent – an area outside the control of health funds - is currently one of the major causes of discontentment with private health insurance.

In almost 20 percent of privately insured hospital episodes patients faced unexpected bills, according to the most recent figures released by the Federal Department of Health and Ageing[7].

Australian Unity believes it is in the interests of our members for the lead clinician involved in a medical procedure to be legislatively required to inform each patient of all the costs they will face during the procedure. Hence the lead clinician (often the surgeon) would provide information about not only his/her costs but also those of the anaesthetist, pathologist, and any other practitioners involved in a procedure.

We note that the Australian Medical Association has been conducting an information campaign to encourage doctors to obtain IFC, and that the AMA's policy is that the admitting practitioner provide patients with information about their own fees and estimated fees of other medical providers where possible, but as a minimum to provide their names and contact details. The Federal Government has stated that if there is not substantial improvement in the level of IFC by early 2007, it will legislate to require doctors to obtain IFC or face penalties.

In our view obtaining IFC should be required by legislation rather than relying on self-regulation, because of the importance of the issue and the need to ensure that it is resolved permanently, not just for the period of an education campaign.

In addition we consider that the lead clinician should be responsible for advising the patient of all fees from all practitioners, rather than merely giving the patient relevant contact details. We believe this is essential so that patients, who are often in a vulnerable situation, can obtain a full assessment of the costs they will incur, without the extra time and effort required to contact a number of individual practitioners.

Our recommended approach is in line with the recommendations of the House of Representatives Standing Committee on Health and Ageing Report on Inquiry into Health Funding, November 2006, which recommended that the PHI legislation should be amended to specify the obligations of the lead clinician for IFC[8].

Once consumers have been provided with information by the lead clinician, health funds have a role to play by providing information on any gaps which may apply, as well as by providing "no gap" or "known gap" products – which Australian Unity already does.

We believe that this is an area of the health system which can easily be improved, furthering the transparency of the system, giving consumers greater control over their own health and more certainty about the costs they will incur.

6.2: Broader Health Cover: to enable health funds to offer products which can provide benefits for services that are part of, substitute for or prevent hospital admissions.

As noted previously, we applaud the initiative to broaden the scope of the services which can be covered by private health insurance, as provided for in subsection 69-1 (1), Division 72 and sections 121-5 and 121-10 of the Bill, and related Rules.

While in principle we support the Broader Health Cover reforms, we wish to make three specific comments.

1. Division 69 of the Bill specifies the coverage requirements for complying health insurance products. It stipulates that complying products must meet the requirements to be set out in the Private Health Insurance (Complying Product) Rules. The Department has issued a Circular setting out its views on the regulatory framework for broader health cover products including those for chronic disease management programs.

   We are concerned that, under this framework, such programs would require the provision of at least 2 allied health services from 2 or more disciplines. We agree fully that under broader health cover the focus should be on "programs" of care, rather than individual treatments, and that as set out on page 4 of Attachment A of the Department's circular, a program would typically involve an initial assessment, some specific goals and activities that the patient agrees to, a specific plan, a responsible person coordinating the plan, and a specific review. However we would be concerned if worthwhile programs, which meet these criteria and which produce positive outcomes for patients, were excluded simply because they did not require the involvement of more than one practitioner, or practitioners from more than one discipline. We feel that such a requirement will rule out some programs, may cause extra personnel to be added unnecessarily to some programs merely to allow them

to qualify, and may make broader health cover more difficult to deliver in rural and remote areas, where access to multiple disciplines is more limited.

We suggest an alternative approach, in the situation where an insurer had a program which met all of the requirements for a complying program, except that it only required the involvement of a single practitioner. We propose that in this case the insurer's Board would be required to certify annually that such a program complied with all the requirements for a bona fide preventative program. In this way, single treatments that would not constitute a program would not be certified and so would not be able to be offered under broader health cover. This approach would therefore enable worthwhile programs to proceed and members to benefit without allowing "broader health cover" to encompass an unrestrained set of individual treatments.

2. To be most effective we would recommend that the Government conduct a significant communication program targeting health professionals, to encourage them to offer appropriate out-of-hospital treatment where relevant and to direct patients to prevention programs. Without such a program, we would be concerned that the new, more cost-effective, options available under broader health cover would not be used to their fullest.

3. A major purpose of these reforms is to obtain cost savings for health insurers and their members by enabling insurers to pay benefits for treatment of members out of hospital as part of an episode of hospital care, where this is medically appropriate. We note that the Bill does not require cost savings in such circumstances to be passed on to health insurers, however we note that the Department's recent Broader Health Cover Regulatory Framework paper would retain scope for health insurers to negotiate with hospitals for separate rates for out-of-hospital services. We would be very keen that this freedom be preserved in the Act and Rules (which are to be based on the framework paper), in order that this major objective of the reform be achieved.

6.3: Directors' obligations and penalties

We have two concerns about the obligations of directors in the Bill, and the attendant penalties:

1. Subsection 152-1 (1) provides that directors have an obligation to policyholders. This subsection and the rest of division 152 replicate the regime governing directors' duties in the Life Insurance Act 1995 (Commonwealth).

   There are, however, fundamental differences in the nature and regulation of life insurance and health insurance including:

   - a life insurance contract is (unlike health insurance) not a contract of indemnity;
   - in the life context there is no compulsion to insure individuals (whereas there is in the health insurance context);
   - most contracts of life insurance and life policies are "financial products" for the purposes of chapter 7 of the Corporations Act (while health insurance is specifically excluded from that regime);
   - private health insurance is more heavily regulated than life insurance; and

- perhaps most importantly, some life insurance policyholders have an immediate participatory financial interest in the form of a reversionary bonus while health insurance members do not. Health insurance members have no right to the assets of the health fund.

Against that background it is difficult to see why it is that directors of private health insurers ought to owe personal duties and incur personal liabilities to policy holders in addition to the fiduciary duties that they already have to act in good faith and in the interest of members of the company as a whole, both under the common law and statute. In particular, directors will at times be faced with conflicting duties to those set out in section 152-1 - for example, duties under common law and the Corporations Act. This position is unacceptable on any level: faced with such a conflict, directors may have no choice but to resign rather than risk the reputational and other impacts of being forced to choose between the "lesser of two evils".

Further, in extreme circumstances (for instance, short-term conditions which encourage material adverse selection risk) directors might even feel themselves duty-bound to close the fund to transferring members. This in turn would be entirely corrosive to the principle of portability: the underpinning concept of the PHI industry framework.

Given that it is a basic tenet that directors owe their duties to corporations not to shareholders individually or other members of the public, we believe that section 152-1 of the Bill should be deleted unless there are very sound policy reasons for retaining it. To our knowledge, no such policy reasons have been identified and, indeed, a large number of reasons have been identified as making section 152-1 manifestly inappropriate.

Further more specific legal advice on this issue is attached.

2. Subsection 169-15 (2) requires that an insurer must notify the Department and PHIAC of any change to the name or contact details of its CEO, before the changes take effect. This is inconsistent with the similar requirement under the ASIC regime, as set out in Section 205B of the Corporations Act, for notification of a change within 28 days.

6.4: Standard product information: to be provided by all private health insurers on a website administered by the Private Health Insurance Ombudsman, providing consumers with comparative information.

We support the Government's intention to make private health cover more transparent and to help consumers choose the best value product that suits their needs. To achieve this, the Bill (in Division 96) requires health insurers to provide information to the Ombudsman, and the Private Health Insurance (Complying Product) Rules will stipulate the form of the information, which will be displayed on a website currently being developed by the Ombudsman's office.

However our experience indicates the importance of attention to several issues in order that this initiative be successful. We suggest that:

- The website incorporate a thorough analysis of consumers' needs, in order to guide them to the products that will suit them, and from which they can make a choice. This will avoid consumers simply comparing products based on price alone without considering other product features which are important to

meet their needs, with the potential for dissatisfied consumers who have made inappropriate product choices.

The way in which the website is used should be monitored and funding be committed to making any necessary refinements based on actual usage and effectiveness.

6.5: Lifetime Health Cover – reminder letters to be sent to people shortly before they will be affected by loadings.

We welcome this initiative, as it will ensure young people understand how Lifetime Health Cover operates and can make an informed decision about private health insurance and the implications of their choice. Since the introduction of Lifetime Health Cover, the influx of younger people into private health insurance has helped to partially offset the ageing of the membership base.

6.6: Annual premium reviews

We are pleased that the current system of premium reviews has prevailed, as set out in subsection 66-5 (1) of the Bill, rather than a change to annual contracts as had been proposed in the Exposure Draft. This will avoid extra administrative costs for health insurers and for employers, and higher initial increases in premiums. Australian Unity is one of the funds which offer a rate guarantee, allowing members to lock in premiums ahead of a premium increase, and intends to continue this practice.

6.7: Electronic transactions

We consider that the legislative framework should permit members to access information and carry out health transactions electronically if they choose to do so. We therefore consider that subsection 65-5 (3) of the Bill should permit health insurers to offer discounts for products where members purchase and transact on-line, to reflect the lower cost of this type of transaction. Further, any barriers to transacting electronically, such as in applications for the Federal Government rebate, should be removed. The Bill provides in subsection 18-30 (1) that the CEO of Medicare Australia can approve the form in which applications for the rebate may be made, and we consider it essential that such a form should permit applications in electronic format or via retrievable voice recording.

6.8: Requirement for current health insurers to re-register under the new regime

We are unclear as to why all existing health insurers are required to re-register under the new legislative regime, as a consequence of section 18 of the Private Health Insurance (Transitional Provisions and Consequential Amendments) Bill. We understand from discussions with the Department of Health and Ageing that all current health funds (except for the few which are not ASIC-registered corporations) would be expected to transfer to the new regime without major change, so the requirement for the remainder to register seems only to be imposing extra cost without benefit. We recommend that all existing health funds whose corporate structure meets the requirements of the new legislation be "grand fathered" into the new regime.

7. What else needs to be done?

In addition to our comments on the details of the reforms, as provided in section 6 above, we also believe that there is scope for further changes to improve the Australian health system.

While we consider that the Government's proposed reforms are generally admirable and necessary, Australian Unity believes more needs to be done to achieve the sustainable health system Australia needs.

A number of these initiatives focus on increased transparency and providing consumers with information to enable them to make informed decisions about their health.

We consider that:

1. Health insurers should help to co-ordinate members' care as noted previously, by educating them about chronic conditions and the options for treatment, motivating members to address risk factors, and by stimulating adoption of programs proven in the public hospital sector or overseas. We would also be keen that clinicians develop best-practice pathways that are effective, with appropriate quality measures, and that we, as insurers can fund;

2. Consumers and their GPs should have access to information about the performance or success rates of hospitals and doctors so that they can make informed decisions about their own health. Such information should recognise the different types of patients and conditions involved, so that clinicians undertaking more complex or risky treatments are not penalised. We note that this approach has been recommended by the recent House of Representatives Standing Committee Report into Health Funding[9]. If disclosure was mandated by law, it is our understanding that no change would be required to the Privacy Act as this information could be published under the exemption for uses permitted by law (as the Privacy legislation itself expressly provides that it is subordinate to other laws in this respect);

3. Further to this point, the development of a pay-for-performance model, which would reward health professionals who produce good results relative to best-practice benchmarks, should be explored. This would enable us to move beyond the current model, which essentially pays for activity rather than outcomes;

4. Consumers should also be able to access information from health insurers about the billing practices of medical specialists so that they can be fully informed before they make decisions about their treatment. Currently health insurers must have the consent of practitioners to disclose this information. Such a change would facilitate health insurers becoming a relevant collection and dissemination agency for this kind of information, enabling members to access it more readily. This change would require amendment to the Privacy Act;

5. Private health insurers should be able to access members' claims information to identify those who might benefit from participation in prevention programs.

   The privacy laws prohibit the use of sensitive information (which includes health information) for purposes other than the primary purpose for which it is

collected. In private health insurance, it is often argued that the primary purpose for which information is collected is no broader than to pay claims.

The focus of the health industry in general, however, is moving to the containment of escalating costs through a shift towards preventative health. The reforms to the PHI legislation broadly support a shift in this direction: necessary to protect the sustainability of the health system in this country.

Private health insurers should rightly play their part in supporting this change in focus, and will need to innovate in order to do so.

Health insurers are in a unique position in terms of access to high quality, timely and relevant health information in respect of their members, through the collection of claims data. A single clinician or medical provider might not be in such a position: seeing information relevant to specific episodes only, but not necessarily the "full picture" (for instance, they may see information relating to an acute care episode, but not relating to optical or dental health needs).

One way in which health insurers can play their part in the shift to preventative health, is to synthesize health information that they collect in order to use it to invite their members into opt-in programs that may assist them to manage their own health in one way or another. We would expect to see a welcomed and rapid expansion of options in this area in the coming years: legislative structure permitting. It should be noted that use of information in this way should ordinarily involve no third party disclosure whatsoever.

We see the use of information in this way as being entirely consistent with public expectations on the use of information, but in many cases hampered by the "primary purpose" test related to health information contained within Australia's Privacy legislation.

We believe appropriate support should be provided to insurers to use claims information in this way, as it is manifestly in the public good and consistent with the aims of the PHI legislation. Appropriate support would be provided by expressly providing in the PHI legislation that claims data may be used by insurers in this way, given the Privacy legislation expressly provides that it is subordinate to other Commonwealth legislation.

6. Brokers offering private health insurance product selection should be subject to full disclosure requirements so that consumers are informed about any commissions paid to brokers or advertising fees paid to websites. Brokers currently receive commissions varying from approx 5% to over 20% of the annual premiums of policies sold, which might provide a substantial incentive to promote particular products. We believe that full disclosure (or perhaps disclosure where commissions exceed the 12% limit permissible for discounts on PHI products), in a similar way to that required of financial planners and life insurance brokers, would enable consumers to be reassured about the impartiality of recommendations made by brokers. This issue could be addressed in the PHI Bill under review by the Committee, or by separate legislation in the near future;

7. The scope to pay private health insurance premiums from superannuation accounts should be thoroughly explored. While we recognise the importance of not depleting superannuation savings, private health insurance

contributions help to contribute towards the community's health costs, enabling individuals to be less of a financial burden on the public health system. Hence we consider that there is merit in examining whether it is possible to apply some funds from superannuation contributions to private health insurance, in a similar way as is done with death and disability insurance.

8. Conclusion

Australian Unity considers that these reforms represent a substantial step along the road to improving the Australian healthcare and health insurance systems, and to keeping them sustainable into the future. We look forward to being able to better meet our members' needs through these reforms, subject to the comments we have made. We will also remain focussed on the need for continuing reform, to meet future changing needs.

We would be happy to expand on these points, either in writing or at the Committee's Public Hearing.

Sources

[1] Membership Statistics, Private Health Insurance Administration Council, September 2006
[2] Operations of the Registered Health Benefits Organisations Annual Report 2005/06, Private Health Insurance Administration Council
[3] Health Expenditure Australia 2004-05, Australian Institute of Health and Welfare
[4] Quarterly PHIAC1 data from Health Funds, Private Health Insurance Administration Council
[5] A Review of Joint Replacement Surgery and its Outcomes: Appropriateness of Prostheses and Patient Selection, Australian Centre for Health Research, October 2006
[6] Operations of the Registered Health Benefits Organisations Annual Reports 1999/2000 and 2005/06, Private Health Insurance Administration Council, Part C tables
[7] Informed Financial Consent Consumer Survey Report, Department of Health and Ageing, http://www.health.gov.au/internet/wcms/publishing.nsf/Content/informed-financial-consent-1
[8] "The Blame Game", Report on the Inquiry into Health Funding, House of Representatives Standing Committee on Health and Ageing, November 2006, recommendation 21, para 8.68
[9] Ibid, recommendation 29, para 9.54

CLAYTON UTZ

Sydney Melbourne Brisbane Perth Canberra Darwin

Clayton Utz
Lawyers
Level 18
333 Collins Street
Melbourne VIC 3000
Australia

DX 38451
333 Collins VIC

T +61 3 9286 6000
F +61 3 9629 8488
www.claytonutz.com

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By Email - vfehlberg@australianunity.com.au

Mr Verran Fehlberg
General Counsel & Company Secretary
Australian Unity Health Limited
114 Albert Road
SOUTH MELBOURNE VIC 3205

Our reference: 338/14996/80045992

Dear Verran

Private Health Insurance Bill 2006

As requested, we have reviewed and considered division 152 of the *Private Health Insurance Bill 2006* (Cth) (the "**Bill**"), which relates to the duties and liabilities of directors.

It is clear that division 152 of the Bill is based on the directors' duties and liabilities provisions of the *Life Insurance Act* 1995 (Cth) (the "**Life Act**"). Our analysis of the differences between the Bill and the Life Act in this respect is set out in part one of our advice below. In part two of our advice, we have considered whether the directors' duties and liabilities imposed by the Life Act are appropriate in the private health insurance context.

1. ***Replication of the directors' duties and liability provisions of the Life Act***

1.1 We have examined the directors' duties and liabilities provisions contained in division 152 of the Bill and contrasted them with the duties and liabilities outlined in sections 48 to 51 of the Life Act. The duties contained in division 152 of the Bill replicate the majority of the provisions contained in the Life Act. We have prepared a schedule outlining the duties imposed upon directors by division 152 of the Bill and sections 48 to 51 (inclusive) of the Life Act. There are, however, some important differences between the proposed regime governing director's duties for private health insurers under the Bill when contrasted with the corresponding regime under the Life Act. Some of these differences are discussed below.

1.2 First, the notion of priority contained in section 48(3)-(5) of the Life Act has been excluded from division 152 of the Bill. In a life insurance context, directors are obliged to take reasonable care and use due diligence to see that in the investment, administration and management of the assets of the statutory fund of the company, the company complies with Part 4 of the Life Act. In circumstances where there is a conflict between the interests of the owners and prospective owners of life policies and the interests of shareholders of a life company, the director is *obliged* to ensure that the life company gives priority to the interests of policy holders and prospective policy holders *over the interests of the life company's shareholders*. In other words, in the event of a conflict, directors of life insurance companies must subordinate the interests of the company (including shareholders) to the interests of policy holders.[1] There is, therefore, clarity in the Life

[1] A Morgan, *"Life Insurance Company Directors: Beyond the Call of Duty?"*, ABLR, Vol. 25 (Feb 1997) 48 at 59.

Act (but not in the Bill) around duties to policy holders which gives protection and guidance to directors of life insurance companies.

1.3 Secondly, division 152-1(8) of the Bill provides that the duties and liabilities imposed by the Bill are not to be taken to affect the duties that are imposed upon directors pursuant to the *Corporations Act* 2001 (Cth) (the "**Corporations Act**").

2. ***Whether the application of duties imposed upon directors in the life insurance context is appropriate in the health insurance context***

2.1 As noted above, division 152 of the Bill is based on the regime governing duties and liabilities of directors of life insurance companies. There are, however, fundamental differences in the nature and regulation of life insurance and health insurance. Some of these are highlighted below.

2.2 To begin with, the Bill seeks to regulate an entirely different class of insurance than that which is regulated by the Life Act. A fundamental difference between a contract of life insurance and a contract for private health insurance is that a life insurance contract is not a contract of indemnity. Conversely, private health insurance is a form of liability insurance whereby the insured is indemnified against amounts that he or she may become legally liable to pay as a result of an occurrence which occurs during the policy period. Private health insurance liability is, in this respect, *uncapped*.

2.3 Another fundamental difference is that in the life context there is no compulsion to insure individuals. By contrast, under the Bill, with the exception of restricted access insurers, insurers *must* insure eligible individuals. This exposure is heightened by the portability and community rating regimes which require private health insurers to accept the transfer of persons from one fund to another without any assessment of risks. This framework exposes directors to an uncontrollable risk which does not exist in the life insurance context. In particular, directors are severely limited in the measures they can undertake to limit costs.

2.4 A further difference is that most contracts of life insurance and life policies are "financial products" for the purposes of chapter 7 of the Corporations Act. The effect is that, where contracts and life policies constitute financial products for the purposes of chapter 7, those entities that issue such policies and contracts and the insurance intermediaries that deal with them, are regulated by the licensing conduct and proper disclosure provisions of the Corporations Act. Section 765A of the Corporations Act specifically excludes a range of products from the scope of chapter 7 and health insurance is one of the products that are specifically included on that exclusions list.[2] The fact that the Government has expressly chosen to impose a completely different regime on life insurance and life policies reinforces the point that life and health insurance are fundamentally different products.

2.5 A fourth difference is that the private health insurance industry framework involves a higher level of regulation than the life insurance industry framework (for example in relation to pricing and portability). Indeed, consumers are well protected under the Bill including via increased reporting obligations, the tightening of portability and the maintenance of community rating. Further, the Government's effective power of veto over price increases means that directors may be severely

[2] See regulation 7.1.07(c).

handicapped in their ability to influence revenue. This price containment, combined with the restriction on cost increases (discussed above), results in a level of regulation unique to the health insurance industry.

2.6 The most critical difference, however, is the fact that some life insurance policy holders have an immediate participatory financial interest in the form of a reversionary bonus (which is effectively a return on investment). The duty to policy holders and related priority provisions were introduced in response to abuses of statutory funds by directors of life insurance companies in the 1990s, in order to protect that immediate financial interest. It is manifestly inappropriate to replicate those provisions in the health insurance context given that:

- there has been no equivalent pattern of abuses in the health insurance context;
- portability in the health insurance context means that members concerned about the financial viability of a fund can easily move funds (while retaining the same entitlement to benefits); and
- health insurance members have no interest in the health insurance fund (other than the payment of benefits, the security of which is underpinned by the existing solvency and capital adequacy regime).

2.7 Indeed, this very issue of whether the member has an entitlement to health insurance fund assets was extensively debated in the context of the proposed Medibank sale. After extensive analysis advice was given to the Government concluding that Medibank members have no such right. The Bill recognises this by providing that, upon the termination of a for profit fund, assets of the fund can be applied for any purpose. This can be contrasted with the position under the Life Act where statutory funds must remain to secure policy liabilities or be transferred to an authorised life insurer which has assumed those liabilities.

2.8 Against that background, it is difficult to see on what possible basis it is that directors of private health insurers ought to owe personal duties and incur personal liabilities to policy holders in addition to the fiduciary duties that they already have to act in good faith and in the interests of members of the company as a whole, both under the common law and statute.

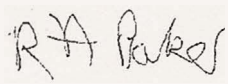
2.9 In particular directors will at times be faced with conflicting duties to that set out in division 152-1. For example, duties placed on directors under common law and the Corporations Act (which are owed to the company as a whole) could be contrary to the interests of policy holders. This could result in directors being placed in a invidious position whereby the only choice is to breach one or more set of duties. For example, if there was an outbreak of avian flu, if directors were to give priority to policy holders, the directors might be obliged to increase benefit levels to accommodate claims to persons suffering avian flu. If, however, the directors were to give priority to the company, the director's obligations might be to minimise the benefits payable. This position is unacceptable on any level: faced with such a conflict, directors may have no choice but to resign rather than risk the reputational and other impacts of being forced to choose between the "lesser of two evils".

2.10 Given that it is a basic tenet of law that directors owe their duties to corporations not to shareholders individually or other members of the public, we believe that division 152-1 of the Bill should be deleted unless there are very sound policy reasons for retaining it. To our

knowledge, no such policy reasons have been identified and, indeed, a large of number reasons have (as discussed above) been identified as making division 152-1 completely inappropriate.

We would be happy to discuss any queries or comments you may have in relation to this letter or the attached Schedule at your convenience.

Yours faithfully



Robyn Baker, Partner
+61 3 9286 6338
rbaker@claytonutz.com

Attachment:

Schedule 1 - Comparison of the duties and liabilities under the Bill and the Life Act.

Schedule 1

PRIVATE HEALTH INSURANCE BILL 2006 (EXPOSURE DRAFT) ("Bill") & LIFE INSURANCE ACT 1995 ("Act")

DUTIES AND LIABILITIES OF DIRECTORS

Division No in the Bill	Wording of Division	Equivalent section in the Act?	Section No in the Act	Wording of Section
152-1(1)	A *director of a private health insurer has a duty to the *policy holders of a *health benefits fund conducted by the insurer.	Yes	48(1)	A director of a life company has a duty to the owners of policies referable to a statutory fund of the company.
152-1(2)	The *director's duty is a duty to tak onable care, and use due diligence to see, that in ıe investment, administration and management of t e *assets of the fund, the insurer complies with this art.	Yes	48(2)(a)	The director' luty is a duty to take reasonable care, and use due dilig ıce, to see that, in the investment, administratio and management of the assets of the fund, the life comp ıy: (a) complies with this Part;
152-1(3)	The *director is not guilty of a breach of the duty imposed by subsection (1) if the director has taken reasonable steps to ensure that systems are in place to ensure that the insurer complies with this Part.	No		

Division No in the Bill	Wording of Division	Equivalent section in the Act?	Section No in the Act	Wording of Section
152-1(4)	If: (a) in respect of any act or omission of a private health insurer, a *director of the insurer is guilty of a breach of the duty imposed by subsection (1); and (b) the act or omission of the insurer results in a loss to a *health benefits fund conducted by the insurer; the director is liable to pay the insurer an amount equal to the amount of the loss.	Yes	48(6)	If: (a) in respect of any act or omission of a life company, a director of the company is guilty of a breach of the duty imposed by subsection (1); and (b) the act or omission of the company results in a loss to a statutory fund of the company; the director is liable to pay the company an amount equal to the amount of the loss.
152-1(5)	If 2 or more persons are liable under subsection (4) in relation to the same act or omission, their liability is joint and several.	Yes	48(7)	If 2 or more persons are liable under subsection (6) in relation to the same act or omission, the liability of those persons is joint and several.
152-1(6)	An action to recover an amount for which a *director is liable under subsection (4) may be brought: (a) by the insurer; or (b) with the written approval of the Council, by a *policy holder of the *health benefits fund involved.	Yes	48(8)	An action under subsection (6) may be brought: (a) by the company; or (b) with the written approval of APRA, by the owner of a policy referable to the statutory fund involved.

Division No in the Bill	Wording of Division	Equivalent section in the Act?	Section No in the Act	Wording of Section
152-1(7)	An approval under subsection (6) may be given subject to conditions relating to the persons, or the number of persons, who may join in the action as plaintiffs.	Yes	48(9)	An approval under subsection (8) may be given subject to conditions relating to the persons, or the number of persons, who may join in the action as plaintiffs.
152-1(8)	Nothing in this section affects duties imposed on a *director under the *Corporations Act 2001*.	No		
152-5(1)	If a private health insurer has contravened this Part, the Council may give the insurer a written notice requiring the insurer, within a specified period, to take such action as is specified in the notice to remedy the contravention.	Yes	49(1)	If a life company has contravened this Part, APRA may, with the Treasurer's agreement, give the company a written notice requiring the company, within a specified period, to take such action as is specified in the notice to remedy the contravention.
152-5(2)	The period specified in the notice must be a period ending not earlier than one month after the giving of the notice.	Yes	49(2)	The period specified in a notice must be a period ending not earlier than one month after the giving of the notice.
152-5(3)	The action to be specified in the notice is such action as the Council thinks appropriate and reasonable to overcome the effects of the contravention.	Yes	49(3)	The action to be specified in a notice is such action as APRA thinks appropriate and reasonable to overcome the effects of the contravention.
152-5(4)	At any time before the end of the period specified in the notice, the Council may extend the period by such further period as the Council thinks fit.	Yes	49(4)	At any time before the end of the period specified in a notice, APRA may, with the Treasurer's agreement, extend the period by such further period as APRA thinks fit.
152-5(5)	The insurer must comply with the notice.	Yes	49(5)	A life company must comply with a notice under subsection (1).

Division No in the Bill	Wording of Division	Equivalent section in the Act?	Section No in the Act	Wording of Section
152-10(1)	If: (a) the Council has given a notice to a private health insurer under section 152-5 in respect of a contravention of this Part; and (b) the contravention has resulted in a loss to a *health benefits fund; and (c) the insurer has failed to comply with the notice within the period specified in it or within that period as extended under subsection 152-5(4); the persons who were the *directors of the insurer when the contravention occurred **are jointly and severally** liable to pay the insurer an amount equal to the amount of the loss.	Yes	50(1)	If: (a) APRA has given a notice to a life company under section 49 in respect of a contravention of this Part; and (b) the contravention has resulted in a loss to a statutory fund; and (c) the company has failed to comply with the notice within the period specified in it or within that period as extended under subsection 49(4); the persons who were the directors of the company when the contravention occurred are jointly and severally liable to pay the company an amount equal to the amount of the loss.
152-10(2)	A person is not liable under subsection (1) if the person proves that he or she used due diligence to ensure that the insurer complied with the notice.	Yes	50(2)	A person is not liable under subsection (1) if the person proves that he or she used due diligence to ensure that the company complied with the notice.

Division No in the Bill	Wording of Division	Equivalent section in the Act?	Section No in the Act	Wording of Section
152-10(3)	An action to recover an amount for which a person is liable under subsection (1) may be brought: (a) by the insurer; or (b) with the written approval of the Council, by a *policy holder of the *health benefits fund involved.	Yes	No	
152-10(4)	An approval under subsection (3) may be given subject to conditions relating to the persons, or the number of persons, who may join in the action as plaintiffs.	Yes	No	
152 15	If the Council thinks that it is in the interests of the *policy holders of a *health benefits fund to do so, the Council may bring an action against a person in the name, and for the benefit, of a private health insurer for the recovery of an amount that the insurer is entitled to recover under this Division.	Yes	51	If APRA thinks that it is in the interests of the owners of policies referable to a statutory fund to do so, APRA may bring an action against a person in the name, and for the benefit, of a life company for the recovery of an amount that the company is entitled to recover under section 50.
152-20	A person cannot be made liable both under section 152-1 and under section 152-10 in respect of the same act or omission of a private health insurer.	Yes	48(10)	A person cannot be made liable both under this section and under section 50 in respect of the same act or omission of a life company.