AUSTRALIAN DENTAL ASSOCIATION

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20 June 2024

Anthony Hilton
Director Competition Exemptions
Australian Competition & Consumer Commission

By email: [redacted] | [redacted]

Dear Anthony

Re: Australian Dental Association Inc application for revocation of authorisation AA1000638 and substitution of AA1000669 – ACCC request for information

In response to your letter of 11 June 2024, the Australian Dental Association (ADA) is pleased to assist the ACCC's consideration of the ADA's substantive application for authorisation, by providing further information relating to that set out in Attachment A of your letter.

Background

As a preliminary comment, the ADA notes that it is important to understand that:

a) This authorisation relates to ***intra-practice*** price setting within one particular type of practice structure that may be used by ADA members where dental practitioners in a specific practice wish to work as a team (see schedule 3 to the ADA's application and the explanation in paragraph 4.4 of the application). This is not the only practice structure that may be used in order to work as a team, and other structures that may be used do not require authorisation for price setting within the practice.
b) Although there are wider issues (see the ADA's 1 May 2023 submission to the ACCC[1]), individual authorisations cannot fix the wider issues. This is something that was understood by the ACCC in the individual authorisations granted in 2023 to private health insurers (PHIs) for preferred provider arrangements.
c) The authorisation sought by the ADA is narrower than that granted to PHIs in 2023, in that (i) it does not involve pricing ***between*** dental practices and (ii) the authorisation sought is limited to Division 1 of Part IV (cartel conduct) and not Division 2 of Part IV (substantial lessening of competition).

The ADA has had long-standing concerns about the overall impact of arrangements between PHIs and dental practices in terms of both *competition in dental services* and *consumer harms*. Incrementally and insidiously, financial service providers have reached into the healthcare relationship between dentist and patient in a way that risks influencing both treatment decisions and the basis on which patients choose a dentist. The piecemeal nature of whether PHIs choose to bring the arrangements they have with dental practices to the ACCC for authorisation and the narrow focus of each individual authorisation have meant that the insidious wider impact of these arrangements has not been properly examined by the ACCC.

At the heart of the insidious wider issue is the intersection between *two different markets*, one involving financial services (private health insurance) and the other healthcare services (dental services). PHIs justifying their behaviour as competition in private health insurance has tended to shift focus away from the impact of that

[1] Available online at: https://shorturl.at/wY4is

behaviour on competition in dental services. The ADA has maintained the position that consumers should be entitled to benefit through competition *in both markets*, and competition in one should never be allowed to detract from competition in the other.

The position the ADA has put to the ACCC is that fixing the wider issues would mean ensuring two fundamental outcomes:

a) That consumers can choose their dentist and their PHI based on competition on the merits in each activity. That cannot happen if (*as is currently the case*):
   - the rebate offered by PHIs differs depending on who the consumer uses as their dentist (i.e., the practice of differential rebates), and
   - most, if not all, dentists are subject to involuntary terms and conditions imposed by PHIs simply as a result of treating an insured patient or having a HICAPS machine[2] (noting that these involuntary terms and conditions are separate to the voluntary terms and conditions that apply to dentists who have chosen to become preferred providers).

b) That consumers can have confidence that their choice to use private health insurance will never result in their PHI being able to undermine clinical confidentiality or treatment decisions agreed upon by them with their chosen dentist in a clinical setting. That cannot happen if (*as is currently the case*) PHIs can have unfettered access to patient records and override the clinical advice of the dentist the consumer has chosen to use.

In 2023 the ACCC considered two authorisations by PHIs relating to pricing provisions under preferred provider arrangements between the PHI and dental practices. One was a re-authorisation of arrangements for which the PHI had been granted authorisation in 2018, and the other was a new authorisation sought by a PHI. In both cases, the reason for seeking authorisation was the technical risk where those preferred provider arrangements involved pricing provisions; specifically, the risk of cartel conduct (price fixing) where PHIs operate their own dental practices in close geographic proximity to third-party preferred provider dental practices.

The ADA put in specific submissions on both these authorisations as well as the 1 May 2023 general submission referred to above, which summarised wider issues that the ADA had previously raised in historical submissions to the ACCC. The ADA provided this general submission as the ACCC was keen to understand the wider concerns the ADA had previously raised, albeit acknowledging that these were difficult for the ACCC to address in any individual authorisation.

The ADA suggested limiting the scope of authorisation granted to these PHIs to the application of Division 1 of Part IV in so far as the PHI is in competition with the third-party dental practices with whom it has such pricing arrangements. This would put the PHIs who seek authorisation on the same footing as PHIs who do not have their own practices *in relation to cartel conduct risk*, but importantly leave all arrangements between PHIs and third-party dental practices subject to the substantial lessening of competition test in Division 2 of Part IV (specifically, section 45) with respect to wider competition impacts.

Ultimately, the ACCC decided to granted authorisation in respect of section 45 for both the 2023 PHI applications on the basis of the limited size and scale of the particular PHI and the particular preferred provider arrangements.

It is against this backdrop that the ADA provides the following answers to the ACCC's questions:

ADA membership

[2] For example, clause 4.2(vii) of the HICAPS terms and conditions requires dental practices to provide to a patient's PHI, amongst other things, "treatment plans" and "treatment records". There are no oversight mechanisms to challenge the reason for the PHI requesting these, or for how these may be used by the PHI.

Q1. We note the proposed conduct provides for the making of and giving effect to contracts, arrangements and understandings where at least one party is a member of the ADA. Please provide further information around the reasoning for limiting the proposed conduct to at least one party being a member of the ADA.

This is a technical issue that goes to the fact that it is the ADA who is the applicant, and the ADA only has a mandate to seek authorisation on behalf of members.

Section 88 allows an applicant to seek authorisation on behalf of other parties. However, as acknowledged in the ACCC's authorisation guidelines, this is on the basis of assumed consent. The ADA has authority to seek authorisation on behalf of its members, but it does not have any authority to seek authorisation (at the ADA's expense) on behalf of non-ADA members.

The original 2008 authorisation was sought by the ADA on behalf of members who practice in a shared practice. The next authorisation was sought on the same basis (i.e. on behalf of members who practice in a shared practice). In submissions relating to the second authorisation application, a third party sought clarification as to what this meant, the concern of the third party being that this might mean the ADA was seeking to limit intra-practice price setting to its members alone.

The ADA proposed the condition that was accepted in the 2013 authorisation by way of clarifying what it means to seek authorisation on behalf of members, noting that even without this condition, an application made on behalf of ADA members cannot result in protection to a shared practice where none of the dental practitioners is a member, and it remains open for any such shared practices (or group of such practices) to seek their own authorisation.

In summary, the ADA cannot seek authorisation on behalf of all dental practitioners; it only has authority to do so on behalf of members. The condition simply clarifies this and ensures that the protection applies to the shared practice of the member on whose behalf the ADA has sought authorisation.

Compliance training

Q2. Please describe any communication, training and/or educational activities, if any, the ADA provides to its members regarding their obligations to comply with Part IV of the Competition and Consumer Act 2010 (Cth) (i.e. the competition provisions) and a summary of any additional training and/or educational activities the ADA is proposing to provide.

The ADA strives to uphold high ethical standards within the dental profession. This includes encouraging members to act in accordance with relevant legislation and regulations.

For example, the ADA policy statement 6.26 regarding dental fees accessible on the ADA's website[3] reminds members of their obligations under competition law with respect to setting their own fees (except as permitted under the shared practice authorisation).

Should the re-authorisation application be successful, the ADA would expect to announce the fact to members, and as part of this remind members of their obligations under competition law, particularly with respect to the topic of pricing ***between*** dental practices.

Public benefits and detriments

Q3. We note the ADA's submission dated 23 May 2024 responds to Private Healthcare Australia's proposal to impose a condition of authorisation that 'all dental clinics covered by this authorisation use price displays for common services'. We note the ADA's response focuses on the impact of the proposal on consumers with private

[3] https://ada.org.au/policy-statement-6-26-dental-fees

health insurance. Noting the significant proportion of Australians who do not hold private health insurance cover for dental services, please provide further information in response to the proposal with regard to consumers without private health insurance.

Around 55% of the Australian population are listed in a general treatment membership of a private health insurance policy. Dental is the largest element of general treatment.[4,5] The ADA understands that more Australians hold private health insurance cover for dental services than do not.

The mix of patients in an average private general dental practice is therefore likely to be representative of the community in which it is located.

Statistics suggest that a significant portion of the Australian population avoids regular dental check-ups and only seek dental care when experiencing a problem. For example, around 49% of adults visited a dental professional in the prior 12 months, and around 33% who needed to see a dental professional delayed seeing or did not see one at least once in the previous 12 months.[6] These trends can be attributed to various factors, including lack of awareness about the importance of preventive care, cost concerns, or dental anxiety.

On the issue of price displays, the ADA notes that the proposal confuses what can be done in an individual authorisation and the wider issues (as discussed above). The merits of price displays in an industry are a complex equation (on the one hand transparency to consumers, on the other transparency to competitors[7]). However, it is always something that must be considered *at an industry level*, and it is not something that can be done via an individual authorisation. A condition attached to this authorisation would only apply to one type of practice structure (refer to schedule 3 of the application) involving an ADA member. It would not deliver consumers (insured or uninsured) the ability to meaningfully compare across practices.

The wider issue of how to achieve transparency for consumers *at an industry level* (should there be a case for this) is very complex, for two reasons:

a) Absent any standardisation effect of PHI conduct, for many scheduled treatment items there would be no standardised price to display in a competitive environment. Item numbers are based on treatment outcome, not the specific needs of the individual patient or the complexity of the treatment to get that outcome, i.e. the scheduled item is not reflective of the time or cost of the treatment involved, and therefore a matter for dental practitioners to assess how to price (as acknowledged in ADA policy statement 6.26).

b) Any meaningful assessment of this issue would require the ACCC to undertake a comprehensive investigation into any standardisation effect of PHI conduct, including the impact of non-discrimination/ 'MFN' practices, as discussed below.

Of relevance to the position of uninsured patients, as noted above, a lot of people do not go to the dentist until they have a problem[8]. Treatment for problems is particularly hard to price without seeing the patient. Accordingly, in this context, uninsured patients would not be assisted by price displays. However, it is important to understand that the ADA encourages dental practices to provide transparency when the patient has been assessed and to obtain informed financial consent to proceed with treatment (see the ADA's policy statement

[4] Quarterly private health insurance statistics Cross-industry. Available at: https://www.apra.gov.au/quarterly-private-health-insurance-statistics-0 (Accessed: 18 June 2024).
[5] Population Australian Bureau of Statistics. Available at: https://www.abs.gov.au/statistics/people/population (Accessed: 18 June 2024).
[6] Oral health and dental care in Australia, Summary Australian Institute of Health and Welfare. Available at: https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/summary (Accessed: 18 June 2024).
[7] e.g. petrol price boards
[8] Oral health and dental care in Australia, Summary Australian Institute of Health and Welfare. Available at: https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/summary (Accessed: 18 June 2024).

5.16 on informed financial consent accessible on the ADA's website[9]).

Q4. The application states that the potential for public detriments remains low, including because 'shared practices still have to compete with plenty of other dental practices in such localised geographic regions' and that 'there has been strong growth in contractual arrangements between dental practices and private health insurers under which the insurer sets fees (and other terms) in exchange for the right for the dental practice to participate in the insurer's "preferred provider" network' (paragraphs 9 & 11). Please provide the following:
a. Information or data supporting the claim that shared practices compete with many other dental practices in localised geographic regions (e.g. size and nature of different dental practices and number of customers, prominent players, number of dental practices in localised geographic regions (potentially by postcode)).

Over 85% of dental care in Australia is provided in private dental clinics. Private dental clinics may be owned by large corporates, private health insurance companies, individual dentists or partnerships. The range of legal structures that may be used in these dental practices is summarised in schedule 3 of the application.

In 2020, the number of FTE dentists in Australia, overall, was 57.9 per 100,000 population. The FTE rate of dentists ranged from 26.3 in remote and very remote areas to 63.8 in major cities.[10]

The Australian population is highly urban concentrated, and major cities and metropolitan areas have a higher concentration of dental practices due to a larger population base and higher demand.

Some remote and very remote areas can have few or even no dental practices. Factors like lower population density, difficulty attracting and retaining dental professionals, and economic limitations contribute to scarcity in certain areas. Efforts to supply oral health treatment in addition to physical practices can include visiting dentists, mobile dental clinics, higher rates of dental therapists, use of the Royal Flying Doctor Service, telehealth consultations, and focus on preventative care.

The ADA understands that most of the Australian population has reasonable access to more than one physical general dental practice. Those who do not are likely to reside in remote or very remote areas[11]. In relation to any such areas:

a) There would often be other alternatives open to patients including those described above.

b) It cannot be assumed that the only practice is a shared practice. It may be that the practice is a single dentist or dentists working as a team using one of the other legal structures where dentists do not need authorisation for intra-practice price setting (as per schedule 3 of the application) and therefore the position is not changed with or without this authorisation.

c) Where the only practice is a shared practice, as there are likely to be strong benefits from working as a team, it cannot be assumed that, in absence of authorisation, the dentists in the shared practice would stop working as a team and start competing with each other on price. It is more likely that they would use one of the other legal structures that would allow them to continue working as a team without authorisation (albeit that this may not have been their preferred legal structure) or simply stop practising (noting that one of the benefits of the shared practice structure recognised in previous authorisations is the potential to attract and retain practitioners in rural and remote areas – as noted on page 12 of the application).

b. Information around the extent and/or effect of private health insurance arrangements capping fees across

[9] https://ada.org.au/policy-statement-5-16-informed-financial-consent
[10] Oral health and dental care in Australia, Dental workforce Australian Institute of Health and Welfare. Available at: https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/dental-workforce (Accessed: 18 June 2024).
[11] Ibid

Australia.

As discussed above, around 55% of the Australian population are listed in a general treatment membership of a private health insurance policy. There are around 30 health funds currently operating in Australia, including for-profit and not-for-profit insurers.[12]

Some PHIs have their own dental practices. As far as the ADA is aware, PHIs who have their own dental practices include Bupa, NIB, HCF and Health Partners.

Several PHIs have 'preferred provider' arrangements with third-party dental practices who have chosen to enter such arrangements. The ADA believes that the ACCC has had visibility over only two of these, being the arrangements authorised in 2023. The ADA is aware of the following PHIs having such arrangements (but there may be more):

1) AIA Australia
2) Australian Unity
3) Bupa
4) GMHBA
5) HCF
6) Health Partners
7) Medibank Private
8) NIB
9) Peoplecare
10) Teachers Union Health Fund
11) Westfund

In addition, several PHIs have involuntary terms and conditions that automatically bind dentists as soon as the dentist treats a patient who is a member of that PHI (regardless of whether the dentist wants that or not). For example, in the ADA's 1 May 2023 submission (items 15, 16 and 17 of Table A) the ADA referred to evidence it had previously provided to the ACCC about BUPA's practice of making dentists bound by terms and conditions set by BUPA as soon as the dentist treats a patient who is a BUPA member. The way this works is as follows:

On BUPA's website[13] it says: "*Eligible members of our fund may receive benefits for ancillary services only if they are provided by practitioners who are recognised by the fund in private practice.*"

This reflects the position in BUPA's fund rules (i.e., the contract between BUPA and the consumer who takes out private health insurance with BUPA) which are accessible from the website[14] (under "Terms and Conditions"). Clause E.4(c)(ii) of the fund rules says that BUPA will not pay benefits for treatment by a practitioner who is not a 'Recognised Practitioner'. The term 'Recognised Practitioner' is defined to mean: "*a health care practitioner other than a Medical Practitioner in respect of whom we will pay Benefits for Treatment provided by that practitioner. We have sole and absolute discretion in determining if someone becomes or remains a Recognised Practitioner and for which of their Treatments we will pay Benefits.*"

The BUPA website[15] also contains BUPA's **Our Ancillary Provider Terms** which govern what being recognised by BUPA means. Practically, this means that, as soon as a BUPA member makes a claim for treatment by a dentist, that dentist is bound by these BUPA terms (with the onus on the dentist to search BUPA's website to find these terms and check for any changes to them).

[12] Register of private health insurers Cross-industry. Available at: https://www.apra.gov.au/register-of-private-health-insurers (Accessed: 18 June 2024).
[13] https://www.bupa.com.au/for-providers
[14] https://www.bupa.com.au/terms-and-conditions
[15] https://www.bupa.com.au/for-providers/ancillary/traditional-therapies

The Ancillary Providers Common Questions on the website[16] explains what happens if a dentist objects to being bound by these involuntary terms: "*Where providers do not adhere to our Ancillary provider terms, we may need to take action that may result in no longer recognising a provider for the purposes of paying benefits. This action does not affect a provider's ability to continue providing services, but it does mean that Bupa will no longer pay benefits for the services provided to Bupa members.*"

In the 2023 authorisation relating to the HCF 'More for Teeth Program', the ACCC (in paragraphs 4.33 – 4.37) raised important concerns about the operation of pricing restrictions, specifically 'most favoured nation' type clauses that effectively restrict Partner Practices from charging lower prices to patients who do not have insurance with the PHI. The ACCC noted the following in the 2023 authorisation:

> *4.33 … these provisions could have the potential to result in public detriment in the form of reduced competition in the provision of dental services by limiting Participating Providers' ability or incentive to offer any promotions to non-HCF member patients (including uninsured patients) that would be more beneficial than those offered to HCF members. …*
> *4.37. However, based on the information available to it at present, the ACCC considers the 'most favoured nation' clauses are likely to result in limited public detriment in the form of reduced competition in the provision of dental services in these particular circumstances. As noted above, HCF is a smaller provider of private health insurance in Australia and HCF's relatively small market share limits the impact the 'most favoured nation' clauses may have on competition in the provision of dental services, as it is unlikely the provision covers a sufficient share of the market to limit incentives for dentists to compete on price. The ACCC may have more serious concerns regarding the 'most favoured nation' clauses if HCF had a more significant market share.*

The ACCC's comments made it clear that there is potential for significant harm if these types of restrictions were to operate more widely. As the ADA has set out below, these types of restrictions *do, in fact,* operate more widely due to the insidious effect of non-discrimination provisions in PHI involuntary terms and conditions.

For example, outside the 'More for Teeth Program' examined by the ACCC in the 2023 authorisation, HCF also has involuntary terms and conditions - see **Terms and Conditions for HCF Recognised Providers of Extras Services** – on its website[17] that apply to any dentist who treats patients who are HCF members.

These involuntary terms and conditions contain a non-discrimination obligation in clause 4.1(o) which says dental practices must not: "*…discriminate against Members because they are covered by private health insurance or their membership with HCF including charging Members more than the Usual Charge that the Recognised Provider set for their goods or services (unless the Recognised Provider is participating in an HCF participating provider program that allows the Recognised Provider to charge a higher fee or they have HCF's express written permission).*"

As another example, BUPA's **Our Ancillary Provider Terms** clause 4(k) says that a BUPA-recognised provider (i.e., any dentist who treats patients who are BUPA members) must not: "*discriminate against or disadvantage Bupa customers, such as by charging them a fee for processing a health insurance claim*." The example of discrimination in the second half of this sentence does not limit the underlying obligation in the first half of this sentence which acts as a strong disincentive to discounting to patients who are not privately insured.

The significance of this is that if all dental practices in a particular area have at least some privately insured patients, then there may be a standardisation effect on price (including disincentive to discount) due to terms imposed by PHIs (whether under preferred provider arrangements or involuntary terms or both).

[16] https://www.bupa.com.au/for-providers/ancillary/ancillary-provider-common-questions
[17] https://www.hcf.com.au/provider-portals/dental/

However, that goes to the wider issues relating to PHI arrangements that the ACCC should examine. For the purposes of the statutory test applicable to this authorisation, the ADA believes there is no public detriment involved in the authorisation it has sought because:

a) The ADA is not seeking authorisation for any pricing conduct ***between*** dental practices and therefore competition between dental practices remains unchanged.

b) Consistent with the approach to mitigating against any public detriment in the previous authorisations, the ADA has focused on ensuring the authorisation is limited to genuine ***intra-practice*** setting in the context where dental practitioners are working as a team (see paragraph 4.4 of the application).

c) The authorisation sought by the ADA merely puts this one practice structure (shared practice) on the same footing as alternative practice structures with respect to ***intra-practice*** price setting (see schedule 3 of the application) allowing dental practitioners wanting to work as a team to choose the appropriate business structure for their needs and circumstances.

Thank you for your time and consideration. Should you wish to discuss further any matters raised in this submission, please contact Ms Eithne Irving, Interim Chief Executive Officer at .

Yours sincerely

Eithne Irving
Chief Executive Officer (Interim)
Australian Dental Association Inc.