AUSTRALIAN DENTAL ASSOCIATION INC.
14-16 Chandos Street
St Leonards NSW 2034

All Correspondence to:
PO Box 520 St Leonards NSW 1590

22 May 2015

General Manager
Small Business, Competition and Consumer Policy Division
The Treasury
Langton Crescent
PARKES ACT 2600

By email: competition@treasury.gov.au

Dear Sir/Madam,

**Submission in relation to the Competition Policy Review Final Report**

The Australian Dental Association (ADA) welcomes the opportunity to be involved in the consultation on the Competition Policy Review Final Report (the Final Report) dated 31 March 2015.

The ADA is the peak national professional body representing the vast majority of Australia's registered dentists and dentist students. ADA members work in both the public and private sectors.

In response to the Final Report, the ADA limits its comments at this stage to Recommendations 32 and 33.

In addition, and for the record, the ADA notes that in the event Recommendation 8 of the Final Report is accepted, the ADA wishes to be involved in any review of the regulatory restrictions concerning private health insurance (PHI). The anti-competitive operational practices of the PHI industry were a major focus of the two earlier ADA submissions to the Competition Policy Review Panel.[1] Please ensure that the ADA is notified of this review.

**Competition Policy in the Health sector – Guiding principles**

The ADA respectfully submits that Government, when considering the competitive framework in health service delivery sector, should prioritise the:

1. best interests of patients;
2. clinical independence of the treating practitioner; and
3. independence of the patient/practitioner relationship.

[1] Copies of our submissions are available on the ADA website as follows: Australian Dental Association: Submission dated 13 June 2014 to Competition Policy Review available at http://www.ada.org.au/App_CmsLib/Media/Lib/1406/M781438_v1_635386214849898729.pdf. Australian Dental Association: Submission dated 17 November 2014 in Reply to Draft Report dated 22 September 2014 available at: http://www.ada.org.au/App_CmsLib/Media/Lib/1411/M828367_v1_635518984852099241.pdf

With these priorities in mind, the ADA maintains that a competitive framework in the Dental health sector or any health sector for that matter should be underpinned by a commitment to ensuring:

i. the long term health interests of patients;
ii. recognition of the role that continuity of care has in quality health delivery;
iii. patients remain free to exercise independent choice in seeking health care;
iv. clinical independence of the treating health practitioner;
v. a level playing field amongst participants;
vi. where possible, monopolies are avoided;
vii. market concentration should not occur; and
viii. conduct by participants is assessed beyond short term cost benefits to consumers.

In health, quality of care and safety of patients should be paramount. Currently, the ADA sees that the pursuit of competitiveness is placing far too much emphasis on the cost of service delivery and is placing this before safety and quality. Too great a focus on cost compromises quality of care, resulting in poorer long term health outcomes and as a consequence additional costs long term. A false economy eventuates.

**ADA Comments regarding Recommendations 32 and 33**

The Final Report contains the following recommendations:

***Recommendation 32 – Third line forcing (subsections 47(6) and (7) of the CCA) should only be prohibited where it has the purpose, effect or likely effect of substantially lessening competition.***

***Alternatively***:

***Recommendation 33 – Section 47 of the CCA should be repealed and vertical restrictions (including third line forcing) and associated refusals to supply addressed by sections 45 and 46 (as amended in accordance with recommendation 30).***

To understand the ADA's comments in relation to these recommendations, it is necessary for the Government to have an appreciation of the role which the PHI industry plays in the Dental health sector.

**Private Health Insurance in Dental Health**

Ideally private health insurance should:

1. represent value for money for the insured (patient) by covering the cost of private health care including oral health care;
2. enable and respect the right of the insured (patient) to make an independent decision about the health care provider from whom they obtain care; and
3. ensure that at all times the best health care, including dental care, is obtained by the insured (patient).

However in practice, despite the high cost of health insurance and the importance of maintaining patient choice:

a. patients remain the biggest contributors to the cost of their oral health care;[2]
b. through the terms of their health insurance policies, the PHI interferes with patient choice by directing patients, either explicitly or through discriminatory rebate practices,[3] from their treating dentists to dentists contracted to their particular PHI funds; and
c. the PHI industry is able to assume an even more dominant role in the oral health care market due to their access to treating dentists' billing practices and patient records.

These developments are not in the interests of the patient nor do they enhance a competitive Dental health sector.

**Prohibition against third line forcing is a necessary protection**

Third line forcing is a category of exclusive dealing currently prohibited by sections 47(6) and 47(7) of the *Competition and Consumer Act 2010*. In simple terms, these sections prohibit the supply of good or services or the refusal to supply goods or services unless the purchaser agrees to purchase or acquires goods or services from a third party.

Health insurance policies which may breach these sections are a feature of the PHI industry and are likely to continue to expand in an increasingly unregulated environment.

Recently, the BUPA Australia Group was notified of an exemption from compliance with the provisions of sections 47(6) and 47(7) in respect of a New Youth Policy. [4] This BUPA policy only pays benefits on a health service, including a dental visit, if a policy holder seeks care from a *Members First network* provider. Members First network providers include dentists contracted to BUPA. Policy holders who seek dental care from *non-Members First* providers, including dentists who are not contracted with BUPA, do not receive any benefits under this policy.

Correspondence available on the Australian Competition and Consumer Commission (the ACCC) website concerning this notification, indicates that the notification was issued to BUPA without a full inquiry by the ACCC. The ACCC did not attempt to ascertain what the impact of such a policy may have on health care delivery relying almost entirely on the representations of BUPA. This is unsatisfactory.

ACCC in its role as the protector of the interests of the consumer should have investigated in some depth the ramifications of this BUPA policy. The issue of the notification represents the authorisation of a participant in the PHI industry (BUPA) taking away the right of a policy holder to choose their own treating health provider. A well respected concept, "continuity of care", has been cast aside and the health consequences to the consumer ignored.

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[2] AIHW 2014. Health expenditure Australia 2012-13. Health and welfare expenditure series no.52. Cat.no. HWE 61 available at http://www.aihw.gov.au/publication-detail/?id=60129548871 accessed 8 May 2015.
[3] Discriminatory rebates refer to the practice of some PHI funds paying different rebates to policy holders who hold the same health insurance policy if they do not seek dental care from a dentist who is contracted to a PHI fund.
[4] The ACCC Exclusive dealing notifications register Bupa Australia Pty ltd – Notification – N97766 available at http://registers.accc.gov.au/content/index.phtml/itemId/1181381/fromItemId/113339 accessed 8 May 2015

The ADA submits that this approach by BUPA and the ACCC indicates that without the retention of the prohibition in section 47, BUPA and other participants in the PHI industry will, ***without any oversight at all,*** increasingly require policy holders to acquire medical care, including dental care from nominated contracted dentists. This will result in a situation where the PHI industry is permitted to engage in anti-competitive practices which:

1. explicitly direct patients to seek care away from their own preferred treating provider to a provider contracted with a PHI industry fund; and
2. continue to reduce the amount of the rebate or alternatively not pay any rebate when patients exercise their own choice and continue to obtain oral health care from their treating health care provider.

Currently, the existing third line forcing provisions provide the best and least costly protection against such anti-competitive practices by BUPA and other participants in the PHI market. If sections 47(6) or 47(7) are either qualified, or repealed in their entirety, the approach of compelling patients to attend contracted dentists will continue to expand. This is a threat to the importance of the patient dentist relationship and has the potential to result in adverse health outcomes for patients.

**A final word about the practice of dentistry**

On the proviso that the best patient care can be assured, the ADA supports the strengthening of the CCA to improve the competition framework *to give small businesses a fair go*.

As an industry made up of professionals, dentistry is dominated by small businesses operated by sole practitioners or partnerships. Based on Australia wide data, ADA members operate in excess of 7500 dental practices which, in addition to delivering oral health care to the Australian public, generate significant employment opportunities for many Australians. A recent ADA survey reported that the average dental practice employs a total of 4.8 staff which represents a work force of approximately 36,000 people.

The role that the independent dentist plays in the Dental health market and the economy more broadly is a significant one. If recommendations 32 and 33 are adopted, it is the ADA's submission that both patients and dentists will be worse off. While recommendation 33 of the Final Report suggests that the revised sections 45 and 46 will be adequate protection against third line forcing, this is not the case.

Given the Dental health market is characterised by numerous participants and a dominant PHI industry, establishing anti-competitive conduct will be complicated and costly; well beyond the resources of our members and/or their patients. A future Dental health sector will accordingly be susceptible to the activities of large corporates with small businesses driven out. The sector will be monopolised by large corporate entities and the PHI industry.

We look forward to the consideration of these issues by the Department or Treasury. It is the ADA's submission generally in relation to the Final report and more specifically in relation to recommendations 32 and 33, that the case has not been made justifying a 'lighter' touch approach to regulation of the PHI industry in Dental health sector, or health sector at large.

The ADA would welcome an opportunity to meet with representatives of the Small Business, Competition and Consumer Policy Division of the Treasury to discuss the issues we have raised in this letter.

We will contact your offices directly to arrange a meeting time. If you have any questions in the meantime, please contact Mr Robert Boyd Boland, Chief Executive Officer of the ADA at ceo@ada.org.au.

Yours faithfully,

Dr Rick Olive AM RFD
Federal President