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Competition Policy Review Secretariat
The Treasury
Langton Crescent
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Dear Panel Members

Australian Dental Association
Reply to The Draft Report dated 22 September 2014

The Australian Dental Association (the ADA) welcomes the opportunity to reply to the Competition Policy Review Draft Report dated 22 September 2014 ("the draft report"). A detailed submission dated 13 June 2014 has already been provided to the Panel.

Overall, the ADA is dissatisfied with the Panel's consideration of the issues raised by it in oral health care, particularly having regard to the references by the ADA to the operational practices of the private health insurance (PHI) industry. The Panel's review has unfortunately focused on short term price "gains" to consumers as opposed to considering the oral health care market holistically. The comparison of the delivery of oral health care to the motor vehicle smash repair industry is unfortunate and, we would respectfully suggest, indicates an alarming lack of understanding of the delivery of health services to Australians. The issue of conflict of interest of an insurer owning the business providing the service for which it insures is one that should be addressed throughout all areas of insurance coverage. Health is not a commodity. Quality and safety are paramount.

A cautious and considered approach to the interests of consumers in health care is required.

Among the principles which guide the Panel's draft report is that *markets must work in the long term interests of consumers*.[1] The ADA agrees with this principle. The ADA also agrees that human services,

[1]Competition Policy Review "The Draft Report" dated 22 September 2014 at p 4 available at http://competitionpolicyreview.gov.au/draft-report/ accessed 24 October 2014.

including oral health care, are a large and growing part of the Australian economy. Expenditure on oral health care is set to increase.

However human services, including oral health care, are unlike other sectors of the economy. All Australians have the right to enjoy the highest standard of physical and mental health, including oral health. It is vital that governments ensure that access to affordable and appropriate oral health care is within the reach of all Australians. While it is acknowledged that financial pressures exist, any policies which are developed and implemented in the health sector, including any competition policy, should always be in the best interest of patients and not compromise the clinical independence of the treating dentist or interfere with the fundamental and important dentist patient relationship. The ADA believes that cost per unit of treatment price is not reflective of quality or overall cost and thus policy which focuses only on the lowest fee/price of each unit of treatment care as the primary benefit to consumers will be detrimental to the health of all Australians. Policy makers, including the Panel, should exercise caution and undertake considered analysis when evaluating any reform in the sector that potentially impacts adversely upon their health outcomes. Given that almost all of oral disease (dental decay, gum disease and oral cancer) can be prevented, a more holistic approach is required.

The Panel's approach to a competitive oral health care market

There are two recommendations in the draft report concerning the oral health care market and the participation of the PHI industry. These recommendations are:

1. consumers have access to PHI products which meet their needs; and
2. consideration be given to a lessening of regulation of the PHI industry.[2]

The ADA agrees with the first recommendation. However in the current environment, PHI policies are not meeting consumers' needs. The ADA's reasoning for this statement is outlined below.

In respect of the second recommendation, the draft report adopts the National Commission of Audit recommendation and suggests that "*there may be scope for a lighter touch*" in respect of regulation of the PHI industry.[3] The ADA rejects this recommendation. The ADA has referred to the inadequacy of current regulation of the PHI industry, particularly the approval process for premium increases and the lack of obligations on health funds to account to policy holders for rebate levels. The growing disparity between health fund premiums and rebates to consumers in oral health care is appalling. To consider watering down regulation of the PHI industry without proper inquiry is not in the long term interests of consumers.

[2] The draft report has also undertaken a cursory review of the submission of the ADA in relation to the effect of preferred provider agreements. The ADA does not accept either the nature of the analysis or the conclusions made.
[3] The Draft report at p 113 (see FN 2).

It will, on past experience, only enable the PHI industry to further advance their interests at the expense of their policy holders. The massive profits of the PHI industry in ancillary [general] treatments are set out in our earlier submission – averaging in excess of $1 billion per annum nationally in the financial years ended 2011 to 2013. In the same period there has been no substantial increase in rebates for dental services or increase in annual limits for dental treatment.

The ADA submits that in undertaking this review, it was incumbent upon the Panel to both consider the nature of PHI polices and consumer needs and the effect of a lessening of regulation on the oral health care market especially upon consumers. This is particularly so given the recommendations which the Panel suggests should guide competition policy in relation to human services, namely:

- *provider choice be placed at the heart of service delivery;*[4]
- *funding, regulation and service delivery be separate;*
- *a diversity of providers be encouraged, while not crowding out community and voluntary services; and*
- *innovation in service provision be stimulated, while ensuring access to high-quality human services.*[5]

All too often PHI staff make recommendations to members to seek treatment from their preferred/ contracted providers. The ADA feels such conduct is contrary to the Committee's comment that:

"Where a purchase advisor is used, the incentives of the advisor must be aligned with those of the consumer. The purchase advisor should not have financial or other incentives to over service the consumer or to refer the consumer to one particular service provider."

Such conduct should be rendered illegal as the motives of the purchase advisor are not aligned with the health interests of the member of the fund, where it is well established that continuity of care by the member's dentist is of paramount/ considerable importance to the patient.

Achieving a competitive market in oral health care – Is it possible?

It is the ADA's position that maintaining quality of care and equality of access is crucial to the health of all Australians. There is little regulation of the PHI industry which addresses the concerns raised by the ADA on quality of care and access. In a sector which is heavily subsidised by taxpayers and encouraged through government policy, government inaction is unfortunate. Until these matters are properly addressed and the PHI industry called to account, notwithstanding competition ideals, the consumer will be significantly disadvantaged.

By reference to the Panel's guiding competition principles, the ADA now poses questions to the Panel. The ADA requests that these questions be considered by the Panel in the next stage of the review process.

[4] The right of choice of provider is a fundamental philosophy of PHI.
[5] The Draft Report at p 5 (see FN 2)

a) In an environment where price signals and limitations on treatment through the terms of PHI policies, direct both the dentist chosen and oral health treatment delivered, how will ***user choice*** be encouraged? Price will drive choice, thereby undermining the independence of any "choice" in these circumstances. Choice is already being eroded in the provision of oral health care because of the PHI industry (it limits the range of treatment and the rebate and it has restrictions like lifetime limits). The discriminatory and punitive rebate offered by PHI if the contributor attends a non-PHI contracted provider or PHI dental clinic rather than the provider of their choice, inhibits user choice.

b) The current operation of the PHI industry enables it to assume the position of funder, regulator and, in the case of PHI owned dental clinics, the provider of services. The three roles identified in relation to government services in the draft report are, in the case of the PHI industry, not separate. A very significant conflict of interest arises. In oral health care, the PHI industry provides the cover for services which it also provides through its dental clinics or alternatively through networks of contracted preferred providers. Not only does the PHI industry set and charge for the PHI cover, it also sets the fee/price the clinic (or preferred provider) 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. ***How will the conflict of interest in the PHI industry be prevented?***

c) The nature of the oral health care market is characterised by small general dentists' clinics spread widely through the community. The PHI industry however, has a dominant position in the market and its operational practices are changing the nature of the oral health environment. The general family dentist whose goal is the health, welfare and safety of their patients will not be sustainable in a market dominated by the PHI industry which funds, regulates and provides services. A corporatised model of care, where profit to shareholders is the sole motivator (rather than quality treatment), is not in the long term interests of consumers. ***How will a diversity of providers be encouraged?***

d) The dominance of the PHI industry in oral health care has the possibility of discouraging innovation. Where a few large entities dominate, which the ADA maintains is the future of oral care if government does not regulate, how is this beneficial for competition? Where barriers to entry exist due to the dominance of large entities, ***who will drive innovation in service provision?***

Conclusion

The ADA respectfully requests that the Panel revisit these issues having particular regard to the above matters. Should the Panel require any further details, please contact Mr Robert Boyd Boland at ceo@ada.org.au. The ADA awaits the final report of the Competition Review.

Yours faithfully,

Dr Rick Olive AM
Federal President
Australian Dental Association