Perspectives on regulating a market for Option C

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Thank you for inviting me to participate in this event.

I would like to start by congratulating the NHHRC for its interim report. I found it a thought-provoking document and precisely the sort of thing that we need if we are going to successfully think about changes to our health system on, potentially, a grand scale.

In particular, I found it to be an enjoyable read – peppered with relevant facts and carefully developed arguments ... and leavened, too, with just enough dry humour to ease the reader's passage. For example, at page 276 the Commission states:

> While many consumers and health professionals wanted 'change', they did not necessarily have well-developed views about how to get from 'here' to 'there'. Working out how to 'fix' the governance of the Australian health system is, after all, neither most people's day job, nor their main recreational hobby.

Perhaps the Commission briefly forgot the important work done by the Menzies Centre when it said that (although I am not sure which element most readily applies!) but from my point of view they are very true words.

So, this is an important opportunity for many of us to stand outside our "day jobs" and to consider a range of options offered by the NHHRC which would, if implemented, undoubtedly change the health system in this country.

PHIAC's role

When approaching this topic I need to caution that I do so as a regulator, not a policy-maker. As you would appreciate, PHIAC performs a task that is closely described by legislation and it must be scrupulous in complying with the rules that have been set down for its operations by the parliament.

In particular, when I look at the options that have been proposed, I must necessarily consider them through the prism of the three objectives that have been assigned to PHIAC by the *Private Health Insurance Act 2007*. These are:

- fostering an efficient and competitive industry;
- ensuring prudential safety of the insurers; and
- protecting the interests of consumers

Our statutory role is to have regard to these three considerations and to strike an "appropriate balance" between them when discharging our responsibilities.

Today, I have been asked to offer perspectives on regulating a market for Option C in the Commission's interim report. I will do so by reference to those central objectives.

1. Competition

I will start by looking at the issue of competition. On this account it has been interesting to read the submissions so far received by the Commission responding to the interim report. (I have not read all of them!). In particular, there has been a diversity of predictions about the implications for competition of Option C for the private health sector. Some have said that, if implemented, the option would result in a reduction in the number of funds thereby reducing "much needed competition" (AHSA). Others have seen it the other way and have predicted that the opportunity provided for a number of "health plans" to become part of the range of potential providers will result in a much greater range of choices for consumers.

My own view is that the option would probably produce a double-pronged effect.

On one hand, I think it is clear that a number of new providers would seriously consider coming into the market to provide health plan services. Indeed the Commission itself has expressly noted that the provider group should not be confined to the existing health insurers when it said, at page 296:

> Large health service provider organisations, or networks of providers, may be permitted to offer health plans, provided they meet the same requirements as all other health plans.

Thus, according to the NHHRC, existing health service providers could also become providers of health plan services. This is not quite the equivalent of a conversion from poacher to gamekeeper (or is it the other way around?), but it does involve a pretty fundamental realignment of roles. Under this model, approved entities could become both the providers and funder/insurers of the same services.

Competition issues, such as the risk of third line forcing (which is the practice of compelling consumers to use related services as a condition of accessing a primary service – and is prohibited by the *Trade Practices Act 1974*) would need to be carefully considered and managed.

Equally there arguably would be an elevated risk of the medical world's expression for essentially the same thing: "managed care".

The large health funds would, I suspect, probably relish the opportunity to engage in this type of business. Indeed it is no surprise to me that the two largest funds, Medibank Private, which is represented here today through George Savvides and BUPAA both support an approach based on Option C. Both these funds are large (each accounting for roughly 30% of the existing market), well-resourced and have the capacity – or the capacity to have the capacity – to engage with the other large health care service providers on the broad national stage that is described for health

plans in Option C. And if pushed they either can – or fairly quickly could – also become providers as well as funders of medical services to contributors. For them a move to "social insurance" could be an important growth opportunity and something which they might be keen to grasp.

On the other, it is, I think, equally foreseeable that many of the small health funds might find it a daunting prospect to become, in effect, "full service health plans" competing on the same stage as these behemoths (and others who might join them from the provider sector). No doubt, there would be a some potential for them to seek and exploit particular niche opportunities within the broader market. And of course, many of these funds have loyal and longstanding members who might be expected to stick with them through the transition.

It is true that the Commission has described a role for the traditional private health insurance industry in the interim report when it said at page 299:

> Careful consideration is also required as to how social insurance would fit with private insurance. It is suggested that private health insurance would continue to have a similar role as it does in the current system – providing cover for services not included in social insurance and for levels of amenity not covered by social insurance.

This thought is not further developed in the report. It does suggest, however, that private health insurers will be faced with a difficult choice either to "step up" and become health plan providers competing openly with a number of large and well-resourced established providers or to, in effect, retreat to a more marginal role providing products which address their contributor's narrower health needs, specifically those not covered in the broader setting of social insurance.

I am not sure yet what the net competitive effect of these changes would be, but they would be an important dynamic to observe in the emerging market for health plan services.

In this context, I note without commenting further that the position of the major industry body, the Australian Health Insurance Association, is to support Option A, but to also indicate a preparedness to discuss Option C if that were to emerge over time.

2 Prudential Safety

Prudential safety is PHIAC's core business. It is our responsibility to ensure that the funds are well run, that they have adequate capital to meet the vicissitudes of their business and, if the worst comes to the worst, that there is enough money to pay all the debtors in the event of insolvency.

Those who operate in the industry understand that existing prudential requirements for private health funds are already quite demanding. The Commission has stated that the prudential standards for health plans would be "similar" to those for current health insurance. If this position is maintained, some would-be competitors may not

proceed faced with the fairly daunting prudential compliance requirements that do apply in this industry.

On the other hand, the fact that the biggest impediment to start ups would effectively disappear – that is to say the competition posed to all PHI providers by “traditional Medicare”, with that program instead being absorbed into the product offering available through the health plan providers – would likely have a galvanising effect. The opportunity would just be so much larger.

Significantly, in Option C, the NHHRC is proposing that the risk weighting process be conducted using a “risk adjustment” model. At present, PHI industry risk is managed using a method known as “risk equalisation” where the costs of servicing older members and expensive claims are pooled and payments are made from the pool to share the risk within the industry. Risk adjustment is another way to address essentially the same risk based on an actuarial assessment (looking at factors such as age, sex, location and health status) as well as the fund’s claims history. Ultimately, the method of risk adjustment employed is a matter for policy, but PHIAC is fairly relaxed about either approach.

The underlying taxation base supporting the scheme could present some prudential problems if it did not possess the capacity to adjust to cover costs which for one reason of another exceed the original amount gathered by taxation. This again is a policy issue, but the analogy of the “Medicare levy” and the real underlying cost of health services - which are largely funded from general tax revenue – does spring to mind.

The proliferation of agreements and contracts which would be necessary for health plans to have in place with providers (hospitals, doctors, allied health professionals) to provide the full service health plan envisaged by Option C would also probably present at least a start up prudential risk.

3 Consumers

Finally, how would PHIAC go about “protecting consumers” in this new world? It is a daunting issue and not one which can be answered comprehensively at this remove.

In particular, you would expect that a major change along the lines of Option C would attract a lot of analysis when it was being proposed as legislation with the particular concerns of consumers much more in focus than they presently are.

The key thing to bear in mind here is that being a health services consumer is different from other traditional consumer situations. Health consumers are often sick and vulnerable. They may be alone and in financial trouble. Pressing your consumer “rights” is not an easy thing if you have to get up out of your sick bed to do it.

PHIAC plays an important role in ensuring that consumers of private health insurance have good information about PHI products. We publish a pamphlet called

Insure? Not Sure which is widely available through health funds and hospitals. It is intended to alert consumers to the range of issues they should consider when purchasing a private health insurance policy and to let them know what the elements of that policy are likely to be.

The consumer information challenge posed by Option C is not likely to be any smaller than the current one. On the contrary it is likely to be larger. At present about 55% percent of the population do not have hospital health insurance cover. They choose instead to remain within the Medicare system. Option C would compel every Australian to make a decision about their health cover – many of these 55% would therefore – possibly for the first time in their lives – be required to make what is an important and potentially financially significant decision about how they will conduct their future medical insurance arrangements.

Ensuring that consumers have the right information and are able to make a choice that they are comfortable with is therefore likely to be quite challenging. Once the system has been "bedded down" the ongoing management of consumer information (dispute resolution processes) will assume a more normal appearance.

Constitutional issues?

On indulgence, I might offer a concluding thought reflecting my legal background.

It was interesting to note (employing the miracle of word search technology) that in such a wide sweeping paper the word "constitution" appeared only once – and that occurred when the Commission was citing from a submission received. This is an interesting omission and my quick reading suggests that the Commission has not yet sought to get its arms around the constitutional issues that the various structural reforms it has proposed may present.

This is not intended as a criticism. On the contrary, as I said at the outset, I think there is a lot to admire about the report and there is a lot to be said for its decision to set its compass by reference to what is good and desirable rather than being too limited at the outset by considerations such those posed by section 51(xxiiiA) of the Constitution. This provision you will recall expressly permits the Commonwealth to make laws with respect to certain social benefits and medical and dental services, but in the case of the latter two "not so as to authorise any form of civil conscription".

But such issues will need to be considered at some time and its seems to me to entirely foreseeable that opponents of one or other of the various options will shortly be dusting off their constitutional law texts to see whether they might be characterised as a form of nationalisation prohibited by the constitution.

The High Court had a good look at section 51(xxiiiA) recently in *Wong v Commonwealth* (2 Feb 2009) which was a challenge to the Professional Services Review Scheme (dealing with medical over-servicing), but it is likely that it have more work to do if significant reform as proposed by the NHHRC proceeds.