AUSTRALIAN DENTAL ASSOCIATION

ACCC Submission on Private Health Insurance

Australian Dental Association
PO Box 520 St Leonards, NSW 1590
14-16 Chandos Street, St Leonards, NSW 2065 Australia
Tel 02 9906 4412 Fax 02 9906 4676 contact@ada.org.au

About the Australian Dental Association

The Australian Dental Association (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.

The primary objectives of the ADA are to encourage the improvement of the oral and general health of the public; 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.

Further information on the activities of the ADA and its Branches can be found at **www.ada.org.au**

Introduction

The Australian Competition and Consumer Commission's (ACCC) upcoming Report to the Senate on Private Health Insurance focuses on "key consumer and competition developments and trends for 2015-16". The ACCC's invitation for feedback requests that stakeholders provide, where possible, complementary sources of data and information that can assist the ACCC's understanding of these developments and trends.

The ACCC clearly recognises that stakeholders have been asked to contribute to a number of consultation processes over the last 18 months and that the ACCC already has access to a wide range of industry data and information.

This submission's discussion of private health insurers' (PHI) behaviour and their impacts are within the context of policies related to dental services, known as "extras", "ancillary" or "general treatment" policies. Please note that the comments in this submission are generally applicable to many, but not all, PHIs. Comments made will relate to PHI conduct in general.

'Business as usual' for PHI anticompetitive conduct – overall trends

The ADA requests that the ACCC consider the Association's previous submissions on the behaviour of private health insurers (hereafter referred to as either "PHI")/"health funds"[1]. The ADA's previous submissions provided case studies and extracts of complaints made by dentists about PHI's potentially anticompetitive activities. In the interest of brevity, the ADA will not attach these complaints received over 2015-16; but can assure the Commission that the trends below have not changed and continue to negatively impact:

1. The dental services market, of which dentist are participants, by substantially lessening competition; and
2. Patients, who are consumers within that market, have less access to continuity of care as well as having higher risk of incurring greater out-of-pocket expenses.

The complaints detail how PHIs leverage their contracted provider arrangements and discriminatory rebate practices, steering consumers to their contracted providers. This interference in the patient/health practitioner relationship effectively removes consumers' choice of provider, and disrupts consumers' continuity of care as well as substantially lessening competition. This largely occurs through PHIs' call centre staff, who:

- Assert that the non-PHI contracted dentist the policy holder is seeing is 'too expensive'. This may be misleading and deceptive conduct and in breach of the *Competition and Consumer Act 2010 (Cth)* (CCA) because the differential rebates applied to a policy holder (who attends a non-contracted dentist) may be the reason there is greater out-of-pocket expense; not that the dentist's fee is higher than the PHI's contracted dentists;
- Inform the consumer that their policy does not provide a higher rebate (or any rebate at all) for services unless they attend a contracted provider. This differential rebate is in place even if the policy holder pays the same premium for the same policy as another policy holder who attends a contracted provider yet the former receives a lesser benefit to access the dentist of their choice;
- State that under the PHI's policies, the policy holder will receive a lesser rebate (or no rebate at all) for a service unless the policy holder seeks the service from a specialist when this may not be clinically required. The reverse has also been reported to occur, where PHI staff interfere in referrals to specialists, directing

[1] The term 'private health insurer' and 'health funds' will be used interchangeably in this submission

consumers to attend general practitioner dentists who are contracted to the PHI without explaining that the latter is not a specialist;

- Shift the blame and attention of policy holder dissatisfaction about inadequate rebates to 'ADA provision/rules' that do not exist; and
- Refer to arbitrary business rules of private health insurance policies that state that no rebate can be provided for an additional service given on the same day even though clinically the other service was able to be provided.

The ADA's past submissions have outlined details about the following PHI activities that negatively impact on competition and consumers:

1. Inadequate transparency and poorly communicated policy details;
2. Lack of transparency about rebates, limits, and exclusions;
3. Misleading and arbitrary use of 'recognition' processes to impose obligations onto dentists; and
4. Disregard for and circumventing the Australian Health Practitioner Regulation Agency's (AHPRA) regulatory requirements for the advertising of health services.

The issues outlined in this submission and previous ones, if unaddressed, will continue to have negative impacts upon:

a. Consumers' out-of-pocket costs;

b. Consumers ability to access quality healthcare; and

c. Open competition in the delivery of dental health care.

While the ACCC's remit of its upcoming report to the Senate concerns consumers, health is a distinct sector where general commercial principles do not apply precisely. In other words, people in the health sector are not only 'consumers' who consume generic goods and services, but are patients; whose wellbeing is impacted by market participants' activities. A higher competition standard should be applied to scrutinising the activities of major market participants, in this case PHIs, in this sector.

1. Rebates have not kept pace with premium increases

Consistently, the industry has failed to ensure that policy holders' rebates for dental services are increased to reflect the annual premium increases paid by consumers. Table 1 shows the amount returned to consumers via policy rebates for general treatment services greatly falls short of the premiums paid for those policies.

Table 1: Financial surplus achieved by PHIs since 2011/12

Year	Average weighted premium increase on 1 April	Annual CPI [Mar quarter]	General Treatment Fund Premium Revenue (000's)*	General Treatment Fund Benefits (000's)*	Surplus (000's)*	Percentage	Hospital Treatment Fund Premium Revenue (000's)*	Hospital Treatment Fund Benefits (000's)*	Surplus (000's)*	Percentage
2011/12	5.06%	1.60%	$4,675,200	$3,536,925	$1,138,275	24.35%	$12,031,185	$10,618,227	$1,412,958	11.74%
2012/13	5.60%	2.50%	$5,017,523	$3,908,684	$1,108,839	22.10%	$12,937,722	$11,504,346	$1,433,376	11.08%
2013/14	6.20%	2.90%	$5,493,873	$4,297,495	$1,142,378	21.00%	$13,874,734	$12,394,487	$1,480,247	10.67%
2014/15	6.18%	1.30%	$5,828,687	$4,500,975	$1,327,712	22.78%	$14,898,638	$13,352,499	$1,546,139	10.38*
2015/16	5.59%	1.30%	$6,187,662	$4,691,714	$1,495,948	24.18%	$15,866,561	$14,079,621	$1,786,940	11.95%
Total					**$6,213,152***				**$7,659,660***	

Source: Private Health Insurance Administration Council (PHIAC) and Australian Prudential Regulation Authority (APRA)'s Reports on the Operations of Health Funds / Private Health Insurers.

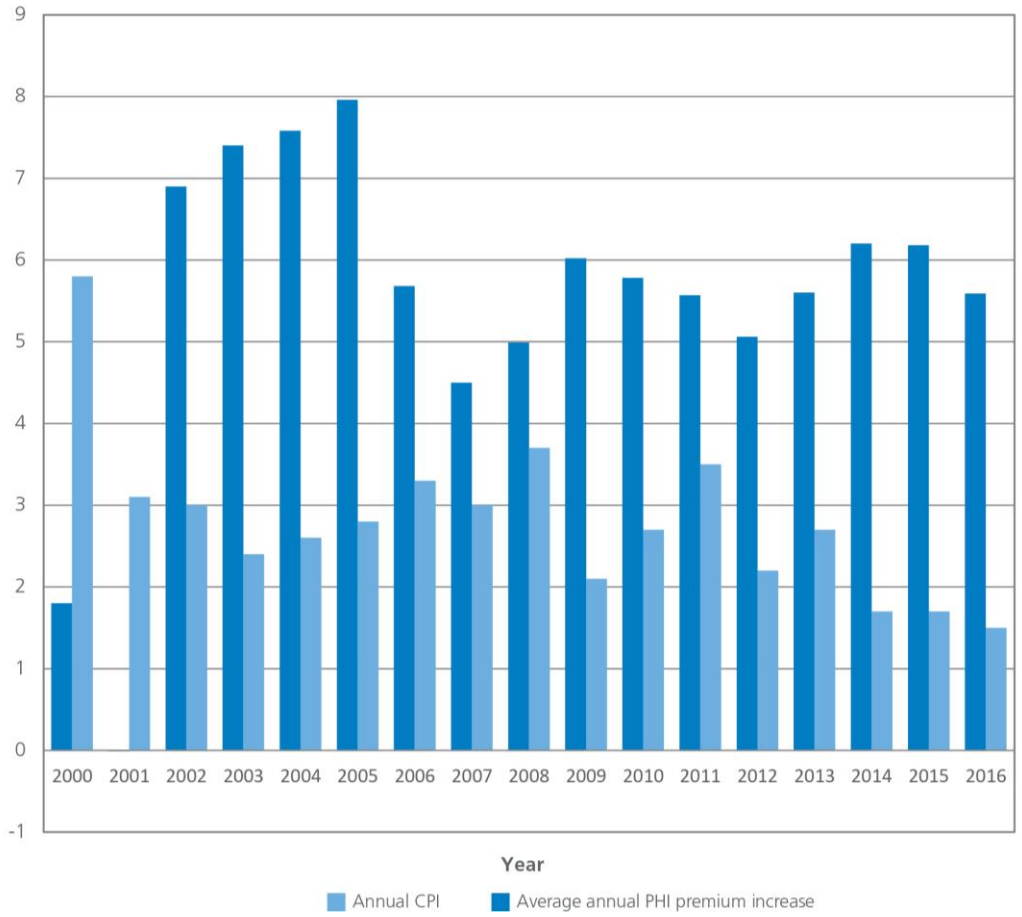
In the last five years, PHIs have made over $6.2 billion surplus in general treatments and almost $7.7 billion surplus in hospital benefits.

The fact that individuals directly funded the majority of expenditure for dental services in 2014-15 ($5.5 billion) compared with that funded by their premiums to PHIs ($1.7 billion), shows that PHIs are not adequately ameliorating consumers' out-of-pocket costs which in turn impacts on their ability to access adequate dental care.[2] PHIs have instead been maximising their profits through legislative incentives supported by the Australian Government (the Medicare Levy Surcharge and Lifetime Health Cover) without adequately reciprocating by providing consumers with value for money policies that help them access the best healthcare they need.

2. Private health insurance premiums higher than CPI

Figure 1 below shows that private health insurance premiums have increased each year by more than the cost of living index (CPI):

Figure 1: Average PHI Premium Increase and Annual CPI Increase (2000 – 2016)



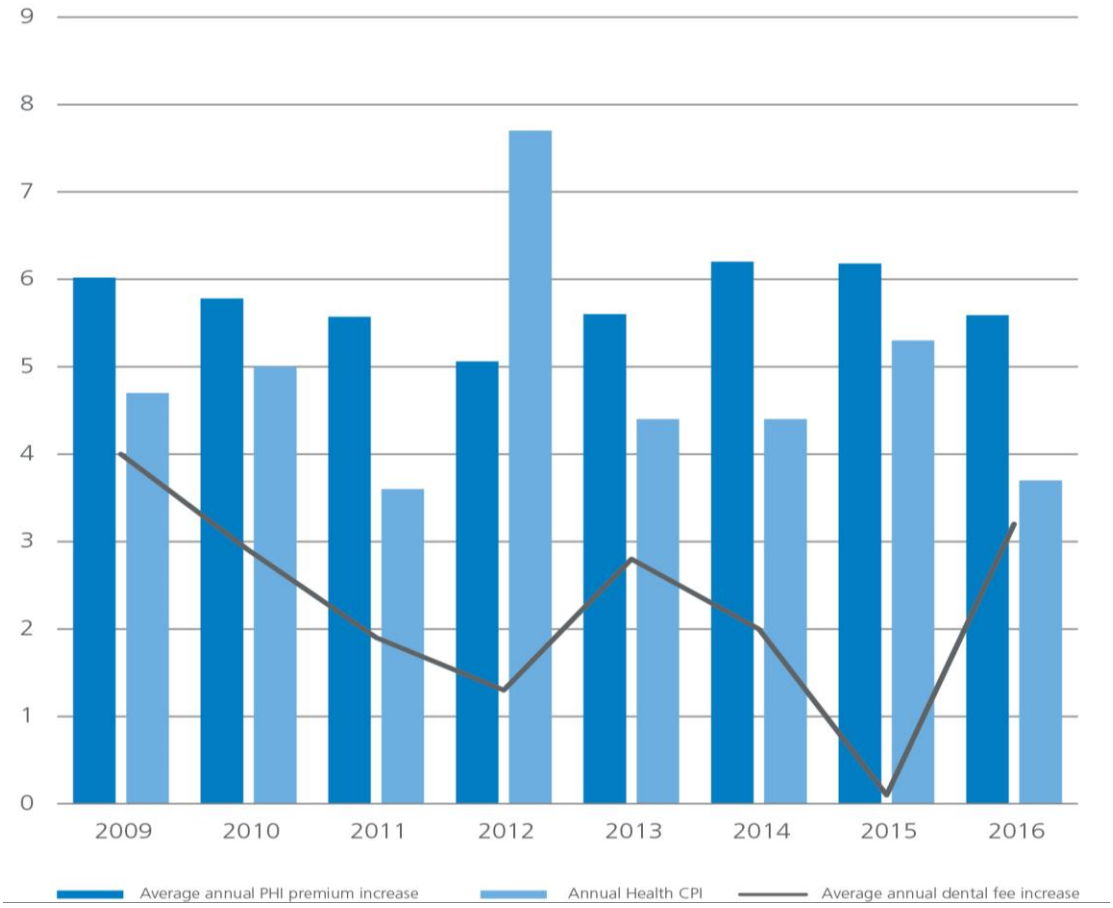
Sources: Previous media releases from Health Ministers, for example the Hon. Greg Hunt, 'Lowest Health Insurance Premium Increases In A Decade', 10 February 2017; Australian Bureau of Statistics CPI reports such as 6401.0 Consumer Price Index, Australia December 2016.

3. Average dental fees lower than private health insurance premium increases

The ADA's annual Dental Fee Surveys consistently show that over the last five years the average dental fee increase has been lower than average private health insurance premium increases and substantially lower on average than the health CPI (see Figure 2). The dental profession in Australia continues to have moderate fee increases. Yet PHIs over the years deflected attention for the increased out-of-pocket expenses away from the fact they did not regularly increase rebate levels; laying the blame on healthcare providers. Out-of-pocket expenses for the majority of contributors will naturally increase if PHIs do not increase rebates in proportion to premium increases. Consumers continue to pay more for less.

[2] Australian Institute of Health and Welfare (AIHW), *Health Expenditure in Australia: 2014-15*, page 75

Figure 2: Average annual PHI premium, health CPI and average annual dental fee increase 2009



Sources: Previous media releases from Health Ministers, for example the Hon. Greg Hunt, 'Lowest Health Insurance Premium Increases In A Decade', 10 February 2017; Australian Bureau of Statistics CPI reports such as 6401.0 Consumer Price Index, Australia December 2016; ADA Dental Fee Surveys.

The fact that half a million policies have been dumped or downgraded by consumers in 2014-15 is an indictment on the inability for PHIs to satisfy four critical requirements:

1. Be a value for money product;
2. Enable consumers better access to their healthcare provider of choice;
3. Protect continuity of care; and
4. Minimise out-of-pocket costs.[3]

Consumer's behaviour shows they recognise there is a market failure for which regulatory action must be taken.

4. Individuals still contribute the most out-of-pocket for their dental services; PHIs contribute the least

The ADA would like to make clear that PHIs have a legitimate role to play within the Australian healthcare sector. However, much can be done to improve the value and effectiveness of private health insurance for consumers. There is a strong policy demand for reform considering that over 13.5 million Australians are covered by general treatment private health insurance; more than hospital insurance (11.3 million).[4] In spite of the fact that dental services are

[3] Minister for Health, The Hon. Sussan Ley, 'Half-a-million Australians downgrade private healthcover' at https://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley134.htm, 8 November 2015 accessed at 14 April 2016 1:00pm

[4] Australian Prudential Regulation Agency (APRA), *Quarterly Statistics September 2016 (issued December 2016)*, page 3

accessed by policy holders the most (constituting 54% of all general treatment rebates paid),[5] individuals are the largest funder of the $9.6 billion spent towards dental services via out-of-pocket expenses (approximately 57%) compared to government (24%) in 2014-15. PHIs come last at 18%.[6]

Insufficient rebates are a significant contributor to consumers' direct out-of-pocket costs. Average dental fee increases have been consistently lower than average premium increases and health CPI. Consistently, the data shows individuals are the largest contributor towards dental services. This raises the question whether private health insurance is value for money? There must be more active regulation of the general treatment portion of the private health insurance industry, considering how much use and impact it has on consumers' ability to access healthcare services.

Key consumer and competition developments and trends 2015-16

Noting that the previous section outlined how there has been little change in the overall anticompetitive behaviour of the private health insurance industry, and that consumers' ability to access quality care and their out-of-pocket costs has suffered as a result, the ADA highlights the following key consumer competition developments and trends over 2015-16 for the ACCC's attention:

1. Consumer survey shows policy holders expect private health insurers to provide better value for money and choice of provider;
2. PHIs engage in third line forcing to coerce dentists to participate in contracted provider arrangements;
3. PHIs are potentially misusing market power by unilaterally withdrawing support for contracted providers towards conflicted PHI corporate owned practices;
4. PHIs misuse sensitive market information to influence and distort the market and healthcare delivery;
5. Inappropriate use of PHI run health practitioner comparison/rating websites; and
6. Unprecedented consumer and dental practitioner initiated complaints about the private health insurance industry's lack of transparency and value for money.

Before the ADA outlines these issues, the ACCC should consider how PHIs with market power are able to potentially substantially lessen competition in the market to the detriment of consumers.

The market power of PHIs

The private health insurance industry in Australia has consolidated significantly and trends suggest this will continue. While 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 market.[7] The *Competition in The Australian Private Health Insurance Market* research paper published by the then Private Health Insurance Administration Council in 2013 (**PHIAC Report**) states that at a national level, the market for private health insurance is "significantly concentrated",[8] with the two largest insurers, namely BUPA and Medibank Private accounting for in excess of 56.2% of policies.[9] It also highlights regional market dominance by the largest PHIs, with:

- BUPA having 52% share of policies in South Australia, 38% in each of the Northern Territory and Tasmania and 34% in Queensland;
- Medibank Private having 44% in the Northern Territory, 36% in Victoria, 35% in Queensland, 33% in Tasmania and 32% in the ACT; and
- HBF having 54% in Western Australia.[10]

[5] Id., page 7
[6] AIHW, *Health Expenditure in Australia*, Table A.3
[7] Australian Government Private Health Insurance Administration Council (PHIAC), *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 2 February 2016
[8] Id., 32
[9] Ibid
[10] Id., 32-33

While this influence and the market power of the larger PHIs is not *per se* problematic, the ADA has over the years raised concerns with the ACCC about conduct by larger for-profit PHIs which has substantially damaged small business dental practices commercially to the detriment of patients/consumers in terms of access to quality healthcare of their choice and costs. These PHIs are likely to have been engaging in misuse of market power that is substantially lessening competition to the detriment consumers and of healthcare providers; which is a breach of section 46 of the CCA.

A large proportion of Australians have contracts with PHIs (11.3 million Australians covered by hospital and 13.5 million Australians covered by general treatment private health insurance – the latter being used for dental services[11]) which means that private health insurance policies have a very large influence on which health practitioners consumers can attend, although ostensibly the primary purpose and underpinning philosophy of having private health insurance is for the consumer to receive their health care (dental) services from the provider of their choice. This choice underpins the entire reason for having private health insurance.

1. Key trend: Consumer survey shows consumers expect private health insurance to provide better value for money and choice of provider

APMI Partners' Research Study, 'Australian Dental Health Study: December 2016' explored aspects of Australian consumers' dental health, including private health insurance; drawing from a nationally representative sample of interviews. Almost 4,000 respondents participated in the survey. The survey results were also compared to responses provided in 2015.

The survey results confirm that consumers expect their policy to enable them to choose their provider and to not only provide higher rebates, but that they should receive the same rebate for dental services under their policy regardless of which clinic or dentist they visit:

- 82% of private health insurance with dental cover policy holders said they prefer to see a dentist of their choice under their private health insurance policy,[12] yet 76% stated that they were not happy with the level of rebates their private health insurance provided for their dental expenses.[13]
- 86% of dental cover policy holders stated that they should be able to get the same rebate for the same dental care regardless of which dentist or clinic they chose to visit.[14]
- Almost 70% (68%) stated that they would consider switching their private health insurance provider if they found a policy that offered a higher dental rebate for the same premium.[15]
- Almost 4 in 10 (37%) respondents had dental cover; where middle-higher income respondents were more likely to have dental cover (55% of respondents with annual household income $75,000 - $100,000; and 68% with annual household income >$100,000)[16].
- Almost half (48%) of respondents said they were more likely to see the dentist if they had dental cover.[17] This suggests that PHIs are in a position through their policy terms and conditions to be able to influence the respondents' choice of provider.
- Looking at the main reason why those respondents did not have dental cover as part of their private health insurance, almost half (48%) said there was poor value of rebates available under that component of the policy; and 26% referred to the premiums being too expensive.[18] In other words, poor value for money overall was a major consideration to why some consumers did not purchase dental cover.

The reality is that the aforementioned practices of PHIs and those detailed below in 2–5 are being reflected in consumers gradually downgrading or dropping their insurance policies altogether. Increasingly, private health

[11] APRA, *Quarterly Statistics September 2016*, page 3.
[12] APMI Partners' Research Study, 'Australian Dental Health Study: December 2016', Question 18
[13] Id., Question 19
[14] Id., Question 20
[15] Id., Question 21
[16] Id., Question 14
[17] Id., Question 15
[18] Id., Question 23

insurance is failing to be the bridge to provide consumers with value for money access to their healthcare provider of choice.

2. Key development: PHIs use of third line forcing to coerce dentists to participate in contracted provider arrangements

In early 2016, Bupa issued notices to existing contracted dentists (**Appendix 1**),[19] stating that they will remove the contracted provider status of those dentists if they do not ensure that all other dentists in the practice they work in are also contracted to Bupa. As outlined above, Bupa has considerable market presence in a number of states; 52% share of policies in South Australia, 38% in each of the Northern Territory and Tasmania and 34% in Queensland.

While the letter's first paragraph appears to be aimed at the individual dentist who is a part of the contracted provider 'Network', the middle of the letter starting with the words "From 1 June 2016, all recognised dental practitioners in your practice must apply to be part of the Members First dental network..." (ADA underlines) appears to also be aimed at the entire practice, and/or owner/principal of the practice.

By threatening that the current contracted provider status of dentists will be removed if those dentists/dental practice owners/principals do not ensure all non-contracted dentists at that practice are also contracted to Bupa constitutes a form of third line forcing. In particular, Bupa could be seen to procure, induce or at the very least be knowingly concerned in third line forcing – which is a per se contravention of the CCA.

Bupa is seeking to coercively compel non-contracted dentists to be contracted with Bupa; offering no real consideration in return. This action would very likely damage the competitive process through the misuse of market power.

3. Key trend: PHIs are potentially misusing market power by unilaterally withdrawing support for contracted providers towards conflicted corporate owned practices

With respect to dentists who are contracted providers with Bupa (and self-impose certain controls on how much they could charge for dental services), they entered such arrangements on the belief they could benefit from the marketing Bupa engaged in.

While Bupa contracted dentists are free to negotiate the level of fees they can charge for services, Bupa is the sole arbiter of the agreed fee. The ADA has previously outlined its objections to discriminatory fee structure and differential rebate practices because they constitute unfair competition that discriminates between consumers and substantially lessens competition between dental care providers not on the basis of providing a quality service or genuine efficiencies.

In spite of dentists who became contracted providers with Bupa, Bupa is engaging in actions which are suggestive of a misuse of its market power and its changed incentives as a vertically integrated business. Previously, Bupa engaged in marketing activities on behalf of its contracted providers. It is now changing its approach, reducing its marketing efforts towards contracted providers, and instead aggressively marketing its own dental clinics and directing patients to attend Bupa owned clinics. PHI owned clinics present a number of conflicts of interest that have the potential to substantially lessen competition and risk compromising the quality of care provided to consumers.

The ADA understands that Bupa has the right to suspend promotion of its contracted providers for any reason without notification. Further, Bupa reserves the right to unilaterally terminate contracts it has with its preferred providers for any reason with 60 days' notice. There is a real risk that Bupa will eventually withdraw support for its contracted providers as it continues to steer consumers to Bupa's own clinics; which the ADA considers to be a misuse of market power.

[19] Note this has been deidenitifed.

It is highly likely that Bupa will use these mechanisms to reduce competition against its 'owned' practices by reducing the number of contracted providers and dental practices. There will be more corporate owned and run clinics in South Australia. These will have their own risks due to the inherent conflict of interest that will increasingly be driven by Bupa's ultimate aim to generate profit. The consumer's ability to maintain continuity of care with the practitioner of their choice will be largely impacted.

What should also be kept in mind is that these issues impacting on dental care also apply to all other ancillary providers in South Australia (and nationally) for which a general treatment/ancillary policy provides such rebates to patients. Two examples are physiotherapists and optometrists.

The ADA has received complaints that echoes these practises are also being undertaken by Medibank.

The ADA does not begrudge the role of competition within the dental sector, far from it. However, the practices outlined above illustrates a misuse of market power that substantially lessens competition and penalises those consumers who do not attend a contracted provider yet pay the same premium for the same policy.

4. Key trend: PHIs misuse sensitive market information to influence and distort the market and healthcare delivery

The above examples of vertically integrated PHIs engaging in potential misuse of market power is highly likely to have been facilitated through the systematic collation and use of market sensitive data in a manner which distorts the market and ultimately is not in consumers' interests.

Whether by manual processing of claims or through the use of the HICAPS system, where the vast majority of private health insurance claims are processed, PHIs have collated data about the charging practises of individual practitioners across different practices. Where PHIs are operating 'owned' practices they have the advantage of granular sensitive information of the pricing practices, and clinical practices of their competitors (where the PHI's members have attended the 'other' practice and are making a claim following that visit). **This places the PHI in an unique position of being privy to the actual prices of its competitors; knowing which services are being provided and the busyness of those practices thus being able to vary its own prices having regard to this information as well as 'steer' customers to the PHI owned dentist either by way of pricing signals such as level of rebate/level of out of pocket expenses or contractually in the terms and conditions of policies. They are also privy to the busyness and volume of trade so may consider establishing a clinic nearby.**

Vertically integrated PHIs in the above examples have information advantages about the fee rates of competitor dentists and set the rates of their employed dentists. They have used this information to communicate with non-preferred dentists about their rates, essentially seeking to affect their rates. Also, PHIs can use this data to derecognise otherwise productive dentists, or reduce rebates on profit draining expensive services which otherwise are in high demand due to the health needs of consumers.

This conduct has a materially detrimental effect on competition as the PHIs are privy to the commercially sensitive data of their competitor dentists and PHI and have the ability and incentive to utilise this information to their advantage and to thereby skew the competitive process.

PHIs also require that healthcare providers adopt the HICAPS billing and payment processing system as a condition of entering into a contracted provider agreement – a form of third line forcing that ultimately substantially lessens competition. In other words, these arrangements are requiring healthcare providers to over time disclose their business fee models to PHIs – an untenable proposition in any other industry. Key trend discussed in point two above represents one market consequence of this particular use of sensitive information that is not in the interests of competition nor consumers.

5. Inappropriate use of PHI run health practitioner comparison/rating websites: Whitecoat

Whitecoat purports to be an "online health care provider directory and customer review website. Think TripAdvisor but for health care." The website states it has over 210,000 health practitioners listed Australia wide across 25 different provider types. It aims to expand to include medical specialists and doctors as well as hospitals.

The ADA objects to comparison sites for health practitioners as such platforms are not the appropriate way in which patients receive information about treatments and services. Sites such as Whitecoat treat healthcare service as a commodity, and act as a barrier to encouraging a genuine conversation between health practitioners and patients about treatment needs and the treatment process. Instead, these sites provide an avenue for those who may have had different expectations of their treatment to vent without encouraging them to approach the practitioner directly to clarify any misunderstandings.

What is particularly concerning is the fact that Whitecoat is inadequately transparent about declaring its conflict of interests; being partly owned by PHIs Nib, Bupa and HBF. The ADA believes that such ownership therefore puts the website in a position to be more favourable towards practitioners or practices contracted and owned by these respective insurers; for example, being listed ahead of non-insurer affiliated practitioners or practices. Similarly, Whitecoat has been known to remove consumer's negative feedback about rebate levels provided by policies from these PHIs, which is rather hypocritical considering the website purports to allow consumers to provide feedback about their healthcare experience.

Whitecoat has developed its directory by data mining details from practitioners' practice websites without their consent. Throughout 2015-16 the ADA received complaints from dentists who have requested Whitecoat remove their details from the website. However, the operators of Whitecoat have been tardy in complying with these dentists' wishes; effectively interfering in their practice via potential exposure to unfair comments about the quality of their practice. Furthermore, Nib, the creators of Whitecoat, at its presentation to the Private Healthcare Australia Fraud Conference in December 2016, purported that the site provided practitioners the full choice to participate or not. The ADA made it very clear at this event that this was not the feedback it received from its members.

Also, the ADA has received reports that for those practitioners making the decision to remain on Whitecoat do not immediately receive the benefit of potential consumer contact. The online booking service feature on Whitecoat can only be activated if the practitioner in question pays $200. Whether or not a practitioner participates in or seeks to extricate themselves from this platform, Whitecoat has been leveraging its power in an inappropriate way.

In 2016 Whitecoat expanded to become a joint venture between nib, HBF and Bupa; representing over 43% of policy holders in the market.[20] The considerable market share and consumer reach these insurers have makes their initiatives such as Whitecoat have real potential to influence choice of provider, such as by prioritising contracted providers to the consumer at the expense of non-contracted providers on no other objective basis.

Contrary to representations made in December 2016 by Nib, Whitecoat's General Manager recently provided feedback to an ADA member stating that health practitioners can no longer opt out of Whitecoat (see **Appendix 2**[21]). This one-sided use of health practitioners' information by this platform, disregarding the wishes of those practitioners who have requested their information to no longer be used in the manner outlined by Whitecoat, is inappropriate and must be compelled to cease.

Considering the other activities of PHIs outlined in this submission, this Whitecoat trend must be closely monitored by the ACCC.

[20] Private Health Insurance Ombudsman (PHIO), *Quarterly Bulletin 81: 1 October – 31 December 2016*

[21] Note that personally identifying information has been removed – an irony considering Whitecoat's refusal to respect requests from health practitioners that the same occurs on the Whitecoat website.

6. Public Time2Switch campaign generating unprecedented complaints to the Commonwealth Ombudsman

In late 2016, seeking to obtain public support for the Australian Government to take action to address these systemic problems in the private health insurance industry, the ADA embarked on its Time2Switch campaign (www.time2switch.com.au).

The ADA's Time2Switch campaign has helped generate over 3,700 public complaints about private health insurance, particularly as it pertains to dental services, skyrocket to represent almost 84% of complaints lodged to the Private Health Insurance Ombudsman for 2015-16 alone.[22]

Time2Switch also provides to the public a dental profession-developed comparator that assesses private health insurance policies' rebates for general dental, major dental, endodontic and orthodontics services. Time2Switch is the ADA's contribution to addressing the shortcomings of existing comparison websites, identified by the ACCC in its previous reports,[23] such as the limited proportion of PHIs considered; and commissions which fund some comparators. While the Australian Government's own privatehealth.gov.au website allows consumers to search for the range of policies available, it does not provide analysis of these policies in relation to their value when it comes to particular types of treatment including dental care.

The ADA's Time2Switch website's comparator aims to ameliorate the informational asymmetries by examining the dental rebates provided by private health insurance policies in relation to a proportion of the average fee for that service, and the competitiveness of these rebates rebate compared to other insurers' policies.

The ACCC should recognise the unprecedented number of complaints lodged to PHIO and accordingly take regulatory action to address PHI practices in relation to general treatment policies and their impact on the dental sector and consumers.

Rectifying the suboptimal PHI market

A Private Health Insurance Code of Conduct with healthcare providers

The Private Health Insurance Code of Conduct (CoC) is a self-regulatory code intended to promote informed relationships between PHIs, consumers and intermediaries. However, the CoC does not mention healthcare providers.

To address this gap, the ADA has sought to work with the PHI industry to develop a CoC in relation to PHIs, consumers, intermediaries and health providers, drawing from the ADA's Policy Statement 5.1 *Dentistry and Third Parties* and Policy Statement 5.5 *Funding Agencies*.[24] These policy statements outline the terms of the relationship between dentists, patients and PHIs that should be in place to result in the best health and financial outcomes for consumers.

Unfortunately, in spite of ADA attempts to engage with PHIs and their peak body, Private Healthcare Australia, to consider jointly developing such a CoC, there has been little interest.

The ACCC should consider encouraging the private health insurance industry to work with healthcare providers to develop a CoC.

[22] PHIO's Quarterly Bulletin 81 stated it has not included these complaints in its statistics as they do not fit the profile of complaints for which individual action is sought with respect to a consumer and PHI. Nonetheless the QB has reported on it accepting these complaints and noting the concerns and call for action within.
[23] Australian Competition and Consumer Commission (ACCC), *The comparator website industry in Australia*, November 2014
[24] http://www.ada.org.au/Dental-Professionals/Policies/Policy-Index/ADAPolicies_Index.

The need for regulatory change and regulator action

The ACCC should not have any uncertainty about whether there is a public demand for greater action to be taken by the Australian Government and its agencies to address the market failures within the private health insurance industry.

For a number of years PHIs have continued to engage in anticompetitive and anti-consumer activities, namely concerning the use of discriminatory rebate practices to steer policy holders towards contracted providers; interfering in the patient/health practitioner relationship and compromising consumers' choice of provider, and disrupting continuity of care. These activities operate against the backdrop of market that is oversaturated with policy products that lack transparency. PHIs have also used 'recognition' processes to impose obligations onto dentists in a misleading and arbitrary way at the expense of dentist and to the inconvenience of consumers. Furthermore, PHIs have been known to engage in activities that circumvent AHRPA's regulatory requirements for the advertising of health services.

These all combine to influence the increasing market consolidation of the private health insurance industry, and greater representation of for-profit PHIs. This has not resulted in consumers benefiting; who continue to the majority funder of dental services which raises questions as to whether private health insurance industry is providing value for money and better access to healthcare services.

Consumer research conducted in December 2016 reaffirms that consumers still value choice of provider and providing value for money whereby out-of-pocket costs are minimised as much as possible as the primary value proposition that private health insurance provides in the first place. However, in PHI behaviour in practice shows that these expectations are increasingly not being met. This dissatisfaction is filtering through the increasing trend of consumer's downgrading and dropping of their private health insurance policies altogether.

This submission has discussed the following key trends and developments of 2015-16 that reflect greater market wide activity by larger PHIs that is potentially substantially lessening competition and compromising consumers' level of healthcare access and value for money received from private health insurance:

1. Use of third line forcing to coerce dentists to participate in contracted provider arrangements lessening choice and continuity of care for consumers;

2. Potential misuse of market power by unilaterally withdrawing support for contracted providers towards conflicted corporate owned practices; lessening choice and potentially compromising on the quality of care for consumers;

3. Use of sensitive information to influence and distort the market and healthcare delivery; which, over time, risks reducing consumers' access to health practitioners with whom they have an established relationship and also increase their out-of-pocket costs over time; and

4. Inappropriate use of comparison/rating websites for health practitioners: Whitecoat; disrupting continuity of care through encouraging incomplete impressions of treatment by patients to be publicised without addressing patient concerns.

Finally, the ADA's Time2Switch campaign has attempted to raise awareness about the private health insurance industry's shortcomings. The public response to the campaign has been increased demands for reform that results in greater value for money, transparency and equity in rebates provided under general treatment policies.

The ACCC must take action to address this situation.

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 the ADA Chief Executive Officer, Mr Damian Mitsch at ceo@ada.org.au or 02 9906 4412 should you have any questions.

Dr Hugo Sachs
Federal President
Australian Dental Association
17 March 2017

Appendix 1: Bupa letter requiring all dentists in a practice be contracted providers, dated 29 February 2016

29 February 2016

Dear

As a valued Bupa Members First Dentist you have contributed to Bupa's success in broadeningthe availability of dental network services. This support has assisted our members in receiving greater value from their health insurance and encouraged them to put into practice living healthier and happier lives.

Bupa Members First Dental Network indexation from 1April2016

From 1April2016, the enclosed Schedule will replace the existing Schedule of Set Benefits and Maximum Chargeable Amounts in Table 1ofthe Bupa Members First DentalAgreement which includes the Rules of Participation (Agreement).

Important changes to the Bupa Members First the Rules of Participation (Agreement) from 1June 2016

At Bupa, everything we do is for the health of our members. Our aim is to help our member's live longer,healthier,happier lives.

From 1June 2016, all recognised general dental practitioners within your practice must apply to be part of the Members First dental network.

This means that our members, your patients will enjoy greater certainty and higher benefits at all general dental practitioners within your practice.

The current Agreement will be in place until 1June 2016,unless terminated earlier by you or Bupa.

What do Ineed to do?

Please ensure that you review the attached Members First Agreement.

To continue your participation inthe Bupa Members First network,all general dental practitioners at your practice must complete and return a Rules of participation Agreement.

If we do not receive a completed Agreement prior to 1June 2016, your current Agreement will end with us from 1June 2016.

Where do Ifind further information?

We're here to help so if you have any questions, please contact Kate Linnell on (08) 8100 6613.

We look forward to your continued support and are confident that these improvements will further strengthen our relationship with you as a valued Bupa Members First provider.

Correction to Table 1–Schedule of Set Benefits and Maximum Chargeable Amounts

Please note Item 946 in the enclosed schedule of set benefits and maximum chargeable amounts should be listed as 987.

Yours sincerely,

Tom Russell
National Ancillary Networks Manager

10202-04-16P

Bupa
PO Box 14639
MELBOURNE *VIC* 8001
bupa.com.au

Bupa Australia Pty Ltd
ABN 81 000 057 590
10182-04-14S_LTH

Appendix 2: Correspondence regarding health practitioners' right to not be listed on Whitecoat

From: X [mailto:X@whitecoat.com.au]
Sent: Wednesday, 1 March 2017 10:04 AM
To: X
Subject: Re: Removing names from whitecoat

Hi X,

Below is what is currently listed on Whitecoat website.

https://www.whitecoat.com.au/providers/page/frequentlyaskedquestions

Can my profile be removed from Whitecoat?

No, you can't opt out of Whitecoat.

Your Whitecoat profile includes basic directory information, such as your practice location and phone number, which will always be displayed. Additional Provider Profile information (such as opening hours, billing methods etc) can be added or removed by logging into your account and modifying your Provider Profile details.

You can elect not to display patient comments. You can remove these by logging into your account and changing your Provider Profile settings. If you choose to remove these items from display, any member of the public viewing your Provider Profile will be notified that you have elected to remove these items from display on Whitecoat.

I would have to revert with nib to find out what they have presented as I am unaware of it.

I have also attached a copy of the Whitecoat Report - every Whitecoat Provider would've received this with their personalised stats last week.

X

On Thu, Feb 23, 2017 at 2:07 PM, X <….com.au> wrote:

Dear X,

The ADA Newcastle division uses a local newsletter to keep our members and some community stakeholders up to date with local dental events and issues. The February newsletter is being compiled to come out next week and I am the editor.

I would like to inform our members where they stand in trying to remove their names from "whitecoat".

Our understanding was that this was a settled issue and this was achieved by a request to Hicaps. It is my understanding that an nib presentation at a recent industry event also said that dentists could remove their names on request. Our understanding from members is that this isn't happening when requests are made.

- Could you please clarify the procedure?
- Confirm the fact that dentists can remove their names on request and
- Give a procedure or contact for communications when removal does not occur in a timely manner.

The newsletter is due out next Tuesday.

Kind regards,

X