Supplementary submission in support of application for authorisation of HCF's More for Teeth program

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RESPONSE TO PUBLIC SUBMISSIONS MADE BY INTERESTED PARTIES ON THE HOSPITALS CONTRIBUTION FUND OF AUSTRALIA LIMITED (HCF'S) APPLICATION FOR AUTHORISATION AA1000402

1. INTRODUCTION

This submission by The Hospitals Contribution Fund of Australia Limited (**HCF**) responds to issues raised in public submission dated 13 November 2017 made by the Australian Dental Association Inc (**ADA**) opposing HCF's application for authorisation AA1000402 (**Application**).

HCF seeks authorisation, for a period of ten years, of its agreements with dentists who participate in HCF's More For Teeth (**MFT**) program in locations that overlap with its own dental centres concerning the fees to be charged by those dentists for the MFT services for HCF members. It does not seek authorisation of the MFT program generally, or of the operation of its dental clinics.

HCF does not understand the vehemence of the ADA's opposition to the authorisation sought by HCF. The purpose of the MFT program is not to cause HCF members to switch dentist; the purpose is to encourage HCF members, who may not otherwise go to a dentist because of pricing uncertainty to go to a dentist for diagnostic and preventive services. Any dentist (outside Sydney) who wishes to do so can join the MFT program.

HCF considers that many of the issues raised by the ADA seem to reflect its institutional views on matters such as "corporate" dentistry and are not relevant to the application for authorisation. For this reason HCF has not sought to respond to every issue raised by the ADA. It should not, however, be inferred from the fact that HCF has not directly addressed a particular assertion made by the ADA that HCF agrees with or accepts it. Rather the assertion has not been addressed because it appears to have no relevance to the application for authorisation.

HCF regrets that the ADA's submission contains inappropriate and false allegations and assertions concerning HCF. HCF rejects all allegations of impropriety that are made concerning HCF in the ADA's submission.

2. ADA ERRORS AND MISCONCEPTIONS

The ADA's submission contains numerous errors and misconceptions and invites the ACCC to draw inferences from them.

Assertions based on the assumption that HCF has shareholders
In a number of places the ADA refers to HCF's shareholders. For example, the ADA asserts on Table 2 on the eleventh page of the submission that "*…shareholder pressure to generate higher returns will drive HCF to engage in setting differential rebates* …". There is, in fact, no "shareholder pressure" on HCF. HCF does not have shareholders and the ADA'S mistaken speculation is based on a fundamental misconception.

HCF is, in fact, registered as a public company limited by guarantee. HCF has no share capital and as such, no shareholders. The corporate members of HCF are known as the Councillors, and are entitled to vote at HCF meetings under the under the *Corporations Act 2001*. Up to 16 Councillors are elected by the voting policyholders (or appointed by the Directors where there is a casual vacancy) and up to eight board Councillors appointed by the Board.

HCF is operated on a not-for-profit basis and its Constitution prohibits any distribution of surplus or assets to the Councillors.

The ADA's ignorance concerning HCF's not for profit status and the consequences of its structure as a company limited by guarantee have led it to equate HCF with for profit health insurers and to assert that, if one or more of those companies acts in a particular way, the ACCC should infer that HCF will behave in the same way. Such assertions are misconceived and misleading.

Assertions which are unsubstantiated

The ADA, more generally, makes sweeping assertions in its submission and creates the impression that HCF's application for authorisation should be assessed in the light of those assertions, as if they were relevant to HCF or the authorisation application.

For example, on the twelfth page of the ADA submission the ADA alleges that the business models of corporate/private health insurance owned and operated clinics " .. with their attempts to rein in costs and maximise profitability, may result in over-servicing, seriously compromised standards and ethics of care and compromised professional development for young dental graduates ..". Each of these is a very serious allegation, which should be supported by cogent evidence. The ADA refers to the ABC Radio National Background Briefing program as evidencing these assertions.

There is, in fact, no reference at all to HCF in the transcript of the Background Briefing program and no evidence to support such allegations against HCF. There is, in short, no basis whatsoever for inviting the ACCC to have regard to these allegations in assessing HCF's authorisation application.

Assertions concerning corporate providers of dental services

The ADA submission creates the impression that HCF is a very substantial "corporate" provider of dental services and that, by implication its application for authorisation should be assessed on that basis.

HCF, which currently has 10 dental centres, is, in fact, small when compared with large corporate service providers such as the Dental Corporation (owned by Bupa)(191[1] centres), Dental Partners (76 centres), Primary Dental (56 centres) and Pacific Smiles Group (which runs NIB dental centres)(54 centres), National Dental Care (36 centres) and 1300SMILES (23 centres).

[1] The number of centres cited here are indicative. They reflect HCF's current understanding of the position but the number of centres change frequently.

HCF notes that the Background Briefing program referred to, and attempted to contact for comment, what it describes as "the top six corporates", which it considers includes Bupa, Primary Healthcare, Maven Dental Group, 1300 Smiles and the Dental Corporation.[2]

HCF invites the ACCC to place little if any weight on the ADA's general assertions concerning corporate providers of dental services.

Misdescription of the participants in HCF's MFT program

Another area of misconception is the nature of the MFT program. The ADA contrasts those dentists who choose to participate in the MFT program with "independent small business dental practice dentists". The implication is that those dentists who choose to participate in the MFT program are not dentists independent small practices. That is not correct. In fact there is no distinction based on independence. Many of the dentists who choose to participate in the MFT program are "independent small business dental practice dentists". The only area of difference is that those who choose to participate in the MFT program agree not to charge more than the agreed price for the 10 MFT services.

As noted previously, in some cases the same dentist operating under different provider numbers chooses to participate in the MFT program under one provider number and not to participate under the other. This highlights the fact that the ADA's implication that dentists who choose to participate in the MFT program are, as a result, not independent small practice dentists, is misleading.

3. DENTAL PROVIDERS IN HCF'S MFT PROGRAM

The ADA submits that Table 4 of the Application, which contains the number of dental providers in the MFT Program and the year the program launched in the states in which it operates, is misleading by suggesting that there are over 73,500 dental practitioners in Australia. The ADA submits that there are 16,732 registered dentists in Australia, according to Dental Practitioner Registrant Data from June 2017, published by the Dental Board of Australia. The ADA alleges that the information provided by HCF in Table 4 of the Application is "*highly misleading at best and potentially deliberately deceiving.*"[3]

HCF rejects the allegation that it has deliberately deceived the Commission, and submits that it has, consistently throughout the Application, clearly stated where the figures provided refer to provider number or individual dentist head count.

The data in Table 4 of HCF's submission is clearly stated to be by reference to dental provider numbers[4] by state, rather than individual dentist headcount. The provider

[2] Manning, P, (2017), "Drill and fill: dentists up in arms over the risks of corporate dentistry" Background Briefing, ABC Radio National, Sunday 2 July. http://www.abc.net.au/radionational/programs/backgroundbriefing/2017-07-02/8660142#transcript

[3] Page 6, ADA's submission.

[4] Health professionals are required to have an eight digit provider number to claim Medicare benefits.

numbers in the table were obtained from Medicare Australia's Provider Number database and are set out accurately in Table 4.

The data were presented on this basis to reflect the fact that many dentists have multiple provider numbers and that some of them choose to participate in the MFT program under one or more of those numbers but not under others. It would not be possible to communicate this, if the individual dentist headcount data were used. This illustration of the freedom of choice exercised by individual dentists may be at odds with the ADA's characterisation of the MFT program but it is an objective fact which HCF submits is directly relevant to the assessment of the application for authorisation.

4. REBATE DIFFERENTIATION

The ADA's submission contains repeated criticisms of the payment of differential rebates by HCF to members. For example, the ADA states that:

> *"…policy holders receive a lower rebate if they choose to see an independent small business dental practice dentist who is not participating in the MFT program or works for a HCF dental clinic even though they pay the same premium for the same policy as those who do attend."*[5]

The ADA alleges that rebate differentiation results in cross subsidisation between HCF members who attend non MFT providers, and those who attend an MFT provider. That is, that the MFT program provides higher rebates for MFT services for HCF members who attend MFT providers, by providing lower rebates for MFT services for those members who do not attend an MFT provider.

It is correct that that there is a difference between the rebate that a member will receive from HCF for an MFT service if they attend a dentist who participates in the MFT program, as opposed to a dentist who does not participate in the program. The circumstances in which this arises are summarised below.

History of the MFT program

The MFT program was launched as the Regional and Rural Oral Health Program in October 2001 – initially as a pilot – in regional and rural NSW. HCF had formed the view that its members outside Sydney were less likely to visit the dentist, with adverse long term consequences for their dental health and that a no-gap program might encourage them to seek diagnostic and preventive dental services. The MFT program subsequently expanded nationally.

The concept behind the MFT program is to provide HCF members with choice and greater certainty in pricing for diagnostic and preventive dental services, without imposing any onerous or exclusivity obligations on the dentists who participate in the program. Pricing certainty is likely to lead to more frequent visits to the dentist because a significant historic impediment to this has been uncertainty in pricing.

[5] Page 6 ADA's submission.

More frequent visits to the dentist for the MFT diagnostic and preventive dental services is expected to result in earlier detection of dental problems and a reduction in the need for members to have more complex and costly surgical and restorative dental procedures outside the MFT program and incurring resulting claims for such procedures. This has a dual impact of reducing a member's out of pocket costs and reducing overall benefit costs, and thereby reducing pressure on premiums.

When the MFT program was introduced HCF considered that, in order to achieve the objectives of the program, it would be necessary for HCF to incentivise dentists to participate in the program. Part of the incentive was to set the relevant no-gap rebates at levels that would not deter dentists from participating. HCF considers that it is in the interests of its members if it can encourage dentists to offer the no gap arrangements for MFT services. HCF considers that the rebates for the MFT services payable for those services when provided by non-MFT dentists are appropriate. It is always open to a dentist, who, at any time, is prepared to cap their fees for the MFT services for HCF members at the no-gap level, to participate in the MFT program.

HCF considers that incentivising dentists to participate in the MFT program will increase the likelihood that HCF members will obtain the MFT diagnostic and preventive services and that this ultimately reduces the overall cost of dental care claims paid by HCF. This, in turn, is to the benefit of all HCF members.

5. INFORMATION PROVIDED TO CONSUMERS ABOUT THE MFT PROGRAM

The ADA asserts that HCF improperly "steers" its members away from non-MFT dentists.

This assertion is incorrect and without foundation. It is another example of the assertions made by the ADA, which are based on misconceptions and for which there is no evidence concerning HCF. The "evidence" relied on by the ADA to support this and other assertions comprises the 36 complaints received by the ADA since 2012 in Appendix 1.

HCF notes the following concerning this material:

- 29 of the complaints make no reference to HCF and they appear to have been included solely for prejudice.
- None of the 7 that refer to HCF have any relation to the MFT program or HCF dental centres.
- Even if any of the 7 that refer to HCF were relevant, the weight placed on them should take into account the fact that in each of 2015 and 2016 HCF paid benefits in respect of approximately 3,485,000 dental services;
- The text of the "complaints is, in most cases, ambiguous; and
- The complaints cannot be tested for accuracy.

One of the assertions, which the ADA implies, is supported by the complaints is that HCF deliberately provides very little written information on rebates for specific treatments, and encourages them to telephone HCF to find out or clarify information. It

is alleged that the purpose of this approach is to allow HCF the opportunity to "steer" policy holders to HCF MFT providers. Specifically, the ADA states that:

> *"Health funds that have "preferred provider" networks, such as HCF, deliberately provide very little written information on rebates for specific treatments, and encourage their customers to call them to find out. They, including HCF, do this in order to have the opportunity to steer policy holders to contracted "PHI-contracted" providers. They have been known to inform policy holders that no rebate, or a very limited rebate is payable unless they attend a contracted provider."*

This is not correct. In the first place, HCF provides a considerable amount of information to its members on the MFT program in its Member Guide and on the HCF website.[6]

Secondly, HCF encourages its members to contact it for guidance concerning rebates. It is not possible for HCF, or any health fund, to provide members with comprehensive written information concerning the rebates that they can expect to receive for specific treatments. This is because the amount that each individual pays and receives for a treatment will vary depending on a range of factors. These factors include where the member receives the treatment, the member's policy, and the treatment being provided. It is for this reason that members are encouraged in the HCF Member Guide to call HCF in order to understand the procedure or treatment the member is undergoing, and what the provider will charge, in order to avoid "bill shock".[7]

Bill shock occurs where a customer receives a bill for services already provided that is higher than expected. Members may not remember previous claims that they have made or whether they have used their limits, and, accordingly, they are encouraged to seek to confirm their entitlements with HCF before receiving a treatment or procedure. In addition, members may require a complex course of treatment, and telephone HCF in order to understand what benefits are claimable, or they may want to claim for a treatment or item that has rules around claiming, such as an oral appliance for diagnosed snoring or sleep apnoea, which needs a supporting letter from a sleep physician and is only claimable under specific products.

HCF call centre staff are provided with information and training in order to allow them to assist members who phone to enquire about their level of cover. HCF staff are not instructed to steer members to contracted providers by asserting that non-contracted providers have 'higher fees'. The 'Kickstart Training Participant Manual' which is provided to HCF branch and call centre staff includes the following instruction: *"We have a number of provider networks such as Medicover and More for Teeth and More for Muscles where members pay no gap for certain services in certain circumstances. However, it is important to remember that HCF does not recommend one provider over another or endorse the providers' services."*[8] HCF quite clearly does not instruct its staff,

[6] https://www.hcf.com.au/members/no-gap-services
[7] Page 3, https://www.hcf.com.au/pdf/guides/membership_guide.pdf
[8] Branch Participant Manual workbook (page 36), Call Centre Participant Manual (page 47)

as alleged, to steer its members to contracted providers over non-contracted providers or act as purchase advisors to its members.

6. ALLEGED PUBLIC DETRIMENTS

HCF's Dental Clinic Network

As noted above, the ADA made unsubstantiated allegations, by implication, that the dental centres comprising HCF's Dental Clinic Network (**DCN**), over-service patients, compromise standards and ethics of care, and compromise professional development for young dental graduates. The ADA asserts that a lower quality of care is borne from a conflict of interest that arises through health funds employing dental service providers, setting the fees for service providers, and the level of rebates paid to members. HCF refutes each of these allegations.

Quality of care

HCF submits that the standard of care provided at an HCF-owned dental centre is not inferior to the care that patients receive at a dental centre which is not owned by HCF and that there is no evidence to the contrary.

HCF is committed to ensuring that its dental centres are run according to high clinical standards, and to ensuring that dentists who operate at HCF dental centres do not undertake any unnecessary work on HCF members.

The position of Manager, Clinical Quality & Safety at HCF is dedicated to managing the clinical quality of HCF clinical staff (dentists and hygienists). The role is held by a senior clinician in a management position and facilitates 5,000 clinical audits each year across the DCN clinical group. The Manager of Clinical Quality & Safety is also responsible for speaking with clinicians about areas of concern, which is mainly around caries that may have been missed, and the following of clinical protocols.

HCF submits that the conscientious and coordinated approach that it takes to the auditing of its clinicians ensures that its dental centres provide a high and sustained quality of care to its members.

HCF also undertakes significant in-house training, which is designed to support its approach to developing the clinical skills of its clinicians. HCF employs an external clinical specialist to assist in the management and running of clinical courses for its dentists and hygienists. The courses are fully funded by HCF and occur during the working week, which means that HCF accepts the loss of income incurred in requiring its clinicians to attend such courses. The majority of these courses are run with six clinicians or hygienists in each session, and included a mixture of presentations and hands on clinical work. HCF clinicians are also encouraged to attend external courses which HCF contribute towards the cost of. Between July 2017 to early November 2017, the equivalent of 255 clinical surgery days were allocated to clinicians attending HCF's in-house training courses, which demonstrates HCF's commitment to them.

In addition, HCF runs a clinical afternoon twice a year, where dentists and hygienists attend a two hour clinical training session which features presentations from external presenters across a wide range of dental areas. Over 100 clinicians and hygienists attended the most recent of these afternoons in November 2017.

HCF also prioritises the development and training of its dental graduates. In addition to the ongoing training provided to HCF clinicians above, HCF also runs an intern course for post graduate dentists who have just left university. The course is run by an external training clinical specialist and involves an initial one week intensive training program, followed by one day a week of extra training which is lengthened to every second or third week as the year progresses.

HCF dentists on average see between eight to twelve patients per day (not four per hour, as alleged in the ADA's submission). The payment of a commission based salary is standard across the dental industry, and not unique to dental centres owned by health funds. The risks inherent in this model therefore apply equally to dental practices owned by health funds, and those that are not owned by health funds. On both fronts, it is inaccurate to imply, as the ADA does, that dentists operating at health fund owned dental centres prioritise their commission by seeking to treat as many patients as possible in one day, to the detriment of the quality of care provided to each patient. Moreover, a self-employed dentist has a very similar incentive to increase revenue by increasing the number of patients per day.

PHI premium increases

The ADA criticises the premium increases imposed by HCF over the past five years. Private health insurers' annual premium increases must be approved by the Federal Minister for Health. The premium increase approval process involves projections of future claims costs for each hospital and ancillary product informed by analysis of claims trends and assumed future increases in claims volumes and costs, together with mandatory actuarial review. The Federal Minister of Health has the power to reject premium increases if in his/her opinion they are not in the public interest. Private health insurers are constantly under pressure to keep premium increases to a minimum, which increases the focus on justifying decisions to increase benefit and rebate schedules.