Australian Dental Association Inc.

Private Health Insurance Amendment (GP Services) Bill 2014

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About the Australian Dental Association

The Australian Dental Association Inc. (ADA) is the peak national professional body representing the majority of Australia's 15,000 registered dentists as well as dentist students. ADA members work in both the public and private sectors as well as in academia and research.

The primary objectives of the ADA are to encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry and to support members of the Association in enhancing their ability to provide safe, high quality professional oral healthcare.

There are ADA Branches in all States and Territories other than in the Australian Capital Territory. Membership by individual dentists of ADA Branches confers automatic membership of the ADA. Further information on the activities of the ADA can be found at www.ada.org.au.

Introduction

The ADA welcomes the opportunity to provide this submission to the Community Affairs Legislation Committee inquiry and report into the *Private Health Insurance Amendment (GP Services) Bill* 2014 (the Bill). The ADA understands that this Bill, introduced by Senator Di Natale, seeks to prevent private health insurers from entering into agreements or arrangements with primary care providers (general practitioners predominantly) that provide preferential treatment to their members.

The ADA does not have a formal position on this bill. Rather, this submission is intended to assist the Committee in its inquiry by relaying some real world experience of the operation of the private health insurance ('the PHI industry') in the dental care sector. Our members, who have specific knowledge of their patients' circumstances and routinely deal with the industry, are well placed to inform the Committee about the operations of the PHI industry in dental care and its effects on patients.

While some Australians receive dental care through publicly funded government programmes, the vast majority of dental care services in Australia are provided by dentists in private practice to patients, many of whom are covered by private health insurance (PHI). On 30 June 2013, **54.9%** of all Australians were covered by general (including dental) treatment PHI.[1]

[1] Australian Government Private Health Insurance Administration Council *The Operations of Private Health Insurers Annual Report 2012-2013* at page 20 available at http://phiac.gov.au/wp-content/uploads/2013/12/2012-13-accessible-pdf.pdf accessed 9 July 2014.

Operational Practises of the PHI Industry

As part of the health sector, the provision of dental care in Australia is assisted and encouraged by government expenditure and regulation. Where quality of patient care and clinical independence of dentists is paramount, government has an important role to play in the sector as does the PHI industry. However, enabled in part by government, the approach of the PHI industry in dental care has had the effect of:

a) **limiting choice** for Australian consumers;
b) **limiting access** to dental care by Australian consumers;
c) **increasing the out of pocket expenses** for Australian consumers;
d) **artificially inflating the cost** of dental consultations through their business practices;
e) damaging the nature of the dental care environment by **damaging the family dentist whose goal is the health, welfare and safety of their patients**; and
f) ushering in a model of **corporatised care** in dentistry where profit is the sole motivator.

The manner in which dental care is delivered in Australia is being permanently affected by the operational practices of the PHI industry and, in the view of the ADA, Australian patients will be the worse off. The PHI industry, through the terms of their policies and discriminatory rebate practices, seeks to dictate the provider and the nature of treatment received by Australian dental patients. The dentist is best placed to advise Australians on their oral health care, yet this is a role which the PHI industry is increasingly assuming and this is adversely impacting on the quality of care being delivered.

There appears to be four operational practices that form the basis of the business model adopted by the PHI industry which are likely indicators of the possible future for Australia's health system if the industry is permitted to expand its operations into primary health care.

1. The level of rebates paid to Australians with Private Health Insurance

Member fee surveys conducted by the ADA have, over recent years, consistently indicated that annual overall dental fee increases have been at rates less than the Health CPI and average private health insurance premium increases.[2] The increase in premiums being charged by the PHI industry have far exceeded the levels of fee increases being charged for services. In light of this and with an increasing number of Australians having PHI, one would expect the level of rebates paid back to Australian consumers for dental care would have increased relative to fees, with individuals making a decreasing monetary contribution to their dental care.

[2] ADA Annual Fee Survey: 2008/09 4%; 2009/10 2.9%; 2010/11 1.9%; 2011/12 1.3%; 2012/13 2.8%.

Figures released by the Australian Institute of Health and Welfare show that for the period 2011-2012 individuals were by far the biggest contributors to the cost of dental care. A total of **$4.736** billion was contributed by Australians in this period compared with $1.261 billion contributed by the PHI industry.[3]

Figure 1 shows a percentage breakdown in the contributions of government, the industry and individuals to the cost of dental care. In 2011-12, total expenditure on dental health was estimated at $8.336b. Governments (Federal and State) contributed $2.3b of this amount with $6.03b coming from either the industry or individuals. Notwithstanding the level of premiums paid by Australians for PHI, the industry contributed only $1.26b to the cost of dental care while individuals contributed **$4.736b**. Indeed with the exception of medication expenses, dental care is an individual's highest health expense.

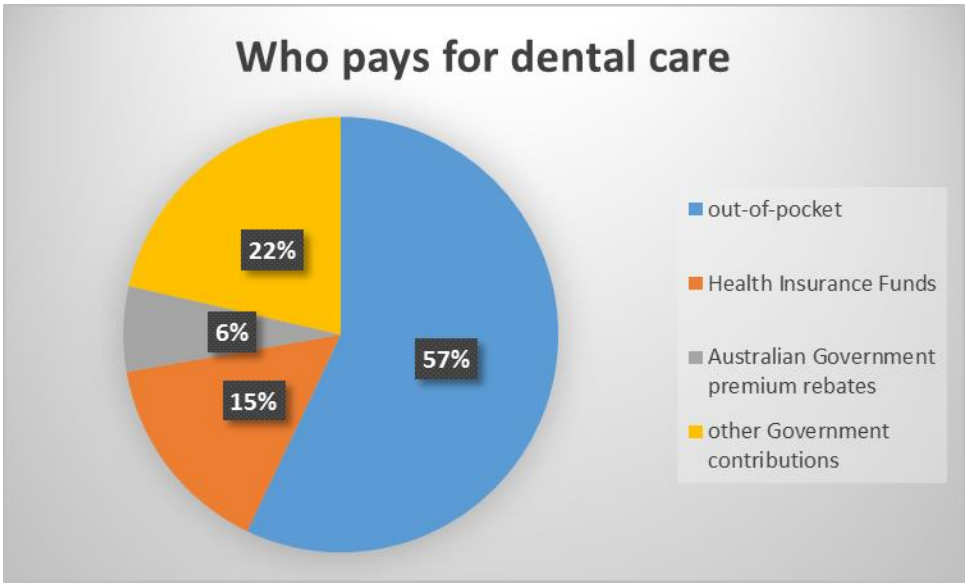

Figure 1: Dental Expenditure in Australia 2011-12

The ADA has made a submission to the Senate Community Affairs References Committee inquiry into out of pocket (OOP) costs in Australian healthcare. Research undertaken by the ADA indicates an increasing discrepancy between customary fees charged for dental services and the rebate levels paid by the PHI industry. Australians with PHI are required to meet the difference

[3] Australian Institute of Health and Welfare *Health expenditure Australia 2011-12* Table A3 available at http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544656 accessed 11 July 2014.

or gap. This increasing gap has an adverse impact upon insured patients accessing dental care which in turn results in less than optimal care being obtained. This submission is available at www.ada.org.au.[4] The end result for Australians will be increasing dental costs and decreasing dental care visits.

2. Preferred Provider Agreements [PPA]

Preferred Provider Agreements (PPA) are a mechanism adopted by the PHI industry which seek to create a contract between a particular fund and a particular dentist referred to as a preferred provider (PP). A patient accessing dental care from a PP, as opposed to their family dentist, may have the effect of lowering the OOP or gap for particular patients however the PHI industry, through PPAs, is:

a) interfering with a patient's **freedom to choose their own dentist**;
b) **applying a punitive measure**, to patients who choose their own dentist, even though they pay the same PHI premium; and
c) **artificially inflating** the price of dental care for other patients who cannot access a PP.

While there is no overt compulsion on the part of the PHI industry, the higher rebates paid (or nil gaps) to patients who access PPs, has the above effects. Choice of provider and continuity of care should be the paramount consideration in the delivery of health services including dental care. The PHI industry should not dictate or inappropriately influence choice.

3. Private Health Insurance Owned Dental Clinics

A recent development in the PHI industry has been its further expansion into the ownership and operation of dental clinics. These clinics, generally located in major Australian cities, offer dental care to policy holders from dentists either employed by or contracted to particular PHI funds. PHI industry dental clinics:

a) interfere with a patient's **freedom to choose their own dentist;**
b) **apply a punitive measure** to patients who choose their own dentist or for whatever reason cannot attend an industry dental clinic, even though they pay the same PHI premium;
c) **artificially inflate** the price of dental care for other patients who cannot access an industry dental clinic, particularly those patients in the rural and regional centres where there are no industry dental clinics; and

[4] Australian Dental Association: Submission to Standing Committee on Community Affairs *Inquiry into the out-of-pockets costs in Australian healthcare* 12 May 2014 available at http://www.ada.org.au/App_CmsLib/Media/Lib/1405/M769771_v1_635355802511720971.pdf.

d) represent a **corporatised model** of dental care where patients are seen quickly by dentists who may have no historical knowledge of their medical history.

A very significant conflict of interest arises in such arrangements. Here the PHI industry provides the insurance for services which it also provides. Not only does the PHI industry set and charge for the insurance cover , it also sets the price the clinic will charge for the service, employs the provider of the service (potentially identifying the treatment options to be provided) and then sets the rebate that will be payable. The ability to exploit the patient in such a situation is unbounded.

The dental care available to the patient should be determined by the dentist who places the health, welfare and safety of their patients at the centre of all dental care.

4. The terms of PHI policies

The coverage offered by PHI is subject to the terms of particular policies. Research conducted by the ADA reveals that in respect of dental treatment, there are strict rules and limitations in place which limit the benefits available to Australians through their PHI. These limits in some instances seek to impose lifetime restrictions on the dental care that is available to Australians of all ages, including children. For example, the major health funds all impose a lifetime limit on the orthodontic treatment available to children under their policies.

The intention of these policy terms is to limit the treatment choices available to Australians who pay high PHI premiums and minimise the exposure of the PHI industry. This operational practice directly interferes with the relationship between a dentist and a patient. The dentist is best placed to advise Australians about the most appropriate dental care and this relationship should be free of any interference from the PHI industry. The PHI industry should fulfil its obligation to provide insurance to Australians who pay very high premiums and are compelled by Government policy to have PHI.

By highlighting these four operational practices of the PHI industry, the ADA aims to give the Committee a snapshot of the industry's involvement in dental care. It is one which suggests that the future will see the PHI industry obtain dominance in the sector that goes well beyond a traditional role of funder of dental care to being unqualified providers of dental care. If this dominance continues, Australians with PHI face a future of escalating dental care costs and the local family dentist will be a thing of the past. The future will be even worse for the uninsured. In this regard, the ADA would like to make a final point about public dental care in Australia.

The ADA has previously written to the government regarding the adequacy of public dental services in Australia. It is imperative when considering the role of the PHI industry in health care, access to dental care by the uninsured is borne in mind. If private dental care becomes too costly and Australians get less value for their PHI, there is the potential for the number of Australians seeking public dental care to

increase. Adding to the increasing number of Australians who seek public dental care is not, without a substantial overhaul of dental care delivery, in the long term interests of the oral health of all Australians. The government needs to continue to consider and implement policy that assists the genuinely disadvantaged to obtain dental care.

The ADA would be willing to expand on any of the matters raised in this submission. Please contact Mr Robert Boyd-Boland, ADA Chief Executive Officer, should you have any queries regarding this submission.

Karin Alexander
President
18 July 2014