Australian Dental Association Inc.

ACCC Submission on Private Health Insurance

September 2012

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1. About the Australian Dental Association Inc.

The Australian Dental Association Inc. (ADA) is the peak national professional body representing over 13,500 registered dentists engaged in clinical practice, and dentist students. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

2. Introduction.

It is clear to the ADA from your letter and our discussions that the Australian Competition and Consumer Commission (ACCC) may have some pre-conceived notions about the practice of dentistry in Australia and this is driving the ACCC to consider if there is evidence of anti-competitive or other practices by health funds or providers who reduce the extent of health cover for consumers and increase their out-of-pocket medical or other expenses.

There are many anti-competitive practices by health insurers in Australia that the ADA feels should be brought to the attention of the Commission and the Senate. The ADA has written to the Commission on these issues a number of times.

The ADA shall address the issues that the Commission needs to address in its report to the Senate and in so doing will provide you with a response that will be in three sections:

Section 1: **A response to the specific questions you ask in your letter of 3 September 2012.**

Section 2: **An overview of how dentistry is practised in Australia, and how and why these practices are adopted. It is hoped that this information will enable the ACCC to better inform itself as to the issues raised in your letter.**

Section 3: **A general response to the Commission dealing with the anti-competitive practices of Private health insurers (PHI) in Australia.**

There will be some repetition of some aspects within the three sections but that has been deliberately done for ease of reading.

Section 1:

Response to the letter of 3 September 2012.

The ACCC has indicated that this year it wishes to deal with "*issues that reduce the extent of health cover and increase consumers' out-of-pocket expenses*." Your letter states, *"In particular, the ACCC will enquire into a perceived lack of recognition of certain allied health providers by health funds."*

The ADA notes the reference to circumstances where certain providers of health care are said not to be recognised by private health insurers while others providing the same or similar services, with different qualifications, are recognised.

The ADA knows of no such situations where this occurs in the delivery of dental care.

Legitimate services rendered by all registered dental professionals[1] are recognised by PHIs.

Our discussions with you suggest to us that you may be specifically referring to the fact that services rendered by a dentist and identified as such on a treatment plan would be items of treatment recognised by a PHI and rebated accordingly, but that the same may not be the case where the service was provided by dental hygienists, therapists and oral health therapists (hereafter referred to as ADPs).

This does not occur, as services provided by dentists and ADPs alike (if performed in accordance with the Dental Board of Australia's (DBA) Standards) are all recognised by PHIs.

The Dental Board of Australia (DBA)[2] standard states:

> *"3. Dentists work as independent practitioners who may practise all parts of dentistry and are the clinical team leaders. Dentists may supply and fit dental appliances for the treatment of sleep disorders. They must work in cooperation with the patient's medical practitioner who is responsible for the medical aspects of the management of sleep disordered breathing.*
> *5. Dental prosthetists work as independent practitioners in making, fitting, supplying and repairing removable dentures and flexible, removable mouthguards.*
> *6. Dental hygienists, dental therapists and oral health therapists exercise autonomous decision making in those areas in which they have been formally educated and trained. They may only practice within a structured professional relationship with a dentist. They must not practise as independent practitioners. They may practise in a range of environments that are not limited to direct supervision."*

This means that dentists and dental prosthetists work as independent practitioners but requires all ADPs to practise within a structured professional relationship with a dentist. Furthermore, it states that they may not practise as independent practitioners.

[1] The Dental Board of Australia registers dentists, dental hygienists, dental therapists, oral health therapists and dental prosthetists and only registered practitioners are permitted to practise 'dentistry'. See: www.dentalboard.gov.au.
[2] See DBA –Dental Scope of Practice Registration Standard. Visit: http://www.dentalboard.gov.au/Registration-Standards.aspx

These standards have been written in this way so as to reinforce the key element of the National Law[3] (the legislation that has been created nationally for the registration of health professionals) namely to ensure the safety and quality of all health services.

Where services are rendered by allied dental professionals under the supervision of a dentist then those services are billed under the provider number of the dentist and as such are recognised by the PHI. Rebates are subsequently paid to the patient. The rendering of such an account informs the PHI that the services provided have been provided in accordance with the standards and practice set down by the DBA. PHIs recognise that services carried out under the supervision of a dentist have been identified by the appropriately qualified practitioner as necessary for the proper treatment of the patient.

What occurs in dentistry is similar to what occurs in the delivery of radiographic services. In billing for services in radiology, the account will specify the treatment provided. Invariably, the account will represent services provided by both the radiographer (who will have seen the consumer and arranged the taking of the radiograph) and the analysis of the radiograph that will have been performed by the radiologist. Here there is a team delivering the service; each member providing the service they have been trained to do. The radiologist heads the team and determines the procedure; they instruct the radiographer to perform a service and then the radiologist reports the outcome. While the radiographer's role in the completion of the treatment is not separately recognised in the accounting, the service is 'recognised by the third-party payer and rebated accordingly. The same occurs in dentistry with a similarly based distribution of service delivery.

The suggestion that such practices place *"health care providers at a competitive disadvantage and has the potential to impact negatively on consumers"* has absolutely no foundation. Indeed the exact opposite is true. Compliance with the DBA standards in fact allows PHIs to both recognise services provided by dentists and ADPs, and more importantly ensures that consumers/patients receive services from practitioners they know to be both safe and of high quality. Without these provisions being enforced the safety of consumers would be compromised.

Your letter makes reference to the services provided by allied dental practitioners as being of the same quality as those similar services provided by dentists and this therefore justifies some change in practice adopted by PHIs. This is a selective and incorrect viewpoint. As can be seen in Attachment A – Dentistry in Australia, the education and training of the allied dental practitioners is not comparable to that of a dentist. The level of training provided to dentists far exceeds that provided to ADPs. The dentist is the team leader and is trained in all aspects of dentistry. The ADP is trained to perform limited services. This is borne out by the DBA registration standard referred to earlier, which requires allied dental practitioners to work under supervision.

Your letter then seeks views on 4 issues to which we respond:

1. *"Examples where allied health care providers offer the same or similar services as other providers and are not recognised by health funds".*

In general all such services by allied dental providers are recognised by the PHI.

[3] See Health Practitioner National Law

There may be two occasions when they are not:

a) If the service was provided by an unregistered provider. The ADA would maintain this is appropriate and correct as it ensures the safety and quality of the service provided.
b) The service falls outside the scope of the cover provided under the health insurance contract between the PHI and consumer. This is a matter that is dealt with in greater detail in Section 3 of this response.

2. *"In each instance referred to, whether this lack of recognition is warranted. In particular, are there any regulatory, medical or other reasons for this lack of recognition?"*

As there is no lack of recognition, no further response is required.

3. *"Whether this lack of recognition places allied health care providers at a competitive disadvantage. If so, how are allied health care providers disadvantaged by the practices of health funds?"*

As there is no lack of recognition, no further response is required.

4. *"Whether this lack of recognition results in a reduction in the extent of health cover or an increase in the out-of-pocket medical expenses of consumers. If so, what is the detriment or loss suffered by consumers?"*

As there is no lack of recognition, no further response is required.

Section 2:

An overview of how dentistry is practised in Australia.

As stated earlier the terms of the ACCC's letter to the ADA suggest that the ACCC may have been basing its comments upon a misconception as to how dentistry is practised in Australia. To rectify this and to assist the ACCC to better evaluate its perception of the practice of dentistry, an outline of how dentistry is practised in Australia will be provided.

This will set out:

- The broader regulatory and legislative context that underpins all roles in the dental profession in Australia. The dental profession consists of dentists and allied dental practitioners (ADPs) who are dental hygienists, oral health therapists, and dental therapists;

- How all dental roles are defined and operate in Australia to ensure patients undertake dental treatment with the highest standards of safety and quality; and

- How no anti-competitive issues arise due to the way in which dental treatment is delivered and structured in Australia.

The role of the Dental Board of Australia.

The Dental Board of Australia (DBA) is one of a number of Health Boards set up under the Australian Health Practitioners Regulatory Authority (AHPRA). AHPRA was created under the National Registration and Accreditation Scheme Strategy 2011-2014.

In fulfilling its primary responsibility to protect the public, the DBA applies and enforces the provisions of the *Health Practitioner Regulation National Law Act* (National Law) and ensures that registration of dental practitioners requires those practitioners to meet predetermined criteria.

The DBA has 12 members. There are four community representatives, five dentist members and three ADP members. The DBA, with this make-up, develops standards and guidelines for the scope of practice for all dental practitioners (*Dental Scope of Practice Registration Standard* [Standard]). The ratio of registered dentists in Australia to other ADPs is approximately 3:1.[4]

The DBA sets standards and scope of practice under which all dental practitioners must practise.

The Scope of Practice Standard

The DBA Standard, which applies to all registered dental practitioners (dentists, dental prosthetists, dental hygienists, dental therapists and oral health therapists), makes specific reference to the requirements for each practitioner as follows:

1. *A dental practitioner must not direct another registered practitioner to undertake dental procedures or give advice outside that person's education or competence.*

2. *Dental practitioners must only perform those dental procedures:*

    a. *For which they have been formally educated and trained in programs of study approved by the Board; and*

    b. *In which they are competent.*

3. *Dentists work as an independent practitioner who may practise all parts of dentistry and are the clinical team leaders. Dentists may supply and fit dental appliances for the treatment of sleep disorders. They must work in cooperation with the patient's medical practitioner who is responsible for the medical aspects of the management of sleep disordered breathing.*

4. *Dental prosthetists work as independent practitioners in making, fitting, supplying and repairing removable dentures and flexible, removable mouthguards.*

5. *Dental hygienists, dental therapists and oral health therapists exercise autonomous decision-making in those areas in which they have been formally educated and trained. They may only practice within a structured professional relationship with a dentist. They must not practise as independent practitioners. They may practise in a range of environments that are not limited to direct supervision. (ADA emphasis)*[5]

[4] Section 234 of the National Law outlines the duties of the Board and provides board members with the obligation to act in the interests of the community and provide safeguards that ensure the public receive services that are safe and of the highest standard, regardless of their personal position.

[5] See DBA – Dental Scope of Practice Registration Standard. Visit: http://www.dentalboard.gov.au/Registration-Standards.aspx

The development process for the Standard involved widespread community and stakeholder consultation. The Standard was then submitted and approved for use by the Australian Health Workforce Ministerial Council on 22 April 2010. All registrants are required to base their practice on this scope of practice definition.

In practice, this means that a dentist is responsible for the supervision of all work undertaken by dental hygienists, dental therapists and oral health therapists (ADPs). ADPs have, since their inception, only ever been trained to practise in a supervised team environment. Dental hygienists are most commonly employed in private practice whilst public dental services predominantly employ dental therapists and oral health therapists. More recently, dental therapists and oral health therapists have commenced working in the private sector.

A thorough knowledge of the specific and limited training provided to ADPs is required to have a full understanding as to why they have limited dental practice capability and must work under supervision.

The language of practice supervision has evolved over a number of years and this area has caused many issues for regulators. ADPs have only ever been trained to practice in a supervised environment and this has usually been in the employ of public dental services for Dental Therapists (DT) and Oral Health Therapists (OHT), and more commonly in private practice for Dental Hygienists (DH). It is only in relatively recent times that OHTs and DTs have been able to work in the private sector. A thorough knowledge of the limited training provided to ADPs is required to understand why they are unable to practice “independently”, as governed by The Standard[6].

The Standard is an acknowledgement that in some government clinical settings there have been manpower issues that have limited direct physical supervision of ADPs, and that supervision has been available through electronic communication and, where clinically appropriate, referral to a dentist has been made. This requires a certain level of professional behaviour and responsibility on the part of both the dentist providing the oversight and the ADP.

In our discussion with the ACCC, the question arose about a member of the public choosing to attend a DH without seeing a dentist, so that teeth cleaning could be performed. This question, while seemingly reasonable on the surface, raises complex issues. Knowledge of the practice of dentistry is required in order to understand the reasoning behind the current restrictions. The practice of dental hygiene procedures by DHs has been developed as part of a team care arrangement. Dental hygiene treatment facilitates the ability to properly examine a patient’s mouth, and the dentist is the only person capable of performing a proper examination. ADPs are not qualified to perform this.

To not provide for the dentist examination raises some very serious practice and dento-legal issues. The dentist has been trained in all facets of dentistry and is the team member who will examine and evaluate the patient’s needs. To allow a patient to be only seen by a DH overlooks the value of the diagnostic role played by the dentist in the evaluation of the patient’s teeth. Dentistry is a very complex area of general health, and while this point may be difficult to convey to a lay person, one must have confidence in the provisions of the Standard created by the experts on the DBA. Dentists, not ADPs, have been provided with the education and training to, for example, maintain occlusion, or use their biomedical knowledge and understanding of such frameworks to identify dental problems on a system-

[6] See Attachment A.

wide level. It is in following this essential process that the dentist can appropriately refer on to ADPs for the relevant treatment (if applicable). This is the standard that is conformed to internationally.

The complexity of the issue is increased due to the different levels of training that are provided to ADPs. Dental hygienists in Australia, for example, may graduate with either an advanced diploma (TAFE), associate degree, or a bachelor's degree from a tertiary institution. These different levels of training result in DHs with different skill levels. The DBA takes account of this fact in that the Standard obligates the ADP to work under the supervision of the dentist in respect of all treatment plans. This requirement to oversee the ADPs work is essential in ensuring the safety and quality of treatment that is received.

The Dental Hygienist Association of Australia (DHAA), which is the professional association for Australia's dental hygienists, themselves acknowledge that the hygienists' role requires supervision. The DHAA in its publication *The Dental Hygienist* states[7]:

> ***What is a dental hygienist?***
>
> *A dental hygienist is an oral health professional who is a specifically trained member of the dental team who works together with the dentist to provide fully integrated dental care. ….*
>
> ***What is the role of a dental hygienist?***
>
> *2. Plan with your dentist an oral health maintenance program including assessment of your teeth and periodontal tissue (gum) health, evaluation of radiographs (x-rays) and review of your medical history". (ADA emphases)*

These statements reflect the requirements of the DBA and demonstrate how this particular ADP sees its members working in the team environment with the dentist as the team leader. If there is a limitation imposed on the ADP's ability to practice it is one that reflects the level of skill and competency of the ADP.

To challenge the Standard on the basis of cost is akin to accepting a reduced standard of care. The DBA has constructed the team framework in dentistry to enable safe, efficient and quality care to be delivered to patients.

Recognising this, PHI rebates for services provided by supervised ADPs are the same as for those provided by dentists, and hence the consumer is not in a disadvantaged position.

The implications of the supervisory role of the dentist

The supervisory responsibility of a dentist has been borne out in some of the complaints and cases brought before the DBA and/or its predecessors, the state and territory based dental boards. The ADA is aware of a number of cases where disciplinary action has been taken against dentists for not adequately supervising the services provided by ADPs. The supervisory distinction between dentists and ADPs is accordingly a critical one that needs to be acknowledged and complied with in the interests of public safety.

[7] Dental Hygienist Association of Australia, 'The Dental Hygienist' at http://www.dhaa.info/app/download/5702175919/ORAL+B+HYGIENIST+.pdf?t=1344258306, 20 September 2012.

These supervisory requirements are also recognised by insurers when developing professional indemnity premiums. For example, one of the largest providers of professional indemnity insurance to dental practitioners calculates the premiums for dental hygienists on the basis that the supervising practitioner (i.e. the dentist) can be held vicariously liable for the negligence of the ADP. This has resulted in the professional indemnity insurance premiums for dental hygienists and other ADPs being kept substantially lower than that for a dentist. This would not be the case if the prescriptive and supervisory role of the dentist *vis-a-vis* ADPs was removed. Dento-legal ramifications of missed diagnoses by ADPs (missed due to their limited training in all facets of dentistry) may create significant professional indemnity insurance issues which in turn would place heavy pressure on premiums. Similar premium pressure on indemnity cover is currently occurring with "independent" midwives.[8] This naturally would impact on the costs that would have to be charged by ADPs, if any limitations on practice were removed.

The Standards already provide for ADPs to engage in practice with indirect supervision in a structured professional environment. This provides for situations where, in rural and remote communities, there may be less direct access to dental health professionals:

> *"They may only practice within a structured professional relationship with a dentist. They must not practise as independent practitioners. They may practise in a range of environments that are not limited to direct supervision. (ADA emphasis)"*

What is critically important is the Standard requires that there must be a form of proper supervision. That is, the level of safety and quality of dental treatment must always be maintained and the standards of care remain consistent. This imposes an obligation on the team leader - the dentist - to ensure that the treatment being provided to the patient is appropriate and is being performed by an ADP that is both adequately trained and competent. In such circumstances the dentist must be familiar with the skill level and competence of the ADP before any treatment is provided. There is no variation in the safety and quality of dental treatment on the basis of where a person is located (metropolitan vs. rural/remote), nor should there be.

Arrangements are always required to be put in place to reflect the relationship between the dentist and ADP; these will not be uniform as the skills and competence of the ADP will vary from case to case. As mentioned earlier, different levels of training have been undertaken by ADPs even though they are registered by the DBA in the same category under the national registration scheme now in place. What has been consistent throughout (both before and after national registration) is that ADPs must work under the supervision of dentists in respect of all treatment plans. The Standard is clear: supervision and the development of a structured professional relationship with the dentist must exist. Remoteness of service delivery is not exempted in the Standard. Any departure from this standard has the potential to place patients at risk and thus is not in the public interest.

[8] See the Midwife Professional Indemnity Scheme (MPIS), which "includes a Commonwealth contribution initiative designed to assist with claims made against eligible midwives and encourage the provision of indemnity insurance policies for private independent midwives. Also, this issue of cost is identified in Recommendation 14 of the "Improving Maternity Services in Australia" report, found in http://www.health.gov.au/internet/main/publishing.nsf/Content/msr-report~msr-report-attachments~msr-report-attachment-a, 20 September 2012.

Risks to public health if supervisory requirement removed

Many advocates of expanded scope of practice for ADPs see paediatric and geriatric care as the area for expansion. This is a convenient argument but it ignores the fact that children can present with complex dental conditions and if not recognised early can have serious long-term consequences. Similarly, elderly patients can have very complex pharmacopeia issues and very complex medical conditions that can easily be compromised by poor dental diagnosis. The incidence of oral cancer is well documented as being on the rise. Early recognition and treatment can be critical. The proposals being questioned by the ACCC and suggested by others (that ADPs should independently address the dental care needs of children or those in aged care facilities) risk creating multi-tiered levels of dental care-exposing those on the lower tier to compromised care.[9] There is a real risk that unnecessary emphasis on perceived cost savings will come at the expense of the high standards of dental care for which Australia has a respected reputation.

Often it is said that some care is better than no care. This is a flawed proposition. Provision of compromised care will lead to escalation of problems and even death. One level of care for all Australians must be adopted.

Dental Workforce

Turning to the issue of rural and remote areas' difficulty in accessing dental treatment, it has been suggested that expanding or 'recognising' ADPs scope of practice to include the ability to practise independently would ameliorate this situation. While access to dental care for Australians in rural and remote areas is a concern, it is important to understand the workforce distribution issues. There has been and continues to be a rapid and significant increase in the training of dental practitioners. The DBA quarterly statistics released in August 2012 show that the number of practitioners registered with the DBA has now reached almost 20,000, an increase of 27% on the 2009 figures.[10]

In the very near future there will be approximately 780 new dentists entering the workforce annually (that is via graduating dentist students and overseas trained dentists entering the Australian workforce through the Australian Dental Council (ADC) pathway).[11] [12] To put these figures into perspective, in the decade up to 2006 around 250 new dentists entered the workforce annually; this increased to approximately 300 per year from 2006 to 2010 and is projected to be 480 by the end of 2014.[13] This does not include the ADC graduate dentists [i.e. overseas trained] which are currently around 300 per year.[14]

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[9] Nash states that oral health therapists can address children's needs provided they continue to be supervised by a dentist. Since oral health therapists can perform the skills of both the dental therapist and the dental hygienist, Nash's points apply to all ADPs. See 'Editorial: On why the dental therapists' "movement" in the United Sates should focus on children, - not adults', in *Journal of Public Health Dentistry* 70 (2010) 259–261; and 'Developing and Deploying a New Member of the Dental Team: A Paediatric Oral Health Therapist', *Journal of Public Dentistry*, 65, 1, Winter 2005.

[10] http://www.dentalboard.gov.au/documents/default.aspx?record=WD12%2f8650&dbid=AP&chksum=ufMvPrPTsC8U%2bKpRhW%2baEg%3d%3d.

[11] Australian Dental Association Inc., 'ADA call to action on dental workforce oversupply', *National Dental Update*, August 2012 at http://www.ada.org.au/app_cmslib/media/lib/1209/m437857_v1_105_du_august_12.pdf, 20 September 2012.

[12] ADC-www.dentalcouncil.net.au

[13] http://www.ada.org.au/app_cmslib/media/lib/1209/m437857_v1_105_du_august_12.pdf ,

[14] Ibid.

Government has recognised this trend, placing the roles of dentist and ADP on the 'flagged' list of the Skills Occupation list. This ongoing monitoring of the labour market conditions will continue.[15] The ADA is of the view that there is no shortage of dental practitioners, and as such, there is no issue of access to dental services related to this.

The issue of remote and very remote dental services is a perpetual one because in small isolated communities it is not financially viable to establish a dental clinic without a significant supporting local population. Many of these areas have access to mobile dental clinics, and in other regions, people travel a great a distance to see a dentist as they would to see a doctor, or to shop for food or other goods and services. There is no evidence to support competition issues as being a factor in this regard. In fact, the ADA has provided a submission to the Senate Committee that looked into the issue of the factors and barriers to the supply of medical and allied health practitioners, on which the Senate Committee has issued a report.[16]

The real issue not being recognised is that unless very substantial and sustained financial assistance and incentives are in place, new practices will not be established in these areas because they will not be viable. This viability issue is the same reason that government services, banks and other businesses have withdrawn from regional areas. Instead, mobile clinics and fixed government clinics in remote areas should be established to provide dental care in the remote areas. Public clinics, already in regional areas, struggle with staffing simply because wages on offer are grossly inadequate. Just to illustrate the point, wages on offer for dental services and practitioners in remote areas lag well behind those of the mining sector.[17]

Furthermore, suggestions that giving independent practice to ADPs would address workforce issues and dental access for those in rural/remote areas belie the fact that the very nature of these areas' dental needs require even more guidance, examination and skills of dentists supervising ADPs.

The dental services required by these patients are mostly of an emergency and more complex nature. Therefore a dentist is required for diagnosis, treatment planning and the provision of many of the services. To allow ADPs who have not received the equivalent level of training to deliver these services puts the patient in danger and the practitioner at professional risk. It effectively means treating those people in rural and remote areas as second-class citizens. The structured professional relationship between ADPs and a supervising dentist is designed to avoid these risks. Teams including ADPs, dentists and other health care professionals are required to give these members of the public appropriate quality oral health care.

The notion that increased scope of practice for ADPs will resolve the problem of dental care in rural and remote areas is overly simplistic.

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[15] See 'ANZSCO: 2523 DENTAL PRACTITIONERS', in *SOL Occupation Summary Sheets* accessed at http://www.awpa.gov.au/labour-market-information/skilled-occupation-list/sol-occupation-summary-sheets/documents/2523DentalPractitioners.pdf; 20 September 2012.

[16] For the ADA submission see 'Senate community Affairs Committee (Committee) Submission: Inquiry into the factors affecting the supply of health services and medical professionals in rural areas', at https://senate.aph.gov.au/submissions/comittees/viewdocument.aspx?id=0cc777bf-cd3b-4848-9046-e857922b47d4, 20 September 2012. For the Committee's final report, see 'the Senate community Affairs References Committee, 'The factors affecting the supply of health services and medical professionals in rural areas', at http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/rur_hlth/report/report.pdf 20 September 2012.

[17] Hansen J., 'Mining engineer graduates have a starting salary of $80,000', *The Telegraph* at http://www.dailytelegraph.com.au/archive/national-old/a-real-gold-mine-for-graduates/story-e6freuzr-1226118820785, 20 September 2012.

Fig. 1:ADA Practice locations

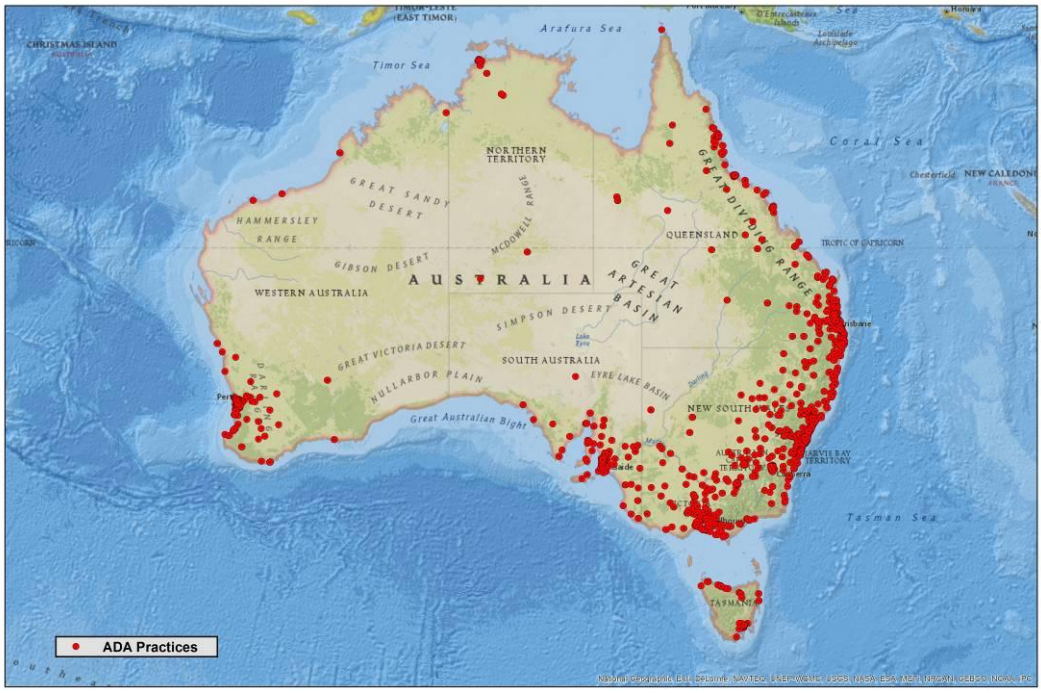
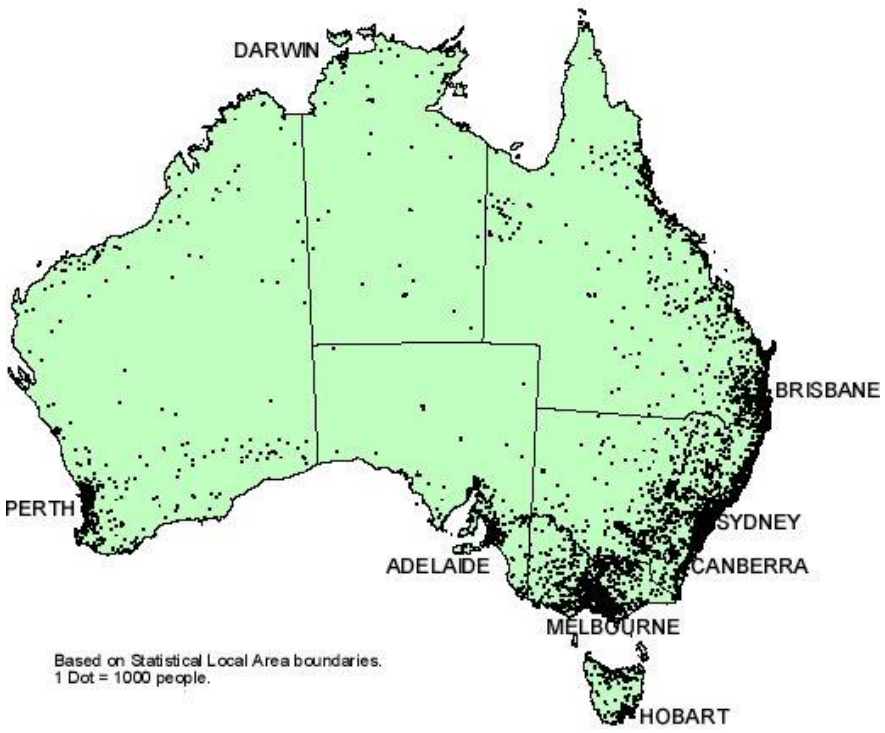


Fig. 2: Australian population distribution



Claims that independent practice for ADPs will reduce dental treatment costs

The ADA does not accept suggestions made that cost savings will accrue to consumers if removal of the supervision requirements created by the DBA were removed for ADPs. While sole ADP practices can be established, the costs associated with the infrastructure of the dental practice, the chair and equipment will largely mirror those of the dentist practice. Public practice oral health therapists' salaries range to approximately $80,000 for an experienced practitioner.[18] Furthermore, private practice oral health therapists are paid approximately $150,000. Considering the likely increase in other costs such as insurance premiums for ADPs (to account for the proposed independent practitioner status), there can be no valid claim made that ADPs could remain viable. The ADA has not been able to find any reliable research that suggests cost savings for consumers would eventuate.

Similarly, the ADA is not convinced that in the private health insurance area, lower costs for consumers will result if ADPs have independent practice. The ADA is not aware of any evidence that this has occurred in any other country with similar PHI arrangements for dental services to that which exists in Australia. On the other hand, evidence exists of the contrary being the case as commented upon by Nash.[19]

The dental prosthetists' experience in Australia is a case in point. Prosthetists previously claimed their fees would be on average 20% lower than dentists. On this premise, rebates and schedules, such as those issued by the Department of Veteran's Affairs for example, were structured accordingly (i.e. 20% lower than for dentists for the same service).[20] Prosthetists now want parity in rebates.[21] This demonstrates that contrary to the argument advanced there will be no advantage to the public.

Another concern is the suggestion that simple Continuing Professional Development courses are all that will be required to 'up-skill' existing ADPs. There is a push for up-skilling to be done through non-tertiary institutions. This could potentially place the public at risk. Furthermore, it has been suggested that this basic 'up-skilling' will enable ADPs to provide dental services to remote and very remote communities. The ADA has not been able to find evidence that this is or will be the case. A survey in Colorado referred to above where ADPs were given independent right of practice as they would be practising in remote areas demonstrates the flaw in this argument.[22] Having been granted independent practice those ADPs in Colorado set up practice in the more highly populated areas. Ultimately, due to market conditions and fixed overheads etc., their fees were quickly at a level equal to or higher than for the same services provided by dentists. In that respect then there was no effective lowering of PHI consumers' out-of-pocket expenses.

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[18] NSW Dental Therapists' Award 2013.

[19] Brown LJ, House DR, Nash KD., 'The economic aspects of unsupervised private hygiene practice and its impact on access to care'. *Dental Health Policy Analysis Series*. Chicago: American Dental Association, Health Policy Resources Center; 2005.

[20] The comparison between the two sets of rebates and schedules can be performed at http://www.dva.gov.au/service_providers/Fee_schedules/Pages/Dental_and_Allied_Health.aspx, 20 September 2012.

[21] This can be seen in the Australian Dental Prosthetists Association's Ltd.'s 'Budget Submission' to the Australian Government at http://www.adpa.com.au/attachments/article/123/ADPABudget%20Submission2012%20(1).pdf, 20 September 2012. Note while this request for parity is with respect to a federal dental scheme, the similar assertion can be inferred as the DVA scheme is a federal one as well.

[22] See Nash, The economic aspects.

If up-skilling is to occur it must only be through approved courses of training sanctioned by the ADC.

The basis on which provider numbers are issued to dentists

Questions have arisen as to why ADPs cannot receive separate 'provider numbers' so as to enable direct access to PHI rebate funding.

It is imperative that the ACCC and Senate understand that PHIs and Government funders[23] have for many years appropriately paid rebates for services performed by ADPs using the dentist's Medicare Australia provider number. Provision of a provider number indicates to the funder that the dentist is registered with the Dental Board of Australia (DBA) and is thus fit to practise. The granting of a provider number carries with it an assurance to the funder of the quality of the practitioner and the fact that the services in respect of which claims are made have been legitimately required and performed in accordance with evidence-based dentistry and DBA requirements.

PHIs' existing practice when providing a rebate for hygiene or ADP services received by a patient is based upon itemisation of the service provided as per *The Australian Schedule of Dental Services and Glossary* - 9th Edition. The services provided by the ADP are billed under the supervising dentist's provider number, i.e. there is no differentiation by provider and the same item number for the treatment irrespective of the provider. This has been well accepted by the profession and PHIs ever since ADPs have been used in private practice.

The suggestion that ADPs should receive rebates directly does not adequately recognise the significance of the fact that their role requires supervision by the dentist. A similar analogy can be made with respect to Medicare rebates eligibility for radiologists or for pathology. (See earlier commentary).[24]

Issuing provider numbers in this context of formal PHI recognition to ADPs would incorrectly and misleadingly impute the status of independence which is not permitted under the scope of practice defined by the DBA Standard. All dental practitioners are able to perform dental treatments under their scopes of practice to the fullest extent for which they are formally educated and trained in programs of study approved by the DBA. The Standard requires ADPs to work in a structured professional supervisory relationship to the dentist.

Competition arguments put forward

The ADA is concerned that the ACCC appears to view the scope of practice of clinical dental services by ADPs as being somehow anti-competitive or not in the public interest. It is hoped that the commentary provided has dispelled this.

Other parties, such as the DHAA, in advocating for an increased scope of practice for dental hygienists, have referred to particular resources in Britain and Canada. However, a review of

[23] See Medicare Teen Dental Plan-http://www.health.gov.au/internet/main/publishing.nsf/Content/dental-teen-factsheet.

[24] The medical radiologist has specialist training to analyse diagnostic images. The radiographer on the other hand, who is requested by radiologists to take images, does not perform diagnosis of those images for patients. Under the Medicare rebate arrangements, the radiographer cannot claim the right to receive a rebate. This is similarly the case with pathology. While the pathology lab can take the blood sample and analyse it, the doctor (who requested the blood be taken), is approximately the one with the requisite skills and qualifications to diagnose it. The ADP professional relationship with respect to dentists is analogously similar to these two examples.

these sources suggests that they are not applicable to the Australian context as those countries' scopes of practice vary greatly from Australia and the health implications of such arrangements do not appear to be comprehensively taken into account in the analysis.

UK Office of Fair Trading

The DHAA in its advocacy referred to a report by the UK Office of Fair Trading, which stated: [25]

> *"Restrictions on patients' ability to access dental care professionals directly: Dental patients are currently unable to access dental hygienists, dental therapists and (except for patients without any teeth) clinical dental technicians without first receiving a referral from a dentist. We do not consider that there is any compelling, objective justification for the current restrictions. Further, we consider that these restrictions are likely to dampen competition in the dentistry market, reduce innovation, limit patient choice and lead to inefficient use of resources in the provision of dental treatment." (page 7)*
>
> *"The report also raises concerns about continued restrictions preventing patients from directly accessing dental care professionals, such as hygienists, without a referral from a dentist. The OFT considers these restrictions to be unjustified and likely to reduce patient choice and dampen competition."*

The purported quote in the second paragraph does not appear anywhere in the OFT report. It would seem to be at best a paraphrase by the DHAA of the DHAA's interpretation of the OFT's views and should be recognised as such.

The ADA warns that the OFT's view (permitting screening and referral by DCPs) massively oversimplifies the distinction between screening and diagnosis, as outlined previously. The American Dental Association further elaborates on this.

American Dental Association

The American Dental Association reviewed a wide range of ADPs in the United States of America. It subsequently said that:[26]

> *"The models above share some basic flaws. They overload midlevel providers with more responsibility than that should be expected to bear. Their proponents consistently refer to certain procedures, including extractions, as 'simple', saying that of course more complex cases will be referred to dentists. However, fully trained and experienced dentists argue that midlevel's training cannot adequately prepare them to distinguish between "simple" and 'complex' cases. In fact, even fully trained dentists do not conclusively pronounce a procedure as simple until it has been successfully completed.*
>
> *"A second weakness rarely mentioned is the midlevel's questionable ability to distinguish between those that cannot be saved and should be extracted and those that could be saved by restorative methods beyond the midlevel's training. If your only tool is a hammer, every problem looks like a nail.*

[25] UK Office of Fair Trading, 'Dentistry: An OFT market study', May 2012, OFT1414 at http://www.oft.gov.uk/shared_oft/market-studies/Dentistry/OFT1414.pdf; 20 September 2012.

[26] American Dental Association, 'Breaking down the barriers to oral health for All Americans: The Role of Workforce – A Statement from the American Dental Association', February 22, 2011, at http://www.google.com.au/url?sa=t&rct=j&q=breaking%20down%20the%20barriers%20to%20oral%20health%20for%20all%20americans&source=web&cd=2&cad=rja&ved=0CCgQFjAB&url=http%3A%2F%2Fwww.ada.org%2Fsections%2Fadvocacy%2Fpdfs%2Fada_workforce_statement.pdf&ei=NW5iUOngMs2ziQfX7YCIDQ&usg=AFQjCNFvfjD4_fP-BZCOCUgliWUgrFmjfQ.

> *"A greater and broader weakness among proponents of midlevel practitioners is their near-obsessive focus on midlevels as the ultimate solution to access problems. Differences in opinion about the appropriate scope and supervision of various dental team members aside, arguing so vehemently for any single workforce model, while failing to place equal or even greater emphasis on the numerous other barriers to care, is either naïve or disingenuous. In some ways, these models are a solution in search of only one part of a problem.*
>
> *"Compensation is a relatively small percentage of the costs of establishing and maintaining a dental facility. The difference between the salary of a dentist and that of a therapist or advanced hygienist would likely be offset by their lower productivity compared to a fully trained dentist and have a minimal effect on the overall cost of delivering care."*

The Canadian Competition Bureau

The DHAA have also referred to a January 2007 letter by the Canadian Competition Bureau (CCB) that states:[27]

> *"When one group of professionals is reliant upon another group of competing professionals for the ability to Practice, the Bureau is concerned that access to the market over which the professionals compete will be unnecessarily restricted. In the Bureau's view, the ability of dental hygienists to compete in the market for dental hygiene services has been substantially limited by the above-noted order requirement. It has served as a significant barrier to entry for independent dental hygienists leaving alternative methods of service delivery for dental hygiene largely unexplored, and has, in our opinion, resulted in decreased patient access to dental hygiene care … This is an exciting time for the dental industry in Canada. Recent legislative changes in some provinces have made the market for dental hygiene services more competitive and it is anticipated that more change is coming." (ADA underlines)*

The ADA is concerned with the selective quoting from the DHAA. The section of the last part of the above quote, underlined by the ADA, refers to a different document altogether. The reference is actually to correspondence from the CCB to the Dental Industry Association of Canada.[28]

Turning to the source for which the bulk of the quote above has been used, the discussion occurs in the CCB's correspondence titled "Reform of Dental Hygiene legislation" and is addressed to both the Royal College of Dental Surgeons of Ontario and the College of Dental Hygienists of Ontario.

This CCB discussion refers to legislation that has been enacted in some Canadian provinces and as such applies to a jurisdiction materially different to that in Australia. The variation in the scopes of practice in those provinces is not comparable to what is in place in Australia and the report is of very limited applicability.

The CCB is within its remit to pass comment with respect to possible competition implications of certain practice structures in Canada, as is the ACCC in the Australian context. However, the CCB's remarks acknowledge they lack a detailed understanding of the health implications that certain arrangements will have ultimately on the patient:[29]

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[27] Canadian Competition Bureau, 'Reform of Dental Hygiene legislation', 18 January 2007 at http://www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/eng/02278.html, 20 September 2012.

[28] Canadian Competition Bureau, 'Reform of Dental Hygiene legislation', 6 December 2007 at http://www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/eng/02549.html, 20 September 2012.

[29] Canadian Competition Bureau, Reform of Dental Hygiene Legislation.

> *When regulating any market for the delivery of health care, finding a balance between the safety of the patient and an optimal degree of choice for the patient is challenging. Achieving optimal patient safety at the lowest cost to consumer welfare should be the goal of regulation.*

The CCB's recognition of this fact is reassuring and the ADA hopes that the explanation/information it has provided to the ACCC illustrates this in the Australian context.

Cost should not be the primary measure of the provision of healthcare services. Quality and safety of dental treatment should be the primary measure to determine the appropriateness or otherwise of professional healthcare structures. It is in this respect that the ADA cautions against the blanket acceptance of such assertions about cost reductions simply by allowing ADPs to independently practice. An analysis of the competition impacts on the existing arrangements, if any, must appropriately recognise the legislative and regulatory parameters in Australia that inform how all dental practitioners are expected to practice. There needs to be adequate recognition that these scopes of practice parameters have been developed independently, and in a manner which best facilitates safety and quality.

The distinctive nature of health care provision

While the ACCC appropriately seeks to ensure the efficient operation of markets, the very structure of its constituting legislation, the *Competition and Consumer Act 2010*, allows for exemptions to be made, such as those relating to authorisations and notifications (Part VII). The policy behind such provisions acknowledges that in some scenarios, applying a purely economics-based analysis and response would not in fact ensure the efficient nor equitable exchange or operation of goods and services in a market and/or that there is a public interest that would not be fulfilled.

The limitations that are placed upon ADPs by the Standards that are imposed by the DBA have been placed there by the DBA in accordance with the public safety benefits that underpin the National Law pertaining to the registration and regulation of health professionals. As stated elsewhere in this document they have been imposed after close scrutiny by the DBA. Noting the make-up of the DBA it would have to be recognised that any limitations imposed are there based upon the analysis undertaken by the Board.

The limitations are therefore imposed for the public benefit. The ACCC in evaluating the material that it has before it must assess the public benefits and detriments resulting from any purported anti-competitive practices. When there is a net public benefit the Commission may grant statutory immunity from legal proceedings under the Act. As such, the adjudication role is essential in achieving the Commission's objective to improve market processes.

The ADA would contend that on any evaluation of the way in which dental care is delivered under the regime put in place by the DBA there is a significant safety and quality benefit for the consumer in maintaining the structure and framework that exists. Any purported limitation is therefore considerably outweighed by the public benefit and should therefore remain in place.

Section 3:
Anti-competitive practices of Private health insurers (PHI) in Australia.

The ACCC's recent report to the Senate with respect to the period 1 July 2011 – 30 June 2012 stated that:

> *The ACCC's objective in producing the PHI Report is to comply with the Senate Order and to improve market practices in private health insurance. ACCC responsibility in the private health insurance sector is limited to encouraging compliance with and enforcing the Competition and Consumer Act 2010 (CCA).*

The areas of PHI behaviour necessitating comment are in the areas of contracting issues, preferred providers and informed financial consent for which the ACCC sought comment about in previous years.[30]

The discussion in this Section forms the basis for the following recommendations the ADA will like to make to the ACCC and the Australian Government:

Recommendation 1

Where health funds attempt to exercise derecognition action, the following must apply:

- There be full and accurate disclosure of the health funds' reasons for such action to both the dentist and the dentist's patients;
- Any communication between a patient and health fund regarding derecognition of the dentist be on agreed terms between the fund and dentist;
- Rights of review of such decisions must be put in place – natural justice must apply; and
- There be procedural fairness in the derecognition process.

Recommendation 2

Controls be put in place to prevent health funds from purporting to "create" contracts where no consideration or meeting of minds between the health funds and provider exists.

Recommendation 3

Discriminatory conduct relating to the payment of rebates based on the provider of the services affiliation with a PHI be declared illegal, as it is against the interest of the patient and undermines open competition.

Where the same contribution rate is paid the contributor must be entitled to the same rebate for the same itemised procedure regardless of which dentist provided the service.

Recommendation 4

The ADA calls for health funds to be brought to account to provide justification for the decline in rebated benefits and if suitable explanation is not provided then remedial action be imposed through legislation to rectify this decline.

Recommendation 5

[30] Note that the terms 'private health insurer' and 'health funds' are synonymous and will be used interchangeably throughout this Section

The ADA calls for health funds to increase dental rebates for all dental services on an annual basis and the review be in line with CPI.

Recommendation 6
There be no annual or lifetime limits on dental rebates in health fund policies.

Recommendation 7
Health funds should be banned from actively and directly attempting to influence their members to receive treatment from the health funds' contracted providers as it interferes with the patient/dentist relationship.

Recommendation 8
Health funds should cease to promote their contracted providers by use of terminology that contravenes the DBA Guidelines and the Health Practitioner Regulation National Law Act (National Law).

Recommendation 9
Legislation should be introduced to repeal those sections of health fund legislation that permit non-disclosure of health fund business rules and there be the introduction of a requirement that health funds publish clear, simple, easy to understand, and publicly available business rules.

Recommendation 10
Health fund rebate structures for services must be designed with the health interests of the member as uppermost and should not be constructed to generate a profit for the health fund.

Recommendation 11
Health experts be engaged to assess the manner in which health fund rules governing utilisation and rebate levels for services are implemented to ensure that the health interests of health fund members are being correctly prioritised.

Recommendation 12
If there are to be annual limits imposed by health funds (which are opposed by the ADA) then health funds be required to provide to all contributors current and complete details of such limits.

Recommendation 13
Health funds be required to provide all general treatment/ancillary policy holders with an itemised copy of current rebate levels for all general treatments.

Recommendation 14
There be greater uniformity in business rules and qualifying periods in order that consumers can make valid comparison between health fund policies.

Recommendation 15
When there is evidence of PHIs:

- Attempting to seek repayment of erroneous claims from service providers;
- Providing erroneous interpretation of dental item numbers; or

- Refusing to rebate for dental services carried out over multiple appointments until all the services in a treatment have been completed,

be imposed (such as financial penalties, or in the case of repeated infringements, loss of licence to operate as a health fund).

Recommendation 16
If the ACCC wishes to assist consumers with provision of information about the financial impact of receipt of healthcare then where services are rebated by health funds, the ACCC must demand health funds publish clear, easy to comprehend rebate tables for each Policy health funds provide.

PHI's recognition and derecognition practices

Health funds' recognition and derecognition practices with respect to dentists have given rise to competition and consumer issues.

Recognising some dentists as unacceptable providers (both noncontracted and contracted dentists) so their patients will not receive a health fund rebate

Health funds will communicate to dentists' patients about the fund's decision to no longer recognise a patient's claims if they continue to be treated by a particular dentist. This must not be able to be done until there has been some form of due process to justify such action. Being unilaterally deemed an 'unacceptable provider' by a health fund means that patients of that provider receive zero rebates for dental services from that private health insurer.

Removal of recognition is often based on non-compliance by the dentist with certain unilaterally imposed health fund requirements. Such non-compliance does not equate with any form of improper conduct by the dentist or delivery of inferior care. All too often, members have advised the ADA that when the fund communicates advice to a patient of termination of its recognition of a dentist or makes critical comment about a proposed treatment plan of the provider, the obvious inference drawn by the patient is that the dentist has been providing inappropriate, improper or dishonest treatment. Such comments are clearly outside the area of competence of most fund staff and the suggested motive for such comments can only be presumed to be in order to influence the patient to change to a 'preferred provider' of the fund.

Strict conditions on the exercise of such derecognition rights must be controlled. Not only does this conduct constitute the creation of a false and misleading perception in the mind of the patient, it is contrary to competition policy as it effectively removes a practitioner from treating a health fund member. It removes the health fund member's choice - a fundamental privilege.

Recommendation 1

Where health funds attempt to exercise derecognition action, the following must apply:

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to both the dentist and the dentist's patients;

- Any communication between a patient and health fund regarding derecognition of the dentist be on agreed terms between the fund and dentist;
- Rights of review of such decisions must be put in place – natural justice must apply; and
- There be procedural fairness in the derecognition process.

Recognising some dentists as a recognised provider without the dentist's agreement to a contract with the health fund

Some health funds have unilaterally sent correspondence to dentists suggesting that the dentist is a 'recognised provider' of their fund, even though there is no contractual relationship between the two. The claim by the health fund that a contractual agreement is now in place binding the treating dentist to the rules and regulations of that health fund is made simply on the basis the dentist has treated a patient who has insurance cover with the health fund concerned. Once this unilateral 'recognition' is provided, the PHI then seeks to impose certain conditions/rules to ensure the provider's patient receives only certain benefits. This unilateral application of requirements on the provider, when no relationship (contractual or otherwise) exists between the two, is inappropriate and the ADA says it is improper for such requirements to be arbitrarily imposed. Non-compliance with the health fund's unilateral provision of this requirement causes inconvenience to the patient and is often used as an opportunity for the fund to recommend to the patient a change of practitioner to one of the health fund's actual preferred providers. It is, in the ADA's view, an unfair exploitation of market position by the health funds particularly where a health fund may dominate a local market. It also compromises the level of care that is being provided so as to suit the ends of the PHI.

Recommendation 2

Controls be put in place to prevent health funds from purporting to "create" contracts where no consideration or meeting of minds between the health funds and provider exists.

PHI practices and activities that result in greater out-of-pocket expenses for consumers

There is a range of activities by health funds which result in greater out-of-pocket expenses for consumers, reduced choice for the consumer and impacts on competition.

The whole philosophy of private health insurance has been built upon the consumer having the choice of provider as distinct from a 'lack of choice' in the public health care system. PHIs, with apparent deliberate intent, have, by means of discriminatory and punitive differences in rebate levels, eroded consumers' freedom of choice of provider.

Health Funds have introduced practices that lead to lower rebate levels when the member wishes to use the services of their dentist of choice with whom they have an established relationship. Continuity of care is a key lynch-pin in health care. Continuity enables the

practitioner and patient to develop a familiarity with each other and this enhances the quality of care provided.

As all members of a fund pay identical premiums, the level of rebates for the same service should also be identical – however, this is not the case. Despite the ADA and members of the public having raised this issue on several occasions there has been no action taken by the ACCC to remove this unfair practice. Transparent competition has been eroded by these 'preferred' contracted provider arrangements and the inequality of rebate is causing increased out-of-pocket expenses for consumers, the very issue the ACCC is trying to address.

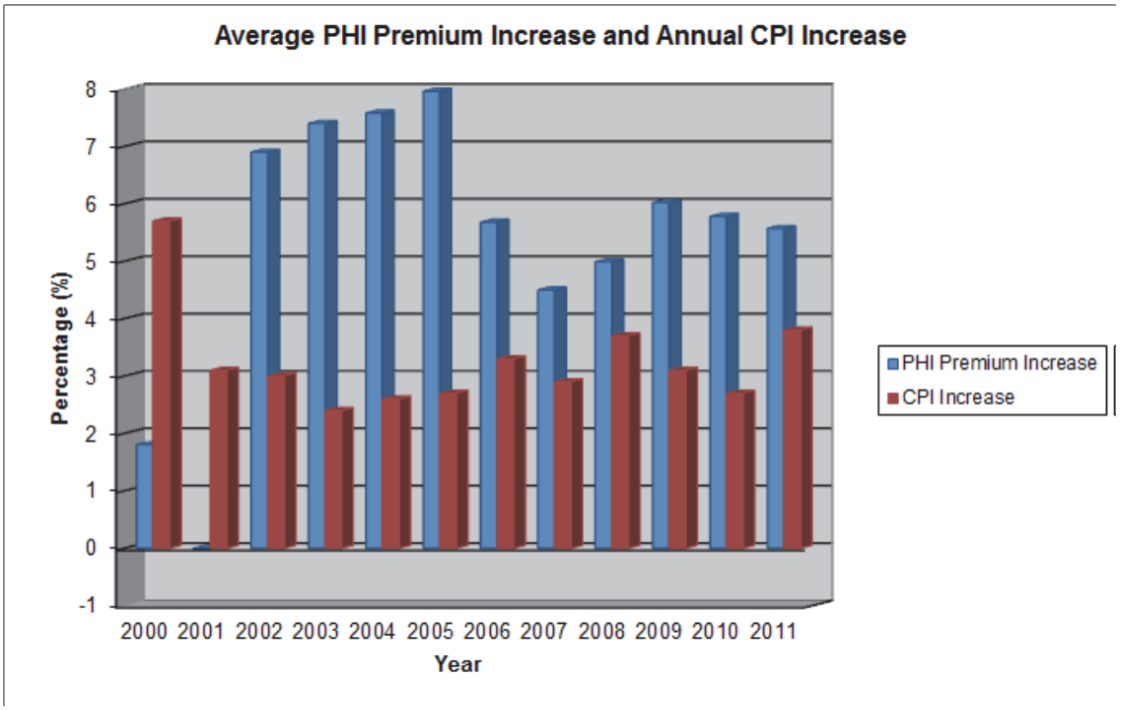
Recommendation 3

Discriminatory conduct relating to the payment of rebates based on the provider of the services affiliation with a PHI be declared illegal as it is against the interest of the patient and undermines open competition.

Where the same contribution rate is paid the contributor is entitled to the same rebate for the same itemised procedure regardless of which dentist provided the service.

PHI premium rate increases compared to CPI

The table below shows the relationship between PHI contribution rate increases and CPI – i.e. the impacts on the consumers' out–of-pocket expenses. There appears to be little proportionate value provided in return to consumers via rebates for the PHI premium increases they pay.



Sources: Previous media releases from Health Ministers, for example the Hon. Min Roxon, 'Private Health Insurance Premiums kept to a Minimum, Individual Fund Information provided', 25 February 2011; and ABS CPI reports such as 6401.0 Consumer Price Index, Australia Sept 2011

With respect to consumers' out-of-pocket expenses, the ADA notes that there are some PHIs who have not increased dental rebates across the board since 1994. Many PHIs have placed restrictions on the numbers of dental services allowed to be claimed per annum. This is poorly communicated to contributors by PHI, if at all. It is no wonder the out-of-pocket expense (OPE) gap has continued to grow. If rebates are not increased annually the expectation must be for consumers' out-of pocket expenses to increase. The ACCC does review the level of out-of pocket expenses that are to be paid by consumers but does not investigate the level of dental rebates. This means that only one side of the equation is being investigated. The ACCC must investigate this and address the increasing disparity between premiums and rebates.

Levels of PHI income from general (ancillary) services vs. rebates provided to consumers

Furthermore, the ADA would like to bring to the ACCC's attention to the massive profitability in general (ancillary) services by PHIs in Australia:

Year	Ancillary Income	Ancillary payout	Surplus	Percentage
2000/01	$ 1,920,519,000.00	$ 1,533,122,000.00	$ 387,397,000.00	20.17%
2001/02	$ 2,121,529,000.00	$ 1,900,328,000.00	$ 221,201,000.00	10.43%
2002/03	$ 2,371,360,000.00	$ 2,043,440,000.00	$ 327,920,000.00	13.83%
2003/04	$ 2,556,786,000.00	$ 2,117,299,000.00	$ 439,487,000.00	17.19%
2004/05	$ 2,724,385,000.00	$ 2,239,925,000.00	$ 484,460,000.00	17.78%
2005/06	$ 2,857,096,000.00	$ 2,276,743,000.00	$ 580,353,000.00	20.31%
2006/07	$ 3,049,798,000.00	$ 2,454,356,000.00	$ 595,442,000.00	19.52%
2007/08	$ 3,433,908,000.00	$ 2,656,255,000.00	$ 777,653,000.00	22.65%
2008/09	$ 3,696,018,000.00	$ 2,869,540,000.00	$ 826,478,000.00	22.36%
2009/10	$ 3,996,818,000.00	$ 3,052,757,000.00	$ 944,061,000.00	23.62%
2010/11	$ 4,309,168,000.00	$ 3,209,104,000.00	$ 1,100,064,000.00	25.53%
Total	**$31,116,866,000.00**	**$24,819,747,000.00**	**$6,684,516,000**	**21.48%**

Source: Private Health Insurance Administration Council Annual Reports

In the 11-year period depicted in the table a surplus of nearly $6.7 billion has been achieved in comparing ancillary income with pay-outs. It would appear that health funds are using the surplus from ancillary cover to support (subsidise) their other insurance products as the declared overall profit of health funds does not reflect these massive profits from ancillary.

The ADA believes that health fund contributors are not informed of this massive surplus. In real terms it means that contributors to ancillary services are not getting full/appropriate value in rebates as significant amounts are being used to offset other aspects of the health funds' business. This is of great concern to the ADA as the Private Health Insurance Administration Council (PHIAC) in the March 2012 Quarterly Statistics indicated about 50% of the ancillary expenditure is for dental services. The ACCC has not challenged those PHIs who have provided the same dental rebates to consumers for decades while at the same time

accruing massive surpluses. Further investigation must be made on the annual limits and business rules which further restrict rebates and cause greater out-of-pocket expenses.

The surplus in 2010/11 would indicate that **all** ancillary services could have had a 25% increase in rebates with PHIs still having a significant profit. An increase in rebates would significantly reduce out-of-pocket expenses for consumers and are well overdue.

These rebate trends are also confirmed by analysis performed by media, pointing out that:

> *"HEALTH fund rebates for dentists, physiotherapists and optometrists have plunged by almost 20 per cent over the past 16 years. … In 1996, health funds covered 57 per cent, on average, for ancillary services such as dental and optical. Data supplied by the nation's health insurance regulator shows that had dropped to 49 per cent by last year." (Dunlevy S., 'Health funds keeping more', Herald Sun, 25 Aug 2012).*

The ADA believes it is inappropriate for the ACCC to be critical of growing out-of pocket expenses when it continues to allow PHIs to avoid annual review of dental rebates and annual limits.

PHIs should not be allowed premium increases of the magnitude currently occurring given the massive ancillary surplus.

Annual limits

Since health funds are often profit driven, some use their business rules to this end by placing a limit on their rebates to their contributors (annual limits). Similar to rebate review health funds do not on a regular basis review the annual limits. Further, health funds also place restrictions on the number of services that are eligible for rebate within these annual limits.

The creation of such limits is arbitrary and set by PHIs to ensure profits and has no relationship to dental needs or the health of the patient. These limitations are not well explained by health funds, if at all, to their contributors. Often the first time the contributors are made aware of these restrictions is after the event, i.e. after having the dental service provided and then attempting to make a claim for rebate. This is misleading behaviour in that contributors are not adequately informed of these limits.

The impact that this has is that it effectively dictates those services that the contributor can use with no regard to the dental health of the patient and the clinical independence of dentist.

Asset Building by "For Profit" PHI

An issue that the ACCC needs to take heed of is the decrease in the number of PHIs overall and the increase in the number of "for profit" PHIs. This market consolidation of "for profit" PHIs (as outlined in the table below) is a matter of serious concern.

Year	2000	2005	2011
Number of Insurers	44	40	34
Open Access	29	26	21
For Profit	4	5	7
For Profit Market Share	12.5%	15.9%	68.6%
Total Premium Revenue	$5.46 Billion	$9.38 Billion	$15.42 Billion
Total Benefits Paid	$4.51 Billion	$8.24 Billion	$13.16 Billion
Total Assets	$3.26 Billion	$5.87 Billion	$9.49 Billion

ADAWA Schedule and Third Party Liaison Committee Report, 'Congratulations – Health Funds are billionaires'.

Another significant concern is the massive build-up of assets of the "for profit" group. The top 5 funds in Australia are MBP, Bupa, HCF, HBF and NIB. All have contracted providers and most are "for profit".

The prevalence of "for profit" PHIs has been driven by the shareholder returns that operate at the expense of the health and welfare of their members. With the increase in market share of for-profit funds to approximately 71% of the market as at 30 June 2011 (compared to 12.5% in 2000) the impact of this focus on shareholder return will only increase. This profit motive may be acceptable in more commercial arrangements but in the sphere of health, it is the interests of the patient (health fund contributor) that must be given the dominant place in the contractual arrangements that exist.

Recommendation 4
The ADA calls for health funds to be brought to account to provide justification for the decline in rebated benefits and if suitable explanation is not provided then remedial action be imposed through legislation to rectify this decline.

Recommendation 5
The ADA calls for health funds to increase dental rebates for all dental services on an annual basis and the review be in line with CPI.

Recommendation 6
There be no annual or lifetime limits on dental rebates in health fund policies.

Contracting Issues

The ADA sees health funds as increasingly interfering with the delivery of dental healthcare by:

Seeking to unduly influence patients in the selection of their dentist for treatment

Continuity of treatment is vital in the proper care of patients. Bonds and confidences are developed over time between patient and practitioner that are invaluable. These should not

be interfered with. This is even more so in dentistry where often phobias or dislike of treatment can be a relatively common occurrence.

Examples of PHI interference with dental treatment are many and varied and set out below are instances of such conduct:

- Some health funds use the opportunity of discussing written estimates of costs of treatments with their members to deliberately attempt to redirect patients to the funds' contracted (preferred provider) dentists.

- Advertising and advice by health fund staff imply that non-preferred provider practitioners deliver inferior service or are perceived as 'not preferred' or 'not approved'. The use of such terms could be contrary to the DBA Advertising Guidelines[31] which bar the promotion of one health provider over another. Use of such terminology therefore exposes a practitioner to an allegation of inappropriate professional conduct and a risk of deregistration as a health practitioner.

- There is evidence of PHIs pushing preferred provider arrangements (PPAs) in remote areas. This is having a most deleterious effect on established remote practices. Dentists in these areas find the practice's goodwill is being eroded by PHI enticing opposing practice[s] to become a preferred provider and then directing all contributors away from the non-preferred provider practices. This is destroying succession plans for practices in remote areas with the end result being loss of practitioners in the remote areas – where the public's overall access and oral health outcomes suffer. Some PHIs are even attempting to push contributors to adjoining country towns on the basis of a preferred provider being located there. In a situation where there is already the need for incentives to be provided to practices to set up in these areas such activity by PHI is against the interests of the community and must be stopped.

- There is evidence of health funds refusing to accept additional healthcare providers as preferred providers primarily because the health fund has assessed that it would not receive adequate utilisation by the new practice. This reflects the total focus on financial outcomes by PHIs; rather than the interests of their contributor.

- There are cases where the non-preferred provider's entire fee is less than the rebate offered to the preferred provider patient; yet, because the out-of-pocket expense is less, staff of the fund promote the preferred provider as being cheaper. This is clearly not the case and is misleading and deceptive.

- Health funds often advertise "free services" or "no charge" services by preferred providers. Quite clearly the provider is paid for their service and the patient pays via their contributions. This is misleading and deceptive. There is lessening of competition as the non-preferred provider's patients are not offered these "free" services. In addition these free services may be unnecessary and can lead to over servicing.

[31] http://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx

- There is now evidence that health fund counter staff have been interfering with direct referrals by GP dental providers to dental specialist providers. This is a most disturbing issue as the referring provider is not consulted or informed that the patient has been diverted to a PHI "preferred provider" specialist. There are cases where the diversion has not been to a bone fide specialist but merely a GP practitioner who has limited their practice to a certain field. This is a most significant breach in patient management that has severe professional indemnity ramifications. The patient is not seeing a specialist but is led to believe the contrary. Furthermore, claims for injury as a result of inappropriate referrals are significant.

In all of the above examples the patients are paying the same contribution rates yet if the patient chooses the provider of their choice they are punitively discriminated against by the differential rebate. This substantially lessens competition.

Recommendation 7

Health funds should be banned from actively and directly attempting to influence their members to receive treatment from the health funds' contracted providers as it interferes with the patient/dentist relationship.

Recommendation 8

Health funds should cease to promote their contracted providers by use of terminology that contravenes the DBA Guidelines and the *Health Practitioner Regulation National Law Act* (National Law).

Fund business rules relating to rebates create dysfunctional incentives that risk patients opting for a course of treatment that is not best suited to them

Some funds adopt a concept of a 'reasonable utilisation level' which, through imposition of financial limitations on payment of rebates, constrains how treatment should properly be delivered to patients. In some cases, a practitioner's mode of practice and delivery of proper dental care to the patient is adversely affected because of the utilisation level. These practices constitute interference in the delivery of proper dental care. Such utilisation levels are based on economic parameters and are not based on sound clinical evidence applied to individual patients. Where utilisation levels interfere with the delivery of proper healthcare they should be disregarded and the health fund be obligated to meet, in part, the fees incurred for the optimal treatment.

Something similar occurs in the case of annual or 'lifetime' limits. Where health funds apply lifetime limits on those services that will be rebated as a "business rule", the contributors often elect to not proceed with necessary treatment if there is no rebate available. Even when the life-time limit has been received for a particular service, the PHI continues to receive premiums from the contributor for such 'Major Dental' entitlements knowing the

contributor cannot claim for such services again. This is deceptive and misleading as contributors are often not aware of the impact of this business rule.

Lifetime cover and annual limits are not applicable to medical cover. There is no uniformity in health funds' business rules, rebates per service, annual limits, lifetime limits and qualifying periods. No other aspect of insurance has such impossible parameters for direct comparison of levels of cover and premiums. This does not occur with household, car, boat or any other form of insurance. It effectively lessens competition between health funds as it is impossible to make direct comparison of what is covered. It also makes it impossible for the practitioner to obtain informed financial consent.

Lack of transparency of PHI business rules

On a more general level, the manner of application of PHI Business Rules is contrary to fundamental contract law. How health funds are able to apply such Rules when premium-paying members are not provided with details of them contradicts any basic tenet of contract law.

Non-disclosure of the rules (either to the ADA by the funds or to their members and providers) is a cause for concern. All financial products require the publication of product disclosure statements and PHI should be no exception. Why funds are not prepared to disclose their rules supports the concerns that have been raised already: that the profit motive is more important than the rights or more importantly the health of their contributors.

These rules should be open to public scrutiny and available to not only educate and inform the fund member but also members of the public who wish to compare policies prior to signing up for private health insurance.

Recommendation 9

Legislation should be introduced to repeal those sections of health fund legislation that permit non-disclosure of health fund business rules and there be the introduction of a requirement that health funds publish clear, simple, easy to understand, and publicly available business rules.

Recommendation 10

Health fund rebate structures for services must be designed with the health interests of the member as uppermost and should not be constructed to generate a profit for the health fund.

Recommendation 11

Health experts be engaged to assess the manner in which health fund rules governing utilisation and rebate levels for services are implemented to ensure that the health interests of health fund members are being correctly prioritised.

Recommendation 12

If there are to be annual limits imposed by health funds (which are opposed by the ADA) then health funds be required to provide to all contributors current details of such limits.

Recommendation 13

Health funds be required to provide all general treatment/ancillary policy holders with an itemised copy of current rebates for all general treatments.

Recommendation 14

There be greater uniformity in business rules and qualifying periods in order that consumers can make valid comparison between health fund policies.

Attempts to seek repayment of erroneous claims from service provider

Often when PHIs claim there is over-servicing, overpayment or errant claims, the health fund demands repayment of the rebate from the provider of the service. The provider is not insured with the health fund – it is the patient who is insured and it is the patient who ought to be refunding the rebate. The contract of service is between the dentist and the patient. The contract of insurance is between the patient and the health fund.

In the case of an error in account to the patient the provider should refund the fee to the patient if that is the agreed outcome. The rebate issue is between the health fund and the contributor. The provider should not be expected to fund a claim from the PHI where it is the contributor who has benefitted.

Erroneous interpretation of dental item numbers by PHIs

The *Australian Schedule of Dental Services and Glossary*[32] is prepared by the ADA and provides numbers and descriptors for various dental services. Health funds, with increasing frequency, are placing their own interpretation on dental item numbers. The *Australian Schedule of Dental Services and Glossary* is a copyright-protected document. It has been accepted by the National Coding Centre as the definitive and authoritative descriptor of dental services. Health funds are invited to contribute submissions to the review of the *Australian Schedule of Dental Services and Glossary*.

The accusatory nature and invariably inaccurate ways in which health funds make claims that the incorrect item number has been used by dentists are destructive to dentist-patient relationships. They often amount to no more than an attempt by health funds to deny legitimate rebates.

Health funds refuse to rebate for dental services carried out over multiple appointments until the services have been completed

Some health funds on a regular basis, but at their discretion, refuse to rebate for dental services carried out over multiple appointments until all the services in a treatment have

[32] The *Australian Schedule of Dental Services and Glossary* has been published by the Australian Dental Association since 1986. Since its inception, it has been accepted as the definitive coding system of dental treatment and endorsed by the National Coding Centre.

been completed. This particularly relates to crown and bridge work. These procedures are usually carried out over at least two visits.[33]

The *Australian Schedule of Dental Services and Glossary* clearly defines the accepted protocol of billing for such procedures at the first visit. These protocols are based on common law contract principles. Health funds refuse to accept this protocol.

This is contrary to how health funds deal with general treatment rebates for other providers and is conduct clearly discriminating against the contributor for legitimate dental services provided. The same health funds that do not rebate the crown or bridge at the preparation date will rebate optical services at the issue of the prescription for the lenses even though not yet provided and will rebate for orthotics merely at the impression-taking stage. Unlike the crown preparation, neither the optical nor the orthotic treatments are invasive or irreversible procedures. Health funds remain inflexible in their attitude to this and incorrectly inform patients on a regular basis that it is the dental provider who is at fault and refuse to rebate on presentation of the account even if the patient has paid for the said service in full.

Recommendation 15

When evidence of PHIs:

- Attempting to seek repayment of erroneous claims from service providers;
- Providing erroneous interpretation of dental item numbers; or
- Refusing to rebate for dental services carried out over multiple appointments until all the services in a treatment have been completed.

sanctions be imposed (such as financial penalties, or in the case of repeated infringements, loss of licence to operate as a health fund).

Preferred Provide Schemes

Examples of third line forcing

The ADA suggests the following examples of third line forcing by preferred provider schemes and health funds:

- Provision of higher rebates for dental services to health funds members **only** if the services are purchased from a PHI contracted dental provider;
- **Refusal to supply** a higher rebate to PHI members for dental services if they attend a non-PHI contracted provider;
- Provision of free check-ups to health fund members **only** if the service is purchased from a health fund contracted dental provider;
- **Refusal to supply** a free check-up to health fund members for dental services if they attend a non- health fund contracted provider;

[33] The first involves the preparation of the tooth/teeth which is an invasive and totally irreversible procedure. It also involves impression taking, temporisation, haemostasis, extensive laboratory procedures and is usually conducted under local anaesthetic administration. Prior to the next visit the crown or bridge is constructed. The second visit involves the fitting of the crown or bridge.

- Provision of free scale and clean treatments to health fund members **only** if the service is purchased from a health fund contracted dental provider;
- **Refusal to supply** a free scale and clean to health fund members for dental services if they attend a non-health fund contracted provider;
- Provision of 'zero out-of-pocket expenses' to health fund members for dental services **only** if provided by a health fund owned dental clinic. The ADA has an additional concern with this issue in that the insurer is providing the service for which the insurance is offered and thus a conflict of interest is created; and
- Restriction of acceptance of preferred providers to those that are contracted to HICAPS.

Informed Financial Consent (IFC)

PHI not adequately facilitating IFC

It is the health funds', not the providers', responsibility to inform the patient as to what the rebate for the dental service will be. Health funds do not issue to their contributors a list of rebates for dental services and nor is it easily accessible.

The subject of IFC[34] has long been an issue for the ADA and its membership. The ADA recognises that the health provider has an obligation to provide IFC *vis-à-vis* the patient/dentist relationship but that obligation extends no wider.

This is because patients with health fund cover have a direct contractual relationship with their health fund. The health provider is not a party to that contract and therefore has absolutely no obligations under that health fund's arrangement. If the patient wishes to know what OPE expenses are to be incurred (i.e. above the rebate received from the health fund) then the determination of that information is a matter between the patient and health funds. It remains the responsibility of the practitioner to simply provide the patient with an itemised account.

It is the ADA's experience that regularly when patients present their proposed treatment plans and fee estimates to the health funds, health fund staff are instructed to opportunistically use this information to try and influence the patient to see the Funds' contracted providers. This is done utilising discriminatory rebates that favour preferred provider arrangements. The patient does not have the choice of a lower premium if they choose to attend non-PPAs. This is anti-competitive.

Recommendation 16

If the ACCC wishes to assist consumers with provision of information about the financial impact of receipt of healthcare then where services are rebated by health funds, the ACCC must demand health funds publish clear, easy to comprehend rebate tables for each Policy health funds provide.

[34] ADA Policy 5.16 - Informed Financial Consent. (Attachment 2)

Conclusion

The ADA remains concerned that its issues raised in submissions over previous years have been ignored and it has sought to draw attention to these issues once again. Health fund behaviour requires significant reform. It is evident that health fund behaviour has deteriorated markedly over the last few years. Immediate steps must be taken to make health funds accountable to consumers in the interests of fair financial accountability and more importantly, their health interests.

Adoption of the recommendations made in this Attachment must occur to achieve this end.

Dr F Shane Fryer
President
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September 2012.

Appendix A

Differences between education and training of dentists and oral health therapists (OHT)

Dentists receive training that OHT do not and this is in the areas:

Integrated Life and Biomedical Sciences

Dentist students undertake this course alongside medical students.

This provides a highly academic rigorous foundational knowledge base that has for nearly a century been accepted as necessary for the safe and effective practice of dentistry. The requirement to undertake this course is even more important considering the pace of modern medical developments.

Oral Surgical and Diagnostic Sciences (based on previous medical model)

- Oral Pathology and Medicine Oral Pathology;
- Oro Facial Pain;
- Oral Surgery; and
- Oral Radiology.

Comprehensive Care Dentistry

- Prosthodontics;
- Endodontics;
- Trauma;
- Implantology;
- Geriatric dentistry;
- Occlusion;
- Orthodontics;
- Paediatric dentistry - sophisticated and comprehensive; and
- Professional and Community Care including dental jurisprudence.

Having completed their course OHT has not been trained to perform:

- Root fillings;
- Indirect or fixed restorations such as crowns, veneers, onlays, inlays, bridges, implant abutments;
- Orthodontics;
- Surgical procedures of any kind including retrieving roots from extractions, surgical drainage, placement of implants, periodontal or endodontic surgery, biopsies etc;
- Construct fixed or removable dentures;
- Treat orofacial pain;
- Occlusal therapy, construct TMJ appliances; and
- Prescribe drugs or provide sedation.