

Australian Dental Association Inc.

Competition Policy

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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 13,000 registered dentists as well as dentist students. ADA members work in both the public and private sectors.

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 and its Branches can be found at www.ada.org.au.

Introduction

The ADA welcomes the opportunity to provide this submission to the Competition Policy Review. As the peak body representing dentists, our membership comprises dentists many of whom work in and conduct small to medium sized businesses with the focus of delivering health care so as to ensure the oral health of the Australian public.

The ADA notes and is encouraged by the comments of the Minister for Small Business the Hon. Bruce Bilson who has said that for business this:

“review means having competition based on merit, not on muscle, creating a more level playing field and supporting a competitive environment where efficient businesses – big and small – have the opportunity to thrive and prosper.”¹

Further the ADA is encouraged by the Review panel's invitation to receive submissions on a wide range of issues including any law, regulation or practice, not just current competition laws and institutions. The ADA supports the intention of the Review to ensure that national competition policy continues to be “fit for purpose” for the current and emerging economy. 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, it is appropriate that government play a role in the sector. In addition, the private health insurance (PHI) industry has developed a role in the funding of the sector. The ADA's view is that the PHI industry has developed a position in the market where it is unfairly advantaged and this should be addressed by reforms to competition policy.

¹Media release by the Minister for Small Business - 27 March 2014, 'Government names competition review panel. at <http://bfb.ministers.treasury.gov.au/media-release/014-2014/> cited 23 May 2014

This submission has been structured as follows:

Part 1 of the submission outlines the provision of dental care in Australia including the various participants in the dental care market. Particular emphasis is given to the operational practices of the PHI industry which the ADA maintains are anti-competitive.

Part 2 of the submission addresses some particular concerns that the ADA has with National Competition Policy and Private Health Insurance and suggests an expanded role for government in the sector.

Part 3 of the submission addresses the specific questions prepared by the Competition Policy Review. Only those questions that pertain to the delivery of dental care are addressed.

1. The provision of dental care in Australia

It is pertinent at this point in the ADA submission to inform the review as to how dental services are provided within Australia. Where appropriate some commentary will be provided identifying areas of anti-competitive behaviour that exists and the ADA will be making certain recommendations as to how that should be addressed.

The main participants in the dental market are:

- Government;
- The private health insurers;
- Dentists; and
- Patients (consumers).

1.1 The Government

At the Federal level, the government primarily participates in dental care as follows:

1. Selected government schemes namely the Department of Veterans' Affairs scheme, a Cleft Lip and Palate Scheme [CLAPS], and the recently introduced *Child Dental Benefits Schedule* (CDBS) which provides funding for some dental care to a means tested group between the ages of 2 and 17;
2. The imposition of a Medicare levy surcharge (MLS) and the lifetime health cover (LHC) premium loading upon taxpayers who do not have PHI; and
3. The provision of Government PHI rebate ("the rebate") which reduces the annual PHI premium paid by Australians and their families².

² Since the introduction of the rebate on 1 January 1999, membership of PHI funds has increased from just over 30% to over half of the Australian population.

Provision of dental care by government is, in most cases, provided to those who suffer some form of disadvantage (primarily financial or geographic) and generally eligibility to receive such care is means tested. At the State and Territory level, governments provide dental services directly through public hospitals or indirectly through the utilisation of private dental practices. The Federal government supplements State and territory funding of these services through the National Partnership Agreements.

1.2 The Private Health Insurance Industry

The **private health insurance (PHI) industry** participates in dental care delivery by:

1. Insuring policy holders, at varying levels, against the costs of dental care (1.2.1);
2. Entering into agreements with dentists as to how and for how much dental treatment will be provided to policy holders (1.2.2);
3. Owning and operating dental clinics which provide dental care to policy holders (1.2.3).

1.2.1 Insuring policy holders – Core business and strategy

Private Health Insurers (PHIs) provide insurance coverage for: hospital, general treatment (or ancillary) and ambulance services. General Treatment PHI policies cover dental care. The former head of the organisation established to oversee the health insurers, the Private Health Insurance Administration Council (PHIAC), has in the past portrayed the traditionally non-profit character of ‘an unusual industry’ in a favourable light referring to it as “a commercial industry whose suppliers, almost exclusively, exist to provide mutual benefit to their respective members rather than to return dividends to external shareholder investors”. This perspective overlooks the changes that have occurred recently and the entrenched institutional vested interest that has developed in the health funds since their inception. This is expanded upon further below.

There are 34 PHIs registered under the *Private Health Insurance Act 2007*, the five largest funds account for 83% of the market, with for-profit insurers accounting for 70% of the market³. The trend in the PHI industry is for continued market consolidation. BUPA and Medibank Private, the largest providers of PHI in Australia, have a combined market share of 56.27%.⁴ The concentration of providers in the PHI market is likely to continue especially with the proposed sale of Medibank Private. It is acknowledged by the industry that the leading PHIs are some of the best known commercial brands in the country heavily advertising in all forms of media as well as sponsoring sporting and other public events and organisations.

Encouraged by the range of supportive policy measures provided by government at point 1.1.2 and 1.1.3 above, namely the PHI rebate, the MLS and the LHC, the number of Australians covered by PHI continues to increase. While the ADA is content for government to provide these measures, their effect is to unfairly assist PHIs to obtain market advantage over the other participants in this market, namely,

³ Australian Government Private Health Insurance Administration Council *Competition in The Australian Private Health Insurance Market* Research Paper 1 30 June 2013 at page 6 available at http://phiac.gov.au/wp-content/uploads/2013/12/PHIAC_Research_Paper_No1-new-format.pdf accessed 23 May 2014.

⁴ PHIAC Annual Report 2012-13 at page 31

patients and health care providers. Specifically the rebate, while now means tested, represents a significant contribution to the income of the PHI industry. As at 30 June 2013, there were **12.6 million** Australians covered by General Treatment PHI⁵. The government’s contribution to PHI through the rebate is projected for the period 2013-2014 to be in excess of **\$5.5 Billion**⁶.

Overall, profitability from general PHI policies is increasing. Income earned through General Treatment policies is considerable as demonstrated by the following table compiled by the ADA.

Year	Ancillary Income	Ancillary payout [General Treatment]	PHI surplus	Percentage
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%
2011/12	\$4,675,200,000.00	\$3,536,925,000.00	\$1,138,275,000.00	24.35%
2012/13	\$5,017,523,000.00	\$3,908,684,000.00	\$1,108,839,000.00	22.10%
Total	\$40,809,589,000.00	\$32,265,356,000.00	\$8,544,233,000.00	20.94%

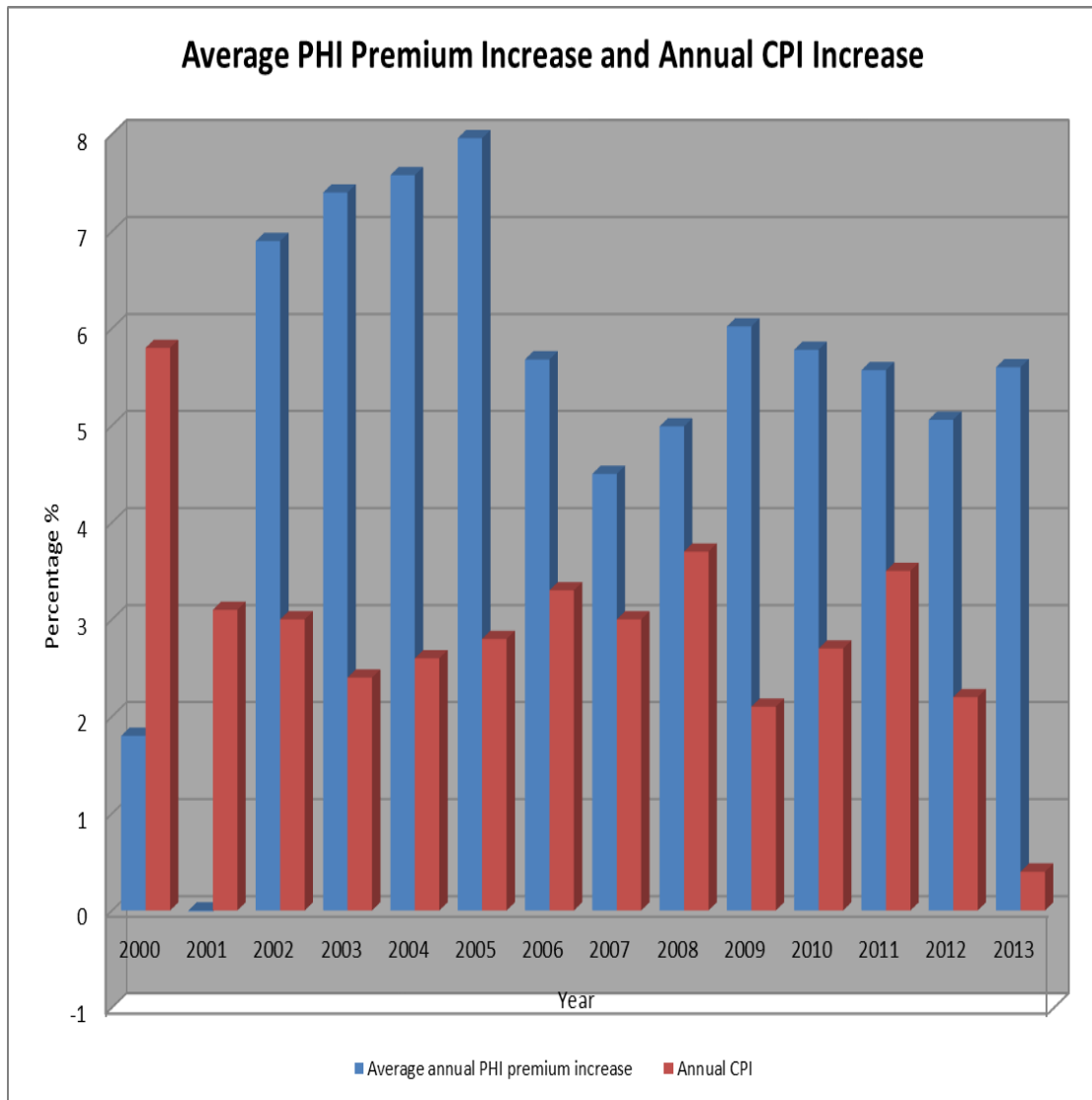
The total surplus for the PHI industry for the years ended 30 June 2001 to 30 June 2013 is in excess of **\$8.5 Billion** or **20.94%** of premiums paid. The last 5 years alone show a \$5,117,717,000 profit.

The PHI industry recognises the high profitability of General Treatment policies. This is particularly so where the premiums charged by PHIs continues to increase. The industry routinely offers new products like gym memberships, free gifts and other inducements like “special deals” on recreational **activities**

⁵ PHIAC Annual Report 2012-13 at page 6

⁶ Australian Government 2014-15 Health Portfolio Budget Statements Outcome 6 *Private Health* available at [http://www.health.gov.au/internet/budget/publishing.nsf/Content/2014-2015_Health_PBS_sup1/\\$File/2014-15_Health_PBS_2.06_Outcome_6.pdf](http://www.health.gov.au/internet/budget/publishing.nsf/Content/2014-2015_Health_PBS_sup1/$File/2014-15_Health_PBS_2.06_Outcome_6.pdf) at page 120 accessed 23 May 2014.

like bowling and theme parks to encourage the take up by new policy holders. However, PHI profit on General Treatment policies are not returned to policy holders in the form of either reduced premiums or increased rebates on care. Indeed research conducted by the ADA reveals that since 2002 overall PHI premiums have increased on average at a rate far in excess of CPI. The overall increase in premiums is demonstrated by the following table:



SoSSources: Previous media releases from Health Ministers, for example the Hon. Min Plibersek, Transcript - Press Conference Sydney - Private Health Insurance Premium Increases - 8 February 2013; and ABS CPI reports such as 6401.0 Consumer Price Index, Australia June 2013.

The surplus generated from these general treatment policies would appear to be utilised by the PHI industry in areas well beyond its core business of providing PHI. One example of this is the expansion by the PHI industry of its operational practices beyond the core business of providing insurance to other health related businesses. These are expanded upon in the next section of our submission which will

explain how these specific operational practices of the PHI industry are anti-competitive in nature. We have also included recommendations to address this anti-competitive conduct.

1.2.2 Arrangements between the PHI industry and dentists

Preferred Provider Agreements [PPA]

Pursuant to Preferred Provider Agreements (PPA) PHI funds create a relationship/contract with a particular dentist. The PHI recognises a dentist as a “preferred provider” and encourages the policy holder to see the “preferred provider”. The recognition as a “preferred provider” is self-generated by the PHI and requires no special skills on the part of the dentist. It merely requires the dentist to provide an undertaking that the dentist will limit charges to the PHI agreed fee to the policy holder. In other words they are “preferred” by the PHI. Although PHIs market their preferred providers as a category of dentist that is superior to other dentists in some way, the title carries no significance outside the PHI/dentist relationship.

PHIs also purport to “recognise” a dental provider in order for their patients to receive a rebate for dental services provided. PHIs claim a contract with a treating dentist merely because a rebate has been paid to the dentist by a fund. The supposed “recognition” criteria created by PHIs include:

- The need for the practitioner to be registered;
- The requirement for the dentist to be professionally qualified or a member of a professional body recognised by the PHI;
- Maintenance of comprehensive and accurate patient records made contemporaneously with provision of treatment which are legible and in English;
- The need for facilities to meet standards determined or recognised by the PHI;
- Compliance with other criteria PHI considers reasonable.

These are not selective criteria and the first three merely represent what the Dental Board of Australia (DBA) requires of a registered practitioner. By suggesting that having the titles “preferred” and “recognised” bestowed by the PHI, carries some special qualification is clearly misleading to the public.⁷

These practices have anti-competitive elements but their significant anti-competitive effect is to interfere with **patient’s freedom of choice** by diverting patients away from their customary treating dentist to particular dentists with whom the PHI has a PPA. This may result in lower out of pocket (OOP) expenses for some patients but it has a deleterious impact on the member of the PHI (who has paid the identical premium) who by choosing to have continuity of care with their dentist of choice receives a lesser rebate. The effect is that it **artificially inflates** the price of dental care for other patients. If policy holders choose not to access dental care from the PHIs’ preferred providers, they incur greater out of pocket expenses. It is a discriminatory and punitive measure.

⁷ PHIs also use other terms to refer to dentist which are confusing and misleading to patients for the reasons stated. These include: contracted providers, agreed providers, members choice providers, members plus providers.

The ADA notes that similar arrangements in other areas of commerce/insurance have been the subject of ACCC investigations - e.g. motor vehicle insurers and related smash repairers.⁸ Here the use, in insurance policies, of provisions that require the use of particular parts or products in the repair of the insured's motor vehicle, **restrict the insured's choice of repairer** or impose additional charges on an insured for choosing their own repairer, were all considered anti-competitive.

Choice of provider and continuity of care should be paramount considerations in delivery of health services. Choice should not be dictated to, nor be inappropriately influenced by the PHI. It should be solely up to the decision of the contributor. Therefore in all cases:

- The PHI contributor and not the PHI should be making the choice of provider; i.e. the consumer makes the choice without a punitive rebate differential. All providers should have the same level of rebate for their patients. There should be open competition for dental services;
- The cost of provision of service to the recipient should be no different whether they have PHI or not. This minimises predatory advertising and servicing by providers;
- Regardless of which PHI the recipient is insured with, the cost of service should be the same.

The rebate on offer from the PHI should be determined by open competition.

Deemed Approved Providers

In many cases, PHI funds seek to create a contractual arrangement between the PHI and dentist when none exist. This occurs where a patient claims on their fund for a service provided and the PHI, by meeting the claim, unilaterally creates a contractual relationship with the dentist provider. Such dealings do not have any element of a contractual relationship despite PHIs' assertions to the contrary.

What can then occur, is the PHI can sanction the dentist provider should the PHI consider the dentist's conduct to be outside some pre-determined PHI designed model of care. There are many examples of compliant dentists being **unilaterally** suspended or having "recognition" cancelled by PHI's funds. This means that the dentist's services, although legitimate and clinically sound, can be de-recognised by the PHI with the effect that a patient's claim for rebate will be denied if provided by that dentist.

Such PHI actions do not require any degree of reasonableness on their part and decisions to derecognise a dentist provider can be purely based upon PHI "opinion". De-recognition can follow the PHI determining (without any reference to best-practice) that a dentist's treatment is outside the **PHI's** declared normal range (of number and type of services provided for instance). There is a distinct lack of procedural fairness in this process of "de-recognition".

As recently as last week one major PHI wrote to 32 dentists (some of whom were part of a PPA and others not) de-recognising them pursuant to this process. This was based on the PHI's assessment that the provider's treatment patterns were 'inappropriate'. No review of this decision was offered nor is there a process in place to allow the dentist to appeal the decision.

⁸ *Motor Vehicle Repairs (Anti-steering) Bill 2006*



Once 'de recognition" takes effect, the PHI policy holder is notified. Experience indicates that this notice simply states that services received by the policy holder from a dentist will no longer be eligible for a rebate. In many cases, these notices also state that the PHI have deemed the dentist "unacceptable" and "de-recognised". The connotations such a communication creates in the mind of the patient and policy holder are most damaging to the dentist. The logical action by the patient will be to contact the PHI and in so doing the patient is inevitably referred to a PHI preferred provider and a new dentist.

The imposition of such arbitrary sanction without procedural fairness is anti-competitive and must be outlawed.

The ADA sees that what is happening here is that PHI is imposing its own rules and regulations on how a provider conducts their practice in order for their patient to attract a dental rebate for the services provided. Despite the health fund and dentist not being in a direct contractual relationship, PHI by subterfuge through creation of self-created 'business rules' creates an obligation on the part of the dentist to be compliant with PHI rules so as to ensure that the patient obtains benefits in accordance with the PHI requirements and policy. This is in the ADA's view underhand.

In the delivery of dental care, continuity of care is paramount as it enhances the prospects of long term oral health. The interference caused by such PHI conduct compromises the quality of care.

Recommendation 1:

Policy holders that pay identical premiums for cover should be treated equally and certainly not be penalised for choosing their own provider of health service.

Recommendation 2:

Arbitrary action by PHIs in de-recognising duly registered practitioners be declared illegal due to its anti-competitive impact.

Recommendation 3:

Elements of unconscionable conduct and misuse of market power by PHI to the extent that small practices have no capacity to negotiate such contracts or recognition must be prohibited. If dental providers wish to use HICAPS payment system, it should not be conditional upon the dentist's agreement to PHI Fund rules and regulations.

Recommendation 4

That all general practitioner dentists receive the same rebate for the same services.

1.2.3 Private Health Insurance Owned Dental Clinics

A recent development of 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 or contracted to PHIs. These clinics in effect restrict the **freedom of patients to choose** their own dentist.

While the PHI industry may maintain that these clinics reduce the out of pocket expenses and are therefore favourable to their contributors, they **increase the dental costs for other policy holders**. These policy holders, while paying identical premiums to other policy holders, either exercise their **choice not to attend the PHI clinic or are unable, for whatever reason, to attend a PHI dental clinic**. This practice **artificially inflates** the cost of dental care offered by the independent dentist. The competitive process within which dental care is provided is therefore jeopardised.

The position of the independent dentist is not dissimilar to the position of the independent petrol retailer unfairly disadvantaged by the tactics of the major supermarket chains. In a speech delivered at a conference in Sydney on 21 February 2014, Chairman Rod Sims stated:

*“Large shopper docket discounts may provide short term benefits to a small number of consumers, however, in our view **they increase petrol prices for other consumers** and can cause **harm** to the fuel retailing sector”⁹*

The further issue is the conflict of providing insurance for a service that the PHI is providing. Not only does the PHI charge for the insurance cover but it is also charging for the service it provides to the insured contributor and the rebate that is payable. The conflicts that exist in fulfilling each of these roles are evident. The PHI determines the premium for cover, what will be eligible for cover, the nature of the treatment to be provided and the rebate that will be payable. The health of the patient should be the dominant role of the health service provider in health service delivery. If a health provider (in this case the PHI) has conflicts with this role then it must not be in a position to simultaneously be the health service provider. The presence of PHIs as insurer, funder and provider of dental care to the patient changes the nature of the market place and introduces a competitor to independent dentists. This is a competitor with a considerable market advantage which is unfair and should be declared contrary to public policy which is designed to ensure the delivery of optimum health care.

⁹ Chairman Rod Sims. Transcript of speech given at *CEDA conference: Looking Forward to 2014* 21 February 2014 available at <http://www.accc.gov.au/speech/ceda-conference-looking-forward-to-2014> accessed 2 June 2014.

What further emphasises this unique market position is that the PHI through its processing of claims made by contributors has inside information as to the actual charges made by dentists and can utilise that information in its own pricing policies.

Recommendation 5:

PHIs be prohibited from owning dental practices, employing dentists and providing dental services for which they offer insurance.

1.2.4 Business Rules

Aided by government regulation, the PHI industry continues to expand its role beyond that of a funder of dental care to provider of dental care and in many instances the decision maker as far as treatment is concerned. This includes the dictation of the nature of care that will be delivered to policy holders. This is achieved **by business practices such as** the imposition of ‘utilisation levels’ , ‘annual limits’, determination of rebate levels that make cheaper but less effective treatment options more attractive to contributors and de-recognition procedures of dentists. All of these practices by PHIs are contained within their business rules and in the fine print of particular policies. Policy holders are more often than not unaware of these limitations or subtleties of rebate levels on treatment until it is too late. PHI funds should be compelled to fully disclose all terms of their policies prior to a consumer taking out a contract of insurance. Further the policy holders should be re-informed upon each renewal of contract of insurance.

Recommendation 6:

Ensure that PHIs have product disclosure statements [PDS] that detail the insurance product being purchased and include the following-

- ***The cost of cover, qualifying periods and annual monetary limits [AML] for each level of insurance cover on offer. PHI have provided inadequate information for consumers to allow them to make informed choice***
- ***Identify rebates for each item of dental service – Online access to such information should be available as Medicare provides identifying benefits. PHI does not offer such information to their contributors. PHIs have provided inadequate information for consumers to enable the making of an informed choice or alternatively attribute the reason for non-payment of a benefit to third parties e.g. ADA. The ADA has no input as to which procedures attract a PHI rebate benefit. PHIs misleadingly suggest otherwise. The PHI decide which procedures attract a rebate therefore PHIs should provide advice as to the items which attract no rebate. PHI contributors are often not informed until after an attempted claim. PHI have provided inadequate information for consumers to make an informed choice***

- *Provide clear categorisation of services - some PHIs have “general” dental, “major” dental and “complex” dental cover and have separate AMLs for each but do not provide this information usually until a claim is made or limit is reached. There is no such categorisation in medical services. PHI have provided inadequate information for consumers to make an informed choice*
- *Provide clear categorisation of service when PHIs offer low, mid, high and public medical tables. Consumers assume because they have public cover it covers public dental which is incorrect. It does not. Similarly for high or top cover, consumers assume they have top cover for everything including dental which they do not. Usually this is not disclosed until an attempted claim is made. PHI have provided inadequate information for consumers to make an informed choice*
- *Advice as to applicable Lifetime limits for some services. These are not advertised and often the consumer is not aware until a claim is rejected. PHI have provided inadequate information for consumers to make an informed choice*
- *PHI should inform consumers before taking out a policy that not all providers of dental services are treated equally and have differential rebates depending upon which dentist provides the care - a practice that itself is anti-competitive. This limits choice.*
- *PHI should inform members that in some preferred provider schemes the contracted fee is actually higher than for the fee charged by some non-contracted providers. This has artificially inflated the cost of dentists through their business practices.*
- *Provide information to consumers that unlike medical specialists under Medicare services provided by registered dental specialists do not attract a higher rebate.*

Recommendation 7

That registered specialist dentists attract a higher rebate than GP dentists.

1.2.5 Interference with the dentist/patient relationship

It is Government policy that consumers have improved choice in health services¹⁰. The underlying principle of PHI is to offer alternative funding of health care to the public. The choice of provider is a

¹⁰Australian Government 2014-1015 Health Portfolio Budget Statements Department Outcomes Private Health :http://www.health.gov.au/internet/budget/publishing.nsf/Content/2014-2015_Health_PBS_sup1/%24File/2014-15_Health_PBS_2.06_Outcome_6.pdf accessed 23 May 2014

fundamental principle of PHI. In an open and competitive market there ought to be no impediment to policy holders choosing their provider of choice. Whether the choice is framed by cost, quality, safety or convenience, that choice remains the prerogative of the policy holder.

PHIs deliberately pitch advertising and various levels of cover to make it difficult for policy holders to compare the levels of cover on offer. It is not possible to make direct comparison of levels of cover on offer by the 34 PHI funds in Australia. The larger PHI funds engage in massive advertising campaigns using minor aspects of their business such as gym memberships or "join now claim now" campaigns to make them attractive but give sparse details about the fine print of eligible services or full cost of premiums. Rather the cheap option is used as "bait advertising" with the aim of having the consumer make direct contact in order to "up sell" the level of cover.

In an ideal market for dental care, choice of provider would be a simple and effective. It would enhance competition. Indeed dental practitioner numbers in Australia exceed demand for services; so in such a market cost of provision of services will be at competitive rates. These factors coupled with the importance of patients having continuity of care from their dentists suggest such an ideal market would include principles such as:

- Cost of the service should be based upon informed financial consent between the recipient of the service and the provider of the service;
- The policy holder and not the PHI should be making the choice of provider. i.e. the consumer should be free to make the choice without interference;
- The cost of provision of service to the patient should be no different whether they have PHI or not;
- Regardless of which PHI the recipient is insured, the cost of service should be the same. The rebate on offer from the PHI should be determined by open competition;
- There should be no restrictions on the number of providers in a given location available to the consumer for which they are able to claim a rebate under their PHI policy.

The lack of information in policies and the roles played by the PHI industry impact on this competitive market to the detriment of the patient. The ADA has developed policies which address the nature of the dentist/patient relationship: Policy Statement 5.1 *Dentistry and Third Parties* and Policy Statement 5.5 *Funding Agencies*. These policy statements set out the terms of the relationship between dentists, patients and PHIs and they should form the basis of the relationship. Copies of these policies are annexed to this submission.

Specifically the following practices by the PHI industry interfere with patient choice.

- a. **Specifically referring patients** to preferred providers as opposed to non-contracted dentists. Advertising and PHI counter staff are active in this process of steering patients away from their existing dentist to dentists linked to a PHI fund.

Governments have expressed concern about this occurring in other sectors and the anti-competitive nature of these practices. In NSW a bill was introduced into Parliament which

sought to address concerns regarding the anti-competitive conduct in the motor vehicle insurance industry. Currently an inquiry is underway which will consider the anti-competitive relationship between motor vehicle insurers and their preferred provider for smash repairs. The NSW Parliament has recognised the impact of these practices upon competition, consumer choice and quality of service.¹¹ It has recognised the potential for conflict where an insurer owns a smash repair business.

- b. **Unilaterally removing recognition of dentists** and deeming them as unacceptable – which means that PHIs will pay zero rebates to patients who receive dental care from these providers.
- c. **Representing contracts** between dentists and PHIs even though no such contract exists.
- d. **Enticing dentists in rural and remote areas** to become preferred providers thereby eroding the goodwill and patient list of non-preferred providers' practices and placing at risk the viability and **accessibility** of these dental care services.
- e. **Restricting the number of preferred providers in certain localities** and in so doing closing the market for such providers thereby **limiting accessibility** of dental care services to contributors.
- f. **Constraining treatment delivery** to patients by the imposition of self-created artificial limitations on policy conditions. Mechanisms such as the creation of "reasonable utilisation levels" place financial limitations on payment of rebates which constrain how often 'best practice' treatment is delivered to patients and adversely affects patients' oral and general health. In addition, the imposition of annual or lifetime limits on coverage also affects treatment delivery.

1.2.6 Advertising

As stated above, PHI funds are some of the best known commercial brands in the country. The industry heavily advertises in all forms of media as well as sponsoring sporting and other public events and organisations. The industry uses contributors' funds to invest in advertising and other promotional strategies in order to increase market presence and profitability. Such expenditure, indirectly contributed to by virtue of the government's support, has not done anything to improve safety and quality of care for contributors.

In these situations where the PHI is the owner and operator of the dental clinic, it becomes a health provider and as such should be subject to the same limitations and requirements that are imposed upon all health providers under the National Law.¹² Currently there is no such limitation imposed upon PHIs

¹¹ New South Wales Legislative Assembly-Thursdays 19 September 2013 **Smash repair industry** available at http://www.parliament.nsw.gov.au/Prod/Parliament/hanstrans.nsf/V3ByKey/LA20130919?open&refNavID=HA4_1 accessed 6 June 2014.

¹² Health Practitioner Regulation-National Law Act 2009-as enacted across Australia for health professions.

and this places them at a significant advantage to health practitioners. For example the DBA imposes significant restraint upon dentists' advertising.¹³

1.3 The Dental Practitioner

There are more than 15,000 **dentists** registered in Australia¹⁴ operating across approximately 6,000 dental practices. Based on data held by the ADA, the majority of dentists are sole practitioners operating their own businesses or are practitioners employing other dentists in small unincorporated practices.

1.4 The patient

The patient, the final participant in the market, is at the centre of all dental care. Despite an increasing number of Australians having access to PHI and premiums paid to the PHI industry continuing to rise, **individual patients remain the highest contributors to the cost of their own dental care.** Health expenditure figures reveal that in the period 2011 to 2012, total spending on dental services was in excess of \$8.3 billion. Of this amount, PHI funds contributed \$1.2 billion and individuals contributed \$4.7 billion¹⁵. In Australia, where governments encourage PHI and in effect "gift" customer bases to the PHI industry, means that the potential for advantage to be taken of patients by profit driven PHI funds should be strongly guarded against.

2. General Areas of Concern with NCP and PHI

The ADA does not mean to imply that competition is a threat to dentists. Competition is not something from which dentists recoil. Dentists have always competed against other providers to service the dental needs of their patients. However, the position of the PHI industry in the dental care market:

1. Gives it an unfair advantage over dentists;
2. Enables it to operate as a barrier to new dentists entering the market;
3. Allows it to artificially inflate the prices of competing independent dentists for the reasons outlined in the paragraphs commencing 1.2.1.

While the establishment of PHI owned dental clinics, preferred provider agreements and associated arrangements where contributors are enticed to preferred providers might provide some short term cost benefits to some dental patients, the dental prices for other dental patients (contributors to the same PHI) become artificially inflated. It makes no difference that both type of contributor might pay an identical premium for their insurance. This activity makes it impossible for an average dentist, operating as efficiently as possible, to compete with the PHI industry.

¹³Guidelines for advertising of regulated health services-Dental Board of Australia-<http://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx> accessed 23 May 2014

¹⁴ Dental Board. *Registration Date Table* December 2013.pdf at <http://www.dentalboard.gov.au/About-the-Board/Statistics.aspx> accessed 23 May 2014.

¹⁵ AIHW 2013. Health expenditure Australia 2011-12. Health and welfare expenditure series 50. Cat.no.HWE 59. Canberra:AIHW. *Appendix A: National health expenditure matrixes* at <http://www.aihw.gov.au/publication-detail/?id=60129544658> accessed 23 May 2014.

It is crucial to recognise here that the ability of PHIs to influence the practice and delivery of health care is created in part by the role that governments play in encouraging and subsidising the cost of insurance cover. Were it not for the rebate levels offered and incentives to obtain PHI provided by the MLS and LHC, PHIs would not have their current market position nor the ability to use these subsidies in underwriting health care delivery.

The ADA can accept that government may adopt policies to encourage the public to take out PHI. However, in return PHIs should have imposed upon them an obligation that the insurance packages they offer deliver optimum insurance cover to policy holders equally and without discrimination. This is an important role for government.

In these circumstances the relationship between government, PHI and policy holder should be a social pact which require PHIs to ensure that the best level of insurance cover is provided to the policy holder. The focus needs to shift in this social pact from ensuring profitability to the PHI to ensuring better care is delivered to policy holders by the health care provider of choice. Profits alone does not necessarily result in quality and equitable healthcare outcomes.

3. Competition Policy Review Issues

With all these issues in mind, the following additional recommendations are made specifically in response to the Competition Policy Review questions.

What should be the priorities for a competition policy reform agenda to ensure that efficient businesses, large and small, can compete effectively and drive growth in productivity and living and health standards?

Competition policy should be used as a constructive force to ensure:

- A level playing field amongst participants in all markets;
- Where possible, monopolies in any particular market are avoided;
- That market concentration, where a small number of large corporates dominate control of particular markets to the disadvantage of consumers, does not occur;
- The impact or effect of any strategy adopted by industry participants be considered beyond any immediate short benefit which may accrue to consumers;
- A holistic approach to the regulation of competition is considered in any particular market place.

To have a situation where the for-profit sector of PHI accounts for 74.76% of the PHI based upon number of policies and the top five of a total of 34 PHI occupy 82.30% of the market share conflicts with optimal competition. With Medibank Private to be sold, there needs to be an awareness created of the impact this will have on competition.

Specifically, as far as the PHI industry is concerned, competition policy should be used to prevent the PHI industry from misusing/abusing its market power to artificially inflate the price of independent dentists by:

- a) Continuing to decrease effective rebate benefits to dental patients when compared to premium increases;
- b) Using market sensitive data about dental industry charging practices obtained through analysis of insurance claims' information to then enable PHI owned clinics to compete with dentists;
- c) Actively influencing dental patients' choice of dentists by paying smaller (or nil) rebates to dental patients whose dentists are not preferred providers; i.e. there should be no punitive and discriminatory rebate differential.
- d) Ensuring that where identical dental services are provided, the rebate paid by a PHI fund to holders of identical policies is the same for all dental patients regardless of the dentist attended;
- e) Refusing to recognise some dentists as acceptable providers so that dental patients receive nil rebates;
- f) Imposing annual limits on policy holders without up-front disclosure; and
- g) Omitting to provide policy holders with itemised details of current rebate levels for all general treatments.

The ADA feels that the statements made by the head of PHIAC in 2011, as quoted earlier, highlight how quickly this market has changed to "for profit" with returns to investors as focus. **The core business of providing reasonable rebates for all contributors regardless of the provider of service has been overlooked** with more commercial interests at heart. The competitive process referred to by the head of PHIAC of ensuring adequate and increasing rebates has been cast aside and the competition review must ensure PHIs return to core principles of providing higher rebates encouraging contributors to access care through their provider of choice. This core principle of choice of provider is the key difference between private and public insurance. PHI have been allowed to manipulate and flaunt this fundamental principle of choice of provider under the guise of added benefits when in fact all it has done has significantly increased profits in general treatment cover. When one PHI fund of note can have no increased dental rebates across the board since 1994 while at the same time continue to post increasing annual profits, illustrates that there is a glaring failure in the competitive process. The concept of 'preferred provider' has been nothing more than a clever marketing tool that has increased PHI profitability.

Are there unwarranted regulatory impediments to competition in any sector in Australia that should be removed or altered?

The PHI industry is regulated under the *Private Health Insurance Act 2007* ("the Act"). The Act provides that the Minister for Health must approve premium increases upon the application of a PHI fund. The premium applications are considered by the Minister after examination by the Private Health Insurance

Administration Council. The Minister is obliged to approve the proposed premium increase unless the Minister is satisfied that a change would be contrary to the public interest.

As demonstrated previously in this submission, the rise in premiums imposed by PHI has risen dramatically without any proper account given to policy holders. The current process by which premium increases are approved is neither transparent nor open to comment or submission by other interested parties such as the ADA.

The Act should be examined to ensure that the process is open to the public and that reasons for decisions by the Minister are published.

There must be an obligation imposed by government to create parity between premium increase and rebate level increases. Without this, PHIs are achieving an unfair market advantage by the increased subsidisation increased premiums provide.

As mentioned previously, dentists as registered health practitioners must comply with guidelines issued by the DBA in relation to advertising a health service. These guidelines limit the marketing strategies that a dentist can utilise to promote their services. Such restraints are not imposed on entities such as PHIs and this provides them with a market advantage over dentists when both are competing in the same market. These guidelines or other legislation should be examined to ensure that all participants in the dental care market are held to the same standards as far as advertising and marketing is concerned.

Are government provided goods and services delivered in a manner conducive to competition, while meeting other policy objectives?

Not applicable at the federal level. At the State and Territory level services provided are primarily to persons of disadvantage. The ADA has no issue with this in the context of competition law.

Would there be a public benefit in encouraging greater competition and choice in sectors with substantial government participation (including education, health and disability care and support)?

As stated at the commencement of this submission, the ADA supports the participation of the government in dental care. The policy measures introduced by the government to encourage the take up of PHI are matters for government to consider and can be seen as justified in the public interest. However, they provide the PHI industry with an advantage in the market which must be taken into account in the formulation of competition policy and its application to the provision of dental care. The advantages provided by government to PHIs in encouraging take up of PHI must be reciprocated equitably by the PHI and not used to increase their profitability.

Earlier, the ADA has proposed competition policy priorities in the provision of dental care. The ultimate beneficiaries of the ADA's proposal will be dental patients who will benefit when all providers of dental care operate on a level playing field. In these circumstances there is a public benefit in encouraging greater competition in dental care.

Are the current competition laws working effectively to promote competitive markets, given increasing globalisation, changing market and social structures, and technological change?

It is the ADA's submission that current competition laws are too narrow in their focus and are unable to ensure a competitive process where small business dentists can compete on a level playing field with dental care provided by the PHI industry. The narrow focus of competition policy on cost to patients to the exclusion of other factors relevant to optimal dental care such as quality, safety and continuity of care prevents a holistic view of the dental market. It is not appropriate to view dental care as a commodity thereby focusing on cost reduction rather than quality and continuity of care.

Are competition-related institutions functioning effectively and promoting efficient outcomes for consumers and the maximum scope for industry participation?

It is the experience of the ADA that presently the Australian Competition and Consumer Commission (ACCC) is unable to effectively carry out its role by promoting efficient outcomes for consumers and ensuring maximum scope for industry participation. Since 1999, the ACCC has submitted a formal report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance. These reports are available on the ACCC website as are the submissions of the ADA to the ACCC.

The ACCC has not adequately dealt with the issues raised by the ADA tending to focus on cost issues at the expense of a more holistic approach. The practices of the PHI industry require significant reform however the ACCC have been reluctant to act. The ACCC does not have sufficient expertise in the operation of PHI and the unfair advantage which it has in the dental services market.

If the activities of PHI were fair, equitable and competitive, PHI should have achieved:

1. A reduction in cost of PHI;
2. Improved choice for Australian consumers;
3. Unlimited access to dental care services by Australian consumers;
4. Overall reductions in the cost of delivery of dental services through their business practices;
5. Provision of uninhibited freedom of choice and comprehensive financial information for consumers to make an informed choice of PHI.

None of this has occurred and the reason for this is the PHIs pursuit of the profit motive at the expense of the safety and quality of care delivered to their members.

Conclusion

The ADA would be happy to provide clarification on any of the points made in this submission or further comments if required. Please do not hesitate to contact Mr Robert Boyd-Boland at ceo@ada.org.au



should you have any questions. The ADA awaits with interest the Competition Policy Review and looks forward to its findings.

A handwritten signature in black ink that reads 'K. Alexander'.

Dr Karin Alexander
President
Australian Dental Association
13 June 2014

DENTISTRY AND THIRD PARTIES¹⁶

1 Introduction

- 1.1 Third parties have been associated with dentistry for many years, mostly servicing commercial needs and opportunities related to dentistry.

Definition

- 1.2 A THIRD PARTY is an outside body that can influence the relationship between the dentist and the patient. These include:
- funding agencies (e.g. government departments, agencies and statutory authorities, or private health organisations) which have responsibility for the entire fee for service, or part thereof;
 - owners of dental clinics who are not dentists, including health insurance funds, corporations and the public sector (government departments);
 - regulatory authorities;
 - the dental industry; and
 - professional indemnity providers.

2 Principles

- 2.1 The primary relationship in the delivery of dental care is between the dentist and the patient.
- 2.2 Ideally, the dentist and the patient (or the parent, guardian, or other legally responsible person) mutually develop strategies to ensure long time optimum health outcomes.
- 2.3 Dentists and patients each have obligations to each other as defined by law and ethical considerations.
- 2.4 The placing of restrictions on professional privileges of dentists by third parties for their own financial gain is unacceptable.

3 Policy

¹⁶ This Policy Statement is linked to other Policy Statements: 5.2 *The Australian Schedule of Dental Services and Glossary*, 5.3 *Corporate Ownership*, 5.4 *Complaints Resolution*, 5.5 *Funding Agencies*, 5.6 *Dental Industry*, 5.7 *Professional Indemnity* & 5.21 *Regulatory Authorities*



- 3.1 Third parties must not influence the primary relationship between the dentist and the patient in any way that diminishes a patient's right to achieve long term optimum oral health.
- 3.2 Third Parties should not limit or influence the patient's choice of dental provider.
- 3.3 In dealing with third parties, there is a need for a uniform coding system of dental services which must be *The Australian Schedule of Dental Services and Glossary*.
- 3.4 Complaints resolution mechanisms must be transparent, fair and reasonable.

Policy Statement 5.1

Adopted by ADA Federal Council, November 15/16, 2001.

New version adopted by ADA Federal Council, November 13/14, 2003.

FUNDING AGENCIES¹⁷

1 Introduction

- 1.1 In its simplest form, the transaction between a dentist and patient should involve the provision of dental services by a dentist and the direct payment to the practice of the fee. Often, however, the relationship between dentist and patient is influenced and complicated by the presence of a funding agency.
- 1.2 Contractual agreements exist between:
- dentists and their patients;
 - some patients and funding agencies; and
 - some dentists and funding agencies.

Definitions

- 1.3 BOARD is the Dental Board of Australia.
- 1.4 CAPITATION SCHEME is a process by which a dentist undertakes to provide services for a fixed period for an agreed fee.
- 1.5 FUNDING AGENCIES are third parties which make contributions to the payment of the fees charged by dentists, and include:
- Statutory authorities, e.g., Department of Veterans' Affairs, State health departments, transport accident authorities, workers' compensation authorities;
 - Private health organisations through –
 - a. Rebate entitlements (most funds); and
 - b. Contracted dentist schemes (also known as preferred provider schemes) which have been promoted by some health funds – these involve a dentist agreeing to work for a fixed fee for service for a contracted period, or capitation schemes.
- 1.6 DERECOGNITION is the unilateral withdrawal by a funding agency of the right for patients of a particular dentist to receive rebates for treatment by that dentist.
- 1.7 CO-PAYMENT is payment made by patients in addition to the contribution of the funding agency.
- 1.8 SCHEDULE/GLOSSARY is *The Australian Schedule of Dental Services and Glossary*.

2 Principles

¹⁷ This Policy Statement is linked to other Policy Statements: 2.5.1 *Delivery of Oral Health Care: Funding: Government*, 5.1 *Dentistry and Third Parties*, 5.2 *The Australian Schedule of Dental Services and Glossary* & 5.16 *Informed Financial Consent*

- 2.1 The guiding principle which applies is that the clinical component and financial consideration of that service should be managed as if the funding agency were non-existent (i.e., the primary relationship is between the dentist and the patient).
- 2.2 Health Insurers have an obligation to assist the funding of necessary health care of the insured.
- 2.3 Health Insurers and Health Care Providers are subject to patient privacy laws.
- 2.4 The tort of interference in contract prevents health funds and staff of health funds from recommending preferred providers.
- 2.5 The dentist has the right to refuse to proceed with treatment if limitations which a patient or funding agency wish to impose are incompatible with sound dental practice. The patient has the concurrent right to refuse consent to treatment or some portion of it.
- 2.6 Dentists have an obligation to provide dental services in an ethical and clinically sound manner.
- 2.7 Dentists who enter into contracts with funding agencies must ensure that a patient's dental/oral welfare remains the primary concern and, to that end, must exercise best clinical judgement at all times.
- 2.8 Under no circumstances does the Australian Dental Association (ADA) condone fraudulent practice.
- 2.9 Funding arrangements can include patients making co-payments.

3 Policy

- 3.1 Health Insurers should abide by the ADA's Funding Agencies (including Health Insurers) Code of Conduct (Appendix).
- 3.2 In fixed rebate systems, treatment by specialists in their area of specialisation should attract a rebate higher than the rebate paid for a similar service rendered by a general practitioner. Where rebates on certain categories of treatment or procedural groups are subject to maximum allowances, if the treatment is provided by a specialist, these limits should be higher than if provided by a general practitioner. A differential rebate system must not be established by lowering rebates available on general practitioner services.
- 3.3 Funding of schemes should include provision for patients to make a payment towards their treatment (e.g. a co-payment).
- 3.4 A decision not to provide treatment or to receive treatment should be in accordance with relevant ethical and legal constraints.
- 3.5 Any information regarding treatment is confidential and should not be supplied to a funding agency without the consent of the patient.
- 3.6 Dentists must take all reasonable steps to see that systems and stationery used for accounts and receipts are secure against theft and forgery.
- 3.7 Accounts for treatment should be rendered as described in the edition of Schedule/Glossary current at the time the treatment is provided.
- 3.8 Any dentist or other party requiring clarification or interpretation of the Schedule/Glossary should contact the Federal office of the ADA. In the event of a dispute regarding interpretation or clarification between a dentist and a funding agency, the ADA shall be the sole arbiter.



- 3.9 Dentists should seek advice from their indemnity providers as to whether their indemnity cover will be compromised by entering into contracts with funding agencies before signing such contracts.
- 3.10 If a funding agency suspects a dentist has engaged in inappropriate itemisation of accounts, the agency should:
- Seek an expert opinion from a dentist where there is alleged inappropriate use of Schedule item numbers noting that there is a large variation in practice profiles and treatment philosophies within an ethical framework.
 - Develop pathways that seek to address interpretation or billing concerns in a supportive environment.
- 3.11 In the event of an approach by a health fund, ADA members should seek advice from their Branches before participating in any discussions with funding agencies, and should also inform their indemnity providers of any actions against them by funding agencies.
- 3.12 In the event of a formal hearing before a Criminal Court or a Board, an ADA Branch should advise the member regarding appropriate representation.
- 3.13 Derecognition of a dentist by a funding agency shall only occur with the consent of the dentist or following a conviction in a Court or a finding of unsatisfactory professional conduct by a Board.
- 3.14 Derecognition of a dentist based solely on Schedule item usage per patient (described by funds as “reasonable utilisation levels”) is unacceptable.
- 3.15 When advising their members of the Derecognition of a dentist, funding agencies must not imply that such action is due to inappropriate practice by the dentist.

Policy Statement 5.5

Adopted by ADA Federal Council via electronic ballot, February 13, 2004.

Adoption ratified by ADA Federal Council, April 22/23, 2004.

APPENDIX TO POLICY STATEMENT 5.5**AUSTRALIAN DENTAL ASSOCIATION INC. FUNDING AGENCIES
(INCLUDING HEALTH INSURERS) CODE OF CONDUCT**

In the interest of ensuring that patients have continued access to optimal professional dental care from a dentist of their choice, third party funding agencies including health insurers must:

- Not impose barriers that prevent the dentist and the patient developing strategies which ensure optimal health outcomes
- Respect that the primary contract is between the dentist and the patient and not attempt to influence clinical decisions
- Ensure that the confidentiality of the dentist/patient relationship is respected
- Ensure patient personal information is not used unfairly against the insured
- Ensure that schemes are open to all dentists (of equal qualifications) on common dollar rebate scales (i.e., not offer preferential benefits to patients of selected dentists)
- Ensure clear, timely and accurate information is available on scope and restrictions of benefits, level of benefit and eligibility
- Not introduce adverse changes to terms and conditions during the plan coverage year
- Create an environment in which long-term oral health is paramount
- Use the Schedule/Glossary as the authoritative reference for the description of services
- Recognise that dentists are entitled to set and vary fees for the treatments they provide
- Not impose an unfunded administrative burden on a practice
- Ensure that comments are not made by the staff of a funding agency to its members about dentists, their fees, or their treatment
- Conduct significant and regular review of rebates (based on practice costs and general economic indicators)
- Set premiums fairly and proportionate to actuarial value
- Process claims in a timely and accurate manner, providing clear explanations for alterations in payment levels
- Eliminate lifetime limits on courses of care
- Make use of expert advice from dentists in developing and administering schemes
- Maintain regular liaison with peak professional bodies
- Ensure provider profiling is adjusted to match practice profile and account for variations in severity of conditions treated, patient compliance and other mitigating factors
- Ensure providers are given meaningful opportunity to review and challenge insurer profiling and are afforded process to remedy incorrect profiles.