12 April 2012

Senate Finance and Public Administration Committees
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Senators

RE: Senate Finance and Public Administration Legislation Committee re inquiry into the Health Insurance (Dental Services) Bill 2012 (No. 2)

BACKGROUND TO MY SUBMISSION

I am a dental surgeon and sole owner of , the largest private dental practice in Australia. My practice, which I established as a sole operator over 20 years ago, now engages a total of 38 clinicians, including 11 registered dental specialists and 21 general dentists, operating in 25 surgical suites over three floors and the multi-level tower of the in Melbourne's CBD. The practice services more than 47,000 existing patients and attracts some 600 new patients each month. It is the only practice in Australia where multiple registered specialists work under the same roof with a team of general dentists. In size, revenue and number of clinicians, more than doubles the next biggest dental practice in the country. My business model's success stems from a clear understanding of the public's needs and the treating clinician's expectations.

My submission will focus on (1) the extraordinary and unacceptable levels of over-servicing within the dental industry, (2) the correlations that exist between over-servicing in the private health insurance (PHI) sector and the Chronic Disease Dental Scheme (CDDS), (3) the importance of maintaining the current protocols and rules set for the CDDS, and (4) the need for ongoing expansive audits of high-billing CDDS dentists in order to ensure that over-servicing has not taken place at the cost of public health or the public purse.

I have included in my appendices references to some of my correspondence with various Ministers, the Department of Health, the ACCC, the ADA, PHIAC, and the PHI Ombudsman detailing these issues that are seriously eroding public health and public funds. In this time I have spoken to and sought counsel from over 200 dental health practitioners across Australia.

It is my assessment that the silent majority of dentists are acutely aware of the threat posed by rogue health providers and businesses to their own practising principles, business viability and public health.

However, the lines between acceptable behaviour and what might be deemed to be fraud have become so increasingly blurred that momentum is tipping in

favour of the vocal minority. In reaction to the increasing financial pressures on small business, the exertion of fee setting controls by private health funds, and the reduction in checks and balances caused by the introduction of electronic claiming in relation to private health insurance, and now the proposed dental services Bill in relation to the CDDS, the aforementioned minority group is proliferating, with numerous adverse consequences.

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Dental Surgeon

Submission by Dr Kia Pajouhesh to Senate Finance and Public Administration Legislation Committee re inquiry into the Health Insurance (Dental Services) Bill 2012 (No. 2)

As a matter of principle, I oppose any legislation or regulation that would serve to reduce the compliance parameters currently required for dental practitioners to seek Medicare funding under the Chronic Disease Dental Scheme (CDDS).

I refute any assertions that the current administrative processes are cumbersome and unnecessary, and that Medicare did not provide dental practitioners with adequate information about the scheme.

I believe that some patients treated by dental practitioners who did not comply with all the rules of the scheme may have been adversely affected in various ways, including potential for physical and/or administrative over-servicing standards and practices to deny the patient adequate care and in turn cost the taxpayer unnecessarily.

One rule in particular – namely the provision of an itemised treatment plan and written quotation before treatment begins – is a fundamental safeguard that must be upheld rigorously to ensure the provision of (1) good medicine, (2) patient acceptance, (3) provider compliance, and (4) transparency for audit and complaint resolution purposes. This is no different from the underlying expectation the Dental Board of Australia places on dental practitioners to provide services to privately paying patients in this country.

My submission is based on nine key issues, as follows.

1 <u>The challenge with “administrative oversights”</u>

Whenever a Medicare dental audit discovers services charged for and not provided, the respondent invariably argues that the oversight was either (a) an administrative error or (b) an instance of care yet to be provided in good faith but charged for at an earlier date.

As I understand it, Medicare has thus far in many cases accepted both of these arguments as reasonable, flying in the face of prosecution as a deterrent.

A substantial amount of potential fraud has also been tossed into the “administrative error” basket, tarnishing the efforts of the Department of Health Services (DHS) and the Government.

In an MTR radio interview on 12 October 2011, the Hon. Tanya Plibersek MP noted that, in one Medicare audit, "more than $25,000 has already been voluntarily repaid because... the practice themselves have identified that they have not properly charged or have charged for work that hasn't happened". The Minister, backed by the Department of Health, went on to deem this instance an "administrative oversight".

2 Over-servicing and fraud

In the provision of health services as a business, fraud can only mean one thing: over-servicing. It is that simple. While in most people's minds the word *fraud* conjures up criminal activity, the term *over-servicing* somehow sounds a lot more benign. And yet, in the health industry, over-servicing IS fraud – nothing less and nothing more.

There is only one way to commit fraud in the health industry, and that is to over-service a patient.

Administrative over-servicing occurs on paper and in computer software. Physical over-servicing is done in the patient's body. *Sadly, in our community, vested interest groups have adopted a foolproof self-preserving position.* On record, they make statements that they will deal harshly with any practitioner committing "fraud", but at the same time they argue that virtually all examples of "administrative over-servicing" are simple errors and oversights and virtually all "physical over-servicing" boils down to variance in opinion and treatment modalities among clinicians in the provision of health care. Only the most blatant cases of fraud – those that border on flagrant stupidity – ever see prosecution. *The net result is a health industry, and in particular a dental industry, that is becoming ever more reliant on over-servicing principles for its viability. In other words, over-servicing is now endemic within our system.*

3 Why is over-servicing becoming such a large problem in our current dental health system?

All private dental practices, as professional businesses, depend for their financial viability on a basic average hourly rate of revenue. While this factor is a constant in all dental businesses, the figure itself can vary from clinic to clinic – subject to numerous factors, including (but not limited to) location, specialised equipment, specialised clinicians, and management principles.

On any level playing field, natural economic forces will determine the fees that a practice can set to remain viable by continuing to attract patients who will invariably weigh up the cost versus the level of service. In such an environment, over-servicing may still exist but it usually amounts to greed rather than necessity.

In the controlled and contracted environments of preferred-provider private health insurance schemes (and, in a somewhat similar fashion, under the CDDS), dentists are engaged to carry out works at fees *often well below their regular scheduled practise fees*. This one factor is the motivation, out of sheer necessity rather than greed that converts honest clinicians into over-servicers, both administratively and physically.

As indicated throughout my submission and in the evidence I provide, over-servicing becomes endemic when dentists and their businesses are contracted or

'cornered' into one-size-fits-all scheduled fees below their standard fees. A comparison between the key clinical care indicators of a dentist offering general private dental care to a member of the public and a contracted dentist offering dental care within a predetermined government or private health insurance fee schedule will show the extent of the over-servicing problem. *Appendix A* demonstrates the variation that exists between the two groups in the provision of more lucrative procedures such as dental crowns within the CDDS. *Appendices and D* demonstrate the substantial and statistically significant variation that exists between the two groups in the provision of additional item numbers and services in private health insurance.

One can argue that there is always a choice for a practitioner to partake in any of these schemes, yet careful analysis of this notion proves it to be a fallacy. For example, in outer suburban areas or country towns, where two or three practices are servicing an entire community, the decision to not join any of the available schemes would be tantamount to business suicide. Central business district practices do not fare much better. As more patients join private health insurance companies actively pushing their preferred provider schemes, and as more patients become aware of schemes such as the CDDS in its bulk-billing potential, dentists are left with little or no option but to take part, usually quite unwillingly, in such schemes.

In *Appendices and D*, I demonstrate that competition businesses that overtly embrace such schemes and still stay viable are all too often willing to bend the rules by way of physical or administrative over-servicing. This leaves every honest clinician with a huge dilemma to join ranks or suffer considerable losses.

4 <u>The importance of maintaining good processes</u>

Health correspondent Mark Metherell, writing in the Melbourne *Age* on 20 October 2011, reported that Medicare had received 700 patient complaints regarding dentists and the Chronic Illness funding scheme, a proportion being as a result of patients finding out later, when seeing another dentist, that the first dentist had already made the full claim of $4250 from Medicare. If over-servicing of this nature has happened, how many more cases like this exist where patients have not become aware of the problem because they didn't swap dentists? Only a very small minority of patients swap dentists mid-treatment.

The above finding highlights just how important it has been for Medicare to demand that treatment plans and quotations be sent to the patient and the treating GP. The significance is above and beyond the obvious one, which is that a chronic condition requires ongoing input from the GP, and excluding the GP would negate the benefit in such a scheme.

Various dentists have argued that most GPs are just filing these notes without even reading them because they trust that the dentist knows best and is doing the right thing for the patient's oral health.

Other crucial benefits of adhering to the current system include the following.

(a) *The patient would be fully informed of the amount the dentist was to claim from Medicare and would need to agree with it before they began treatment.* Otherwise, by keeping the patient in the dark, a dentist intent on bending the rules can claim whatever they want, including work that may never have been administered at all or never fully completed to the satisfaction of the patient, thus removing the patient as an effective auditor of the Medicare claiming process. In summary, when legislated protocols are not followed properly by dentists and the patient is not provided with a treatment plan and itemised quotation before start of care, they have effectively been removed as an active participant and auditor of their own health program. This has the dire consequence that choice of treatments is based on the clinician's expectations rather than the patient's genuine needs.

(b) *In a simple and inexpensive Medicare audit, the GP can supply Medicare with the patient's pre-approved treatment plan and this can be cross-checked against the dentist's claim amount.* In instances where due process has been dismissed, GPs are not able to provide Medicare with a quote and treatment plan, making the process of auditing the dentist far more cumbersome and expensive. Such flouting of due process also leaves the way open for retrospective doctoring of the notes and the numbers by the audited dentist, a practice that can only be cross-checked by widening the audit net to include interviewing and examining the patients. This is why Medicare's current dentist auditing process is very slow, somewhat ineffective and costing the taxpayer more than it should. Furthermore, less money is being retrieved from the over-servicing providers, thus limiting the funds available to Australians in desperate need of dental services.

(c) *In the event of patient complaints such as those mentioned above, where the patient may claim not to have received a particular treatment plan or quotation, a simple cross-check against the GP's records would show whether the dentist has a case to answer in terms of over-servicing.* Any patient complaints where there is a clear match between the total claimed and the GP's records would be deemed a service-related complaint, while any that reveal significantly divergent numbers would point to the likelihood of over-servicing. In the absence of cross-checks, Medicare cannot currently monitor this with any ease or certainty.

5 How much of a problem is over-servicing within the CDDS?

(*Refer to Appendix A.*)

ABC TV's *7.30* program of 30 December 2011 and an article by Sue Dunlevy published in *The Australian* the following day both quoted a study by the Westmead Centre for Oral Health at the University of Sydney. The study, which analysed the CDDS, showed that, within the scheme, approximately one in two CDDS patients had a crown inserted. It also showed that one third of the funds spent under the scheme were for dentures and approximately another third for crown and bridge work.

With the prevalence of poor home care, gum disease, dental decay, tooth wear

and tooth loss amongst the general Australian public, particularly those with a chronic medical condition, I am astounded that the statistics are highlighting the vast majority of dentists' failure to treat these patients' mouths with holistic, low cost treatment methods such as multiple gum treatments, and dental restorations with less expensive yet durable alternatives. *The statistic of 14.7% for oral hygiene instructions is a damning one when it is noted that 100% of all chronically ill patients would be well served by the provision of this type of care.*

However, the fact that one in two patients receive a dental crown must raise some doubt about the nature of care patients have received under this scheme. *To ascertain whether over-servicing has taken place in relation to any one service such as crowns and bridges, one must compare the percentage of revenue raised in the CDDS scheme across all dentists for an item such as a crown, and the percentage of revenue raised for the same item number across all dentists in general private practice.*

I have good reason to expect that these figures will differ by several multiples, demonstrating clearly and indisputably the high level of over-servicing that has plagued the CDDS at a cost to the taxpayer and to patient wellbeing. Not only is it adversely affecting the public purse, but the public's dental health is at risk while patients continue to utilise the program in its current form.

6 CDDS audits – have they unearthed a much bigger problem?

I have evidence that the CDDS Medicare audits have uncovered an over-servicing pattern that is already rife within the private health insurance system, and in particular within the preferred provider schemes, and which is costing the public through the 30% rebate scheme and public ownership of Medibank Private.

I believe that the health funds and their regulatory bodies are not doing enough to tackle this problem. Their reluctance is due partly to the sheer enormity of the issues and partly to the threat that exposing all the facts may pose to the rebate scheme because it will show that this public funding is aiding over-servicing behaviour in the ancillary health industry.

A five-minute analysis of the top 100 billing practices in the CDDS program will reveal that they are largely made up of the 1 in 5 (and growing) practices in the country that have aggressively embraced private health insurance–contracted preferred-provider programs. This is no mere coincidence. What is even more alarming is that this "club" comprises practices with the business model I refer to in my paper "Over-servicing health – The practitioner's dilemma": over the past five to seven years, my analysis of my industry points to the fact that these dental practices have been the fastest growing practices in the country, thriving at levels of revenue growth far beyond others.

Appendix details the substantial variation of claiming behaviour between the HBA-preferred providers contracted to PHI-determined maximum fees and the general population of dentists carrying out procedures on HBA clients. In this analysis, procedures that leave no trace in the mouth and are therefore

considered by over-servicing providers as audit proof are used in substantially higher amounts by preferred provider dentists than by control general population dentists. These procedures include extended vs standard consultation, application of fluoride, oral photographs, tooth vitality testing, provision of study models, and placement of medicaments hidden beneath restorations. The sample size of this analysis is substantial and the statistically significant variations in behaviour for a small handful of item numbers (procedures) is damning evidence that the servicing behaviours of dentists change significantly depending on the contracted conditions within which they practise. *I have sought similar analyses from Medibank Private especially in relation to dental X rays, and in particular the OPG full mouth radiograph, but to no avail.*

"Creative care", a term coined by Mr George Savvides, managing director of Medibank Private, may explain the significant statistical variation between the number of procedures carried out in any given treatment appointment by preferred-provider PHI-contracted dentists and non-contracted dentists (*see Appendix C*). I understand this is approximately 5 to 5.5 for general-population non-contracted dentists versus approximately 6.5 to 7 for preferred provider–contracted dentists, depending on the state or territory under analysis. Interestingly, Mr Savvides also admits that dentists' procedure coding behaviours change when they are aware that they may be under scrutiny. This should come as no surprise, as results in market research (*Appendices J and K*) shows 71% of respondents believe that the person operating the electronic claims machine can influence one's out-of-pocket expenses. That is to say, more than two thirds of people believe item numbers can be manipulated by the health practitioner to improve health rebate levels, in a system that should be inherently black-and-white.

How can such a substantial difference in clinical behaviour be viewed other than as administrative or physical over-servicing in a health provider's attempt to compensate for the reduced contracted fees? In *Appendix D* and *Appendix T*, I demonstrate each and every practitioner's dilemma in maintaining financial viability within the constraints of our current and developing system.

To this end, for almost four years, I have been writing to various ministers, the Department of Health, the ADA, the ACCC, PHIAC, and the PHI Ombudsman detailing these and many other serious issues in relation to PHI funds that are adversely affecting public health and public funds. All parties have stated categorically that the problem of over-servicing is within reasonable limits and is being effectively combated by the health funds. (*See Appendices E, F,* .)

7 <u>The patient in PHI claims, and if possible the referring GP in CDDS claims, must be active auditors in all claims processes</u>

In *Appendix* I detail the important role of the patient as an active auditor in all private health insurance claims. This can be achieved by claims processes that ensure that the integrity of the patient co-payment, commonly known as the "gap" payment, is maintained, and not minimised or avoided altogether by the

health practitioner to increase patient compliance in relation to potential administrative and/or physical over-servicing behaviours (*see Appendix O*).

The electronic claims process currently offered by HICAPS and IBA for private health insurance claims does nothing to ensure that the gap payment has been paid within the relevant transaction. A simple change in the sequence of steps within the electronic claims process to ensure the required gap payment is made would incorporate the patient in the process as a more engaged effective auditor and hence help to actively reduce the incidence of over-servicing. Every time a no-gap claim is processed for a private health insurance ancillary claim, a discrepancy is created between the revenue figures collected by the private health funds and the actual figures lodged by the business to the ATO. As this is occurring across the ancillary health industry on a large and ever-growing scale, the figures provided by the health funds each year to the Department of Health are substantially flawed. The underlying reason for this is that the process often requires the practitioner to make a full claim for all procedures carried out, then opting to accept the health-insurance rebate only without demanding a co-payment from the patient. Although the electronic claims terminal, and in turn the health fund is of the belief that the co-payment has been paid, this is not necessarily the case.

Health practitioner businesses providing no-gap or reduced-gap services are therefore running two sets of financial books, one being the auditable trail from their electronic claims terminal that the health funds and the government are relying on for policy development, and the other being the accounting numbers on their own computer software they are relying on to collate their true revenue figures for tax assessment each year.

In the CDDS program, although there is provision for a co-payment by the patient, bulk billing at the recommended Medicare fees has been systemically and yet somewhat unwillingly embraced by dentists in Australia. It is a universally accepted fact that the bulk-billing fees recommended by Medicare for the CDDS are well below the required income levels necessary to maintain the hourly rate required to run a financially profitable dental business. So why have so many dentists opted to bulk bill in the face of financial loss?

At the core it was public pressure and therefore a market driven phenomenon, as chronically ill patients with a history of Medicare bulk billing were demanding nil out-of-pocket dental care. The dentists in response fell into two broad categories. The first were those dentists who cared for CDDS patients on sound dental principles and incurred inevitable financial loss to assist the most needy in our society. By virtue of this business model, they could only absorb limited numbers of CDDS patients within their existing practices. *Some of these dentists are the genuine victims of the Medicare audits into the CDDS.* The second were dentists who altered their dental principles into the realm of administrative or physical over-servicing to compensate for the financial short fall and in doing so convert the scheme into a financially profitable proposition.

All dentists undergoing an audit, in defence, will claim they are in the philanthropic group. The disproportionate numbers of CDDS patients seen by many dentists, and the aggressive marketing carried out by dentists earlier in the program flies in the face of this plea. Market research (*Appendices J and K*) shows that a reduction in out-of-pocket expenses to a patient will result in a reduction of the patient's scrutiny of the process. Therefore, a dentist intent on over-servicing will do so more proficiently when bulk-billing a patient. However, in the context of reduced patient monitoring, it is still imperative that patients and their referring GPs within the CDDS are provided with an itemised treatment plan and quotation before any formal treatment begins. This step would not only improve the parameters for the provision of good medicine but also ensure some patient participation in policing any potential over servicing.

8 <u>What are the benefits of continuing the Medicare audits and retaining strict compliance processes?</u>

I am aware of dental practitioners who continue to flout the CDDS program by charging Medicare for treatment that may not be consistent with their patients' needs and for treatment they have not yet carried out.

My evidence, however, is anecdotal and far less prevalent than, say, two to three years ago, when dentists were canvassing CDDS patients by way of Internet marketing (*Appendix P*), print advertising and mail drops. The net result of the Medicare audits is best embodied in the reduction of the cost of treating patients in the CDDS. In *Appendix L*, I outline the underlying cause of a pattern of reduced claims by dental providers over the past 12 to 18 months as a direct consequence of the reduction in physical and administrative over-servicing in the total bill to Medicare.

9 <u>Is our over-servicing already beyond the point of no return?</u>

The private health insurance industry maintains that "fraud" within the system amounts to approximately 1% to 2% of total revenues. However, senior members of various funds and their associations privately make utterings that the cost of over-servicing is more in the order of a double-digit percentage. This is because no one has a handle on the extent of administrative and physical over-servicing in the dental industry. So entrenched has the over-servicing become that the definitions of over-servicing and fraud are being continually reassessed by health funds. Statistics provided in part 4 of this submission and *Appendix* point to a much greater problem. What is even more alarming is the fact that the blatant behavioural variation between preferred providers and the general population of dentists (*as noted in Appendices and C*) is above and beyond the basic over-servicing that occurs in any system. However, with all the best intentions, the private health funds are constrained by their deep entrenchment in an over-servicing problem that is now endemic in the health insurance system.

In respect of the ADA, I made a presentation to their Schedule and Third-party committee on 16 July 2010 on the topic of over-servicing in the dental industry. In it, I referred to honest dentists as "white sheep" and over-servicing ones as

"black sheep". At the conclusion of my talk the chairman of the committee stated "the black sheep are also members of the ADA". I mention this not to call into question an association I am honoured to be part of but to say that there comes a point where checks and balances can tip in the wrong direction. It is apparent that the "black sheep" membership is growing, and the ADA (which represents all dentists) must continually adapt.

Dental providers in the current climate have no choice but to respond to patient demands of expecting minimal out-of-pocket expenses, to adapt to increasing business pressures, and to engage against competition forces able to offer more attractive alternatives, by bending the rules. They are therefore left with little or no option but to follow suit or risk annihilation. In *Appendix D*, I outline the practitioner's dilemma in our endemic problem.

The CDDS audits have caught many dental providers on the hop. For so long, over-servicing protocols have been part of their business model and have gone undetected thanks to the flexibility shown by PHI companies. Medicare and their auditors have not been so accommodating by specifically targeting the most active claimants; hence the problem has reared its ugly head. It is now up to Federal Government to address this problem and to face the dilemma of either standing firm and continuing the tough stance of exposing the problem or bending to vested interests at a cost of all Australians. Independent market research (*Appendices J and K*) reveals that around two-thirds of respondents believe any such problems must be tackled by the Federal Government rather than left to the health practitioners or private health funds to sort out.

<u>In conclusion</u>

As I am not familiar with the details pertaining to each specific auditable case, I have made no comment in relation to the enforcement of refunds from individual dentists by Medicare Australia. However, I would like to conclude as follows.

- The threat of audits with harsh consequences has already reduced and will continue to diminish the appetite for over-servicing by dentists partaking in the CDDS. The net result however will be less dentists partaking in the current scheme because the provision of good medicine within the scheme will not remain viable with the prescribed recommended bulk-billing fees that have been set by Medicare.
- In *Appendix M*, I briefly outline the solutions for combating over-servicing in the CDDS, where further investigations by various government bodies and professional associations must be carried out, both on a system level and on an individual practitioner level, to clear the muddy waters that currently exist between physical over-servicing vs good medicine, and administrative over-servicing vs clerical oversights. This will need to happen in relation not only to the CDDS but also Veterans' Affairs public funding, private health insurance, and any future public funding for dental health by way of a Denticare system or equivalent.

- Providing the patient and the referring GP with an itemised treatment plan and quotation before clinical care begins is a crucial step towards ensuring the delivery of good medicine – and indeed the only effective method this current system has to render the patient and the referring GP active participants in the process, thus offering them the opportunity to vet the care plan for both administrative and physical over-servicing.

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APPENDIX A
The Chronic Disease Dental Scheme (CDDS) – is it open to rorting by dentists who over-service?

ABC TV's *7.30* program of 30 December 2011 and an article by Sue Dunlevy published in *The Australian* the following day both quoted a study by the Westmead Centre for Oral Health at the University of Sydney. The study, which analysed the CDDS, shows that approximately one in two CDDS patients had a crown inserted within the scheme. It also showed that one third of the funds spent under the scheme was for dentures and approximately another third for crown and bridge work. However, Hans Zoellner, one of the authors of the study, argued on *7.30* that there is no indication of widespread rorting in the system, for two reasons:

a) most claims fell well short of the maximum claimable amount and if widespread over-servicing was occurring then most of these claims would be at the upper end of the $4250 limit
b) it may be perfectly clinically justifiable that each and every patient who received a crown or bridge needed it.

I am at a loss to understand either of these claims. My reasons include the following.

In relation to point (a), an analogy will serve my argument well.

Any taxi driver will tell you they prefer to pick up one long fare to the airport rather than take four or five short fares around town. The short trips will help out more people, will keep the taxi on the road rather than in a long queue at the destination, and will make just as much money if not more in the same time frame; yet every driver hankers for the customer bearing luggage.

Why?

Maybe because the long trip is easier, with less stress and traffic. Maybe because a reasonable fee can be made and the wait at the other end is time for a nap or a cup of tea, or a chat with a colleague. But in a nutshell, excluding the wait times, the trip to the airport is a strong lure for most taxi drivers.

The same fundamentals apply in the provision of dentistry. A well-orchestrated treatment plan comprehensively addressing the patient's home care program, gum problems, dental decay, teeth wear-and-tear and bite issues, all requiring a series of appointments based on maximizing the bang for buck for the patient, is equivalent to the taxi driver running all over town on short trips when the airport option beckons.

Note that, at $400 to $450 per hour (the average hourly rate for most private dental practices), the CDDS affords patients around 10 to 11 hours of dentistry – or, say, as many as 11 one-hour appointments. Any dentist will tell you that a great deal of good can be achieved by way of wholesome dental care in so many appointments. For patients on the CDDS, this care should be focusing on lower cost procedures focusing on oral hygiene instructions, and removal of gum infections, dental decay and dental infections as a starting point for the first phase of treatment.

However, at the pre-designated Medicare CDDS fees which are well below the industry standards required for running a viable dental business - the administration of good medicine would either need to be done by the clinician at substantial financial loss, or the 'modus operandi' of care would need to be shifted to an over servicing stance to make the treatment of CDDS patients financially equitable. Although inexcusable, this is the precipitating factor, out of sheer necessity, behind the administrative and physical over servicing patterns observed in the CDDS. The number of crowns and bridges that have been claimed under the scheme support this point, since crown and bridge work is one of the most financially lucrative procedures on an hourly rate basis, available within the CDDS.

What we are seeing in the results of the Westmead study is certainly many dentists who have carried out the best medicine they could provide within the constraints of the scheduled fees, yet also a smaller and quite significant number of dentists embracing the CDDS who chose to skim the cream: by treatment planning $1500 to $2500 of work across two or three appointments and offering high net earning treatment options such as partial dentures and crowns. In other words, we see certain opportunistic clinicians opting for the simplest and straightest path to generating their income at the hourly rate they needed to make the program work for them – that is, still retaining an adequate hourly rate to produce a profit, albeit reduced.

With the prevalence of poor home care, gum disease, dental decay, tooth wear and tooth loss amongst the general Australian public, particularly those with a chronic medical condition, I am astounded that the statistics are highlighting the vast majority of dentists' failure to treat these patients' mouths with holistic, low cost treatment methods such as multiple gum treatments, and dental restorations with less expensive yet durable alternatives. It is clear that some dentists have placed income ahead of good medicine. This is akin to the airport run for taxi drivers. Good for the driver, but not of service to a public in need of transport. ***The statistic of 14.7% for oral hygiene instructions is a damning figure when you consider that 100% of all chronically ill patients would be well served by the provision of this type of care.***

In relation to point (b), as I have stated before, the dental community will always justify physical over-servicing of this nature as falling within the boundaries of a clinician's choice of treatment modalities.

However, one in two patients receiving a dental crown must raise some doubt about the nature of care patients have received under this scheme. ***To ascertain whether over-servicing has taken place in relation to any one service such as dentures or crowns and bridges, one must compare the percentage of revenue raised in the CDDS scheme across all dentists for an item such as a crown, and the percentage of revenue raised for the same item number across all dentists in general private practice.***

I have good reason to expect that these figures will differ by several multiples, demonstrating clearly and indisputably the over-servicing that has plagued the CDDS at a cost to the tax payer and to patient wellbeing. Not only is it adversely affecting the public purse, but the public's dental health is at risk while patients continue to utilise the program in its current form.

Any publicly funded dental scheme of the future must inherently deter over-servicing and address the fact that the core needs of the public do not necessarily coincide with the business expectations of the clinician and both of these must be carefully managed.

Finally, I would like to address the patient's role in the CDDS over-servicing debacle and pose three explanations for why this has been so limited.

1. When a dental service is free, the driver of the treatment plan will be the dentist. This is because the patient has less say in something they are not paying for; they are just happy getting something for free! If the funds were allocated to eligible members of the public by way of a token system, for example, they would spend each dollar more carefully, ensuring that they receive the best value for their limited tokens. In private practice, dentists know for a fact that the most effective deterrent to over-servicing is the patient's budgetary constraints and out of pocket expenditure.

2. When legislated protocols are not followed properly by dentists and the patient is not provided with a treatment plan and quotation before commencement of care, they have effectively been removed as an active auditor of their own health program. This has the dire consequence that in some cases, choice of treatments is based on the clinician's expectations rather than the patient's genuine needs.

3. Over-serviced patients who have had their allocated funds spent on high net earning procedures, leaving them with unresolved dental problems, would be feeling grief and disenchantment in the scheme and dental clinicians as a whole.

In conclusion, I feel compelled to point out that an apparent obsession with controlling dentists' fees is at the core of this problem. **In attempting to curb the behaviour of a minority of overcharging dentists whose businesses are doomed in any case, these systems make over servicing an endemic amongst the majority.** ***Dentists are sometimes having to over-service patients, administratively and physically, to make a fixed fee program such as the CDDS***

viable. Some of this over-servicing may be greed, but in most cases it may simply be the fact that the scheduled fees are not in keeping with the costs of running a dental practice in 2012 and at the same time enabling a clinician to provide good medicine not biased towards over-servicing. Every practice is different and the provision of good care across socioeconomic and geographical boundaries cannot be dealt with in a "one fee schedule fits all" mentality. Patients requiring care involving expensive equipment, specialist care or vast clinical experience will be turned away by suitable care providers and attended by practices that are either running dysfunctionally on extremely low overheads or using business principles that allow for over-servicing protocols to compensate for the financial shortfall.

If patients in need of public funding were allocated funds and in turn were able to choose their dentists according to credentials and fees charged, programs such as the CDDS would be self-monitored by market forces by way of competition and patients would receive treatment consistent with the principles of good medicine driven by good economics, rather than a skewed version of care that is clearly not consistent with that received by the rest of the population, those who can afford dental care.

Dr Kia Pajouhesh

B.Sc. (Melb) B.D.Sc. (Melb)

Dental surgeon

APPENDIX C

Comments and questions in response to Mr George Savvides, Managing Director, Medibank Private Ltd, before the Finance and Public Administration Legislation Committee – 18/10/2011 – Estimates – FINANCE AND DEREGULATION PORTFOLIO

Senator BERNARDI: Mr Savvides, I want to ask you a few questions about that innocuous term 'benefit leakage'. Basically, it is fraud upon private health insurance funds. At the time, if I recall correctly, there was some suggestion that benefit leakage was costing the private health insurance industry up to $800 million per year. What steps have you taken to redress or reduce the incidence of fraud on Medibank Private?

Mr Savvides: I think our calculations are sitting between one per cent and two per cent.

How is this figure calculated? Is this percentage demonstrating fraud; or is it leakage, as you term it? Overt fraud is easier to quantify because it is traceable to some degree. Leakage in the form of physical over-servicing cannot be traced at all, and leakage in the form of administrative over-servicing is systemic in the industry as an almost standard protocol. It is virtually impossible to detect via retrospective audits, especially in relation to item numbers relating to procedures that leave no trace, termed as "high-risk items" (see HBA health insurance letter dated 13 February 2008).

It is still a significant amount of money. I am not sure if the Senate is aware, but we actually employ over 20 private investigators. The issue of leakage is important. We do have quite a lot of people invested in tracking and analysing the claims data. Sadly, we do find providers who do the wrong thing. When we do, the police are informed and the appropriate activities occur post that.

With 20 private investigators, and fraud estimated at 1% to 2% of total claims expenditure, one would assume a great many providers may be doing the wrong thing. How many times have the police been called by Medibank Private in, say, the past 12 months?

More and more, systems are used for detection. Some of the leakage you could characterise as overservicing.

All fraud and leakage is, in one form or another, over-servicing. It either takes the form of physical over-servicing, whereby unnecessary treatment is carried out on a patient; or administrative over-servicing, whereby treatment either not carried out or only partly carried out is claimed for.

When we find that, we tighten up contracts and service arrangements or we make sure that our members' choice providers follow a very strong program of right care rather than creative care, if you like. That is something we constantly monitor. Leakage in this area costs all of the membership more premiums and we are trying to minimise that.

"Creative care" seems like a very interesting concept. Is leakage more prevalent amongst your members' choice providers? Can you please explain the significant statistical variation between the number of procedures carried out per visit by members' choice providers and the number carried out by other providers? We have been advised by industry experts that this is approximately 5 to 5.5 versus approximately 6.5 to 7 in dentistry, depending on the state or territory you are analysing. Can you please confirm this? Is this no, mostly as a result of over-servicing? If not, how else can you explain such a substantial difference in clinical behaviour? By definition, if a minority group of providers carries out 1 to 2 more procedures per visit than the average, is that not deemed to be over-servicing? Can you please quantify what portion of these additional services is administrative over-servicing (where the item numbers have been utilised for work not done) and what portion is physical over-servicing (where additional procedures such as X-rays and the like are being taken)? As these additional procedures are in fact over-servicing relative to the majority consensus, do they form part of your leakage calculations? Because it seems an additional 15% to 25% usage of item numbers, whether for administrative over-servicing or physical over-servicing, across approximately 1/4 of all dentists, would amount to leakage figures well above the 1% to 2 % you are quoting.

Senator BERNARDI: You are estimating the figure at one or two per cent. What is the dollar value of that to your policyholders?

Mr Savvides: It is $40 million or $50 million a year, going up to $80 million or $90 million depending on where you are in the range of one to two per cent. You can never know precisely what people are doing. It is bizarre to say this but it happens in other places so I will share it with you. For example, when we do audits we write a letter to, say, 2,000 or 3,000 dental providers in a region, informing them that we are just doing audits of our contractual compliance. It is funny that, in the three-month period of audit, the claims drop a few percentage points, because we are watching and analysing.

So, in fact, when dentists know they are being watched, their behaviour changes. Do you have any data on whether the members' choice dentists change behaviour more than others, or is the behaviour change consistent among all dentists? Is it plausible that the CDDS Medicare audits have resulted in "improved" behaviour amongst participating dentists?

It does not drop from everyone; it drops from the two or three providers that are doing the wrong thing.

We have been doing this now for 10 years and we have a very strong team which has a very good skill set. We share our methodologies with the industry—not the content but the methodology. We try to encourage the rest of the industry to be sharp in this area as well because, if one health fund is weak in this area, it opens the back door for infiltration to the provider network.

Senator BERNARDI: Have you seen a reduction over those 10 years?

Mr Savvides: Yes.

Senator BERNARDI: Can you quantify that?

Mr Savvides: Yes. We get probably two to three times the money back into the health fund for the cost of the investigations that we undertake and the manpower within that.

If it is cost effective, why not throw 40 or 60 or 100 investigators at it when there is $80 million to $90 million to chase. Do you feel the limit of detection has been reached and more investigators would not necessarily recoup any more fraud money?

An interesting calculation: 20 investigators on an average income of, say, $75,000 amounts to $1.5 million total. So you recoup $3 to $4.5 million (2 to 3 times manpower cost) from, as you call it, providers doing the wrong thing. Can you tell us the exact figure that you recoup? In effect, less than 5% of the "detectable" total fraud in the industry is being recouped.

Senator BERNARDI: Are you in a position to tell me what the results of a successful investigation are in respect of not only the repayment of funds but also whether there is disciplinary action against the provider?

Mr Savvides: Yes. If it is a breach of the law the provider is deregistered by their professional association, they are reported through and the police take action as well. So that is a very successful outcome.

By "deregistered by their association", do you mean the ADA? My understanding is that you don't need to be part of the ADA to practice dentistry in Australia. Or are you referring to deregistered from the profession, as in AHPRA and the national Dental Board? Do you know how many dentists were deregistered between 2002 and 2012? By your own figures, it seems the system has been ripped off to the tune of about $1 billion over the past decade. As a response to that, can you please advise how many dentists have been deregistered as a direct consequence of insurance fraud?

Others might be just that people are not aware that they are not reading the compliance requirements of the contract correctly and claiming things in a careless manner that end up costing the fund more than they should. It is unintended and we have to invest in education to make sure that people do the right thing, or we put systems in place. For example, the upgrading of the technology of the HICAPS system that operates in dental, physio and optical providers tends to lock out inappropriate claiming over time, and that is something that we continue to invest in. We talk to the provider of that service and say, 'Look, we need to make this software product much more sophisticated to avoid fraudulent claiming.

Senator BERNARDI: I think we have to accept that mistakes do happen and that quite often they may be innocent mistakes. But, where there has been a demonstration of

wilful fraud or deception and your organisation recommends or makes a formal complaint to the police and to the disciplinary board or the professional association, how many successful prosecutions have there been at a criminal level or how many providers have actually been substantively disciplined, and by that I mean a struck off or deregistered, as a result of your investigations?

Mr Savvides: I am not right up to date but two or three a year would be the high end.

Senator BERNARDI: Is not many, then.

Mr Savvides: Sadly, we also have staff fraud, and that happens with other health funds as well. I was just reading about a competitor fund the other day on this. It is rare, but it happens. People will join the company not because they want to be employees but because they want to infiltrate the claiming process and then send cheques to their mailbox address. But, again, our systems are very sophisticated and we pick that up very quickly. There are strong audit and internal assurance processes within the company, and the ANAO obviously oversights that on behalf of the shareholders.

Would you agree that, if the electronic claiming process enabled the patient being treated to be an active auditor of the service, and in turn the gap or co-payment was enforced as part of this process, then leakage and fraud would be substantially reduced, with the benefit of reduced physical over-servicing resulting in improved public health?

Senator BERNARDI: So, in terms of benefit leakage, are you saying internal fraud is just as big a threat?

Mr Savvides: No, it is not as big. It is certainly smaller but it does pop up from time to time. When we onboard our staff we give them education about the things they must be attentive to. Most of the staff fraud is internally notified by colleagues who see the wrong thing being done.

Senator BERNARDI: When I raised this issue a couple of years ago I was approached by some individuals who suggested that it was mostly 'ancillary healthcare providers', which was the term they used, that were responsible for benefit leakage. Is that an accurate assessment?

Mr Savvides: That is correct. It tends not to be the hospital groups; it tends to be ancillary. Again, when you have a national system of providers on contract—over 10,000 dentists et cetera—we can benchmark claiming by dental chair ratios and traffic ratios. If you can see a blip you say, 'Why is it that an individual has so much more claiming coming out of that practice chair than the one next door?' So you go in and do an investigation, and then they find it hard to substantiate the claims versus the patients through the chair and the evidence then leads to an outcome, which is that they end up

being dropped and the police get notified.

Therefore leakage and fraud in conservative amounts within the bell graph range of Normal can go completely undetected. And in multi-chair practices, dentists can spread their excessive claims patterns across a number of clinicians, with part- time clinicians absorbing over-servicing item numbers that would not be highlighted in your analysis. How do you quantify leakage in these instances, and other undetectable ways, when you state the figure of 1% to 2 %?

Senator BERNARDI: You will have to take this next question on notice, clearly. Are you able to provide me with the disciplinary action? Do you note the disciplinary action that is taken against healthcare providers by the professional associations or by the police? Do you keep an overall catalogue of that in the industry?

Mr Savvides: Yes, when we are directly involved in the follow-through because we want to see the outcome—
Senator BERNARDI: Not just for you; do you do it industry-wide and make assessments? Surely that would be the case if there has been a complaint elsewhere.

Mr Savvides: Yes, I think our team talks to other groups in the sector who are investigators as well. We do have a shared resource. I can take that on notice. If you are interested in how vigorous we are in following that through and what actually occurs, we can certainly provide a summary of that.

Senator BERNARDI: I would be interested in the ultimate result—say, if 15 dentists have been disciplined, what happens? I just want the broad numbers and the industry sectors in which they are operating.

Mr Savvides: I am happy to take that on notice.

Senator RYAN: I have some questions I will put on notice, given the time constraints.

CHAIR: There are no further questions. Mr Savvides, thank you very much for appearing before us. We will see you at the next estimates.

APPENDIX D

Over-servicing health – The practitioner's dilemma

15 November 2011

On 21 September 2009, I held a face-to-face meeting with senior management of Medibank Private. In that meeting, I provided the representative with a promotional pamphlet that had been handed to me at Flinders Street Station. The "no gap" flyer marketed a large dental practice, located two city blocks from my own, that is part of a corporate empire of more than 20 dental practices in Australia. The flyer was offering no-gap initial examinations and cleans for new dental clients – but in the fine print it revealed that this offer applied only when patients underwent a panoramic dental X-ray known as an OPG in addition to the standard small X-rays taken.

The dental practice in question is one of the many being promoted by health funds such as Medibank Private as "preferred choice" providers.

In the two-year period since I was handed the promotional flyer, my practice:

- has seen a total of 12,060 new clients serviced by some 36 dental practitioners, including general dentists and board–registered dental specialists
- has carried out an OPG on just 2,356 of these patients, or fewer than I in 5 new clients. This statistic is interesting when you consider we have substantial orthodontic, oral surgery and implant departments with multiple registered specialists in each field – all dental faculties that, as acknowledged by the ADA, are heavily reliant on full-mouth OPG analysis. (To put our figure in perspective, I would expect most general dental practices to register a proportion of fewer than 1 in 10.)

In this period:

1. if my dental practice had adopted the same "no gap" initial visit approach, offset by additional X-rays, we would have irradiated a further 9,704 people, with a substantially high radiation dose, for a full mouth X-ray that our team of dentists and registered dental specialists deemed unnecessary in more than 4 in 5 cases

2. on an estimated average $85 rebate from the health funds for this scan, our practice would have benefited from an additional $825,000 in revenue (approximately 30% of which would have been subsidised by the Government rebate) – virtually pure profit to the business as the X-ray machine is already in place, has no running costs, and requires all of 60 seconds per patient to operate.

My observations

1. This is the grand scale of the unlevel playing field to which the ACCC was alerted by the Australian Dental Association in its 5 September submission *(Appendix T)*. With regard to this one clinical procedure not only has my practice foregone almost $1 million dollars in

only 2 years but we have had (a) existing patients leave us and (b) prospective ones join other practices, with such inducements endorsed by the anti-competitive behaviour of the PHI funds outlined in detail in the above-mentioned ADA submission.

2. This is the scope of the over-servicing (leakage) problem quoted by the funds as running at 1% to 2%, whereas it is more likely to be a double-digit percentage. The figures above are based on just one procedure and hence one item number; one can only imagine the magnitude of leakage when extrapolated across the full spectrum of services in dentistry and other ancillary care. There are literally tens of, if not over a hundred, ways a provider can over-service a patient in the field of dentistry alone, most of these evading patient scrutiny under current electronic claiming protocols and being undetectable in PHI audits.

3. In this seemingly unchecked environment, if dental practices are to compete effectively in challenging economic conditions, more practices will face the unenviable choice between patient care principles and financial survival. Some may well have to join the dark side of patient management methods at a diabolical cost to public health and the public purse.

4. If certain dental practices have in fact been taking wholesale full-mouth OPGs of all or almost all of their new patients in an attempt to offset the cost of offering examinations and cleans at no gap, three important questions must be asked:

(a) Where has this decision of wholesale OPG x-rays been made at these practices, some of which are part of corporations managing chains of dental practices? At board level? – which may have serious implications for their board of directors; or at a dentist level? – which as "borderline fraud" (as termed by the ADA) would have disciplinary and registration implications for their individual clinicians.

(b) If senior management at Medibank Private has been handed documentation and alerted to the potential problem, where does their duty of care, and that of the company, lie in allowing this kind of over-servicing (as defined by the ADA) of its member base to continue for more than two years after the date of notification?

(b) If this type of clinical behaviour has been deemed by the peak body of dentists as over-servicing, why is the public purse not being protected in the retrieval of the excess funds that have been paid to the company in question with the same vigour as that with which Medicare is chasing dentists on the Chronic Illness Program? One would assume that, if this modus operandi was applicable across some or many of the 20+ dental practice branches of the said company in Australia, and countless others who have followed suit to remain competitive, it would result in multimillion-dollar losses of public money through the public ownership of Medibank Private, our largest PHI fund, and the 30% PHI government rebate.

Where are the regulators, I ask?

The dental practice that I notified Medibank Private about continues to promote on its website the "no gap" initial-visit clean and checks for Medibank Private clients. The fine print requiring patients to have X-rays deemed unnecessary by the ADA in its submission to the ACCC remains as it was two years ago.

For over three years, I have been writing to various Ministers, the Department of Health, the ACCC, PHIAC, and the PHI Ombudsman detailing these and many other serious issues in relation to PHI funds that are adversely affecting public health and public funds. All parties have stated categorically that the problem of over-servicing is within reasonable limits and being effectively combated by the health funds.

Dr Kia Pajouhesh B.Sc., B.D.Sc. (Melb.)

Principal dentist of the largest dental practice in Australia, whose 36 health practitioners are not deemed by Medibank Private to be "preferred" or "member's choice"

APPENDIX E

Letter to The Hon. Tanya Plibersek MP. Minister for Health. 6 January 2012

I am a dental surgeon and sole owner of , the largest private dental practice in Australia. My practice engages a total of 36 clinicians, including 10 registered dental specialists, operating in 25 surgical suites over three floors and the multi-level tower of the iconic Manchester Unity Building in Melbourne's CBD. The practice services more than 45,000 existing patients and attracts some 600 new patients each month. It is the only practice in Australia where multiple registered specialists work under the same roof as a team of general dentists. In size, revenue and number of clinicians, more than doubles the next biggest dental practice in the country.

My business model, which has attracted the attention of many private equity firms, dental corporations and private health funds, is not entrepreneurial; many entrepreneurial companies have failed to reach even half the size of my practice. Rather, it revolves around a clear understanding of the public's needs and the treating clinician's expectations. Having lectured on dental practice management internationally, I now provide ongoing coaching and advice to a number of dental practices across Australia and have also consulted on policy development to major health funds. Hence I have unique experience and knowledge of the activities of practitioners in the dental services industry.

I have to hand statistical data detailing the magnitude of administrative and physical over-servicing in the dental industry and I am writing to you to express my grave concern at this travesty in my industry and in the health industry as a whole.

Not that this is my first attempt to gain your attention. For the past four years I have been trying to alert your office, the Department of Human Services, private health funds, and the Australian Dental Association to the over-servicing problem and to offer genuine solutions, especially given the ways in which your office and the DHS are often attacked by vested interest groups. During the same period I repeatedly sought to discuss these matters with former Minister for Health and Ageing, the Hon. Nicola Roxon, and was politely advised on each occasion that the health funds had succeeded in controlling the problem. This prompted me to write the attached paper, "Over-servicing health – The practitioner's dilemma".

I am bound by my professional regulators and my association to uphold the good reputation of my profession and therefore have been reluctant to publicly brandish my views and my evidence. Nevertheless, I am available to serve you, your office and the DHS in any professional capacity in which you care to call on me. Specifically, I can advise you on parameters to use in statistically demonstrating the wholesale problems in the Chronic Disease Dental Scheme (CDDS) program, and in particular how the clinicians who have

been the most eager to embrace the program have rendered it a major threat to the public purse and public health.

I would also like to provide your office with evidence that the CDDS Medicare audits have uncovered an over-servicing pattern that is systemic in the private health insurance system, and in particular with the preferred provider schemes, that is costing the public through the 30% rebate scheme and public ownership of Medibank Private.

I believe that the health funds, their associations and their regulatory bodies have little or no appetite to tackle this problem. Their reluctance is due partly to the sheer enormity of the issues and partly to the threat that exposing the facts may pose to the rebate scheme because it will show that this public funding is aiding over-servicing behaviour in the ancillary health industry. And yet independent market research reveals that more than 70% of Australians believe any such problems must be tackled by the Federal Government rather than left to the health funds to sort out.

A five-minute analysis of the top 100 billing practices in the CDDS program will reveal that they are virtually entirely made up of the 1 in 5 (and growing) practices in the country that have aggressively embraced private health insurance preferred-provider programs. This is no mere coincidence. What is even more alarming is that this "club" comprises practices with the business model I refer to in my paper "Over-servicing health – The practitioner's dilemma": over the past five to seven years they have been the fastest growing practices in the country, thriving at levels of growth far beyond others.

One must question why, over the last three years, – regardless of its sheer size and massive patient base, and its acceptance of all genuine CDDS eligible patients – has serviced significantly fewer Medicare-funded patients than dental practices a fraction of its size.

I have spent the last 20 years building the largest dental practice in our country based on the principles of ideal patient management and business integrity. I will continue to fight for these principles, which are under direct threat from the wave of modified clinical care designed to prioritise financial viability through administrative and physical over-servicing.

I am at your service to address this problem and I look forward to your response at your earliest convenience.

Dr Kia Pajouhesh

B.Sc. (Melb) B.D.Sc. (Melb)

Dental surgeon

APPENDIX F
Letter to CEO ADA, 8 November 2011

Dear Robert,

I hope this message finds you well.

I have just read with great interest, and indeed admiration of our Association, the ADA's recent submission to the ACCC posted on the ADA website. I commend whoever put this submission together for their courage and clarity in identifying the dire problems our profession now faces and for confronting these issues head-on.

I would like to make some additional comments that may be of interest to the submission's author/s.

1. PHIs, through the manipulation of rebate fees of preferred providers, are driving treatment choices made by clinicians and in turn their patients. By paying a higher percentage rebate on clean, drill, fill and extraction dentistry they are prompting clinicians to steer clear of specialist modalities in dentistry such as endodontics, prosthodontics and orthodontics. They further compound this directive by setting no annual limits on this form of dental care and yet avoid paying, wholly or in part, for comprehensive rehabilitative care.

2**. The statistical fact that preferred providers carry out, on average across Australia, between 1 and 2 more itemised procedures per patient per appointment has vast and far-reaching implications for our patients and our industry – not the least being that health funds, in damage control, are keeping this damning over-servicing statistic close to their chests to avoid the scrutiny of their preferred providers and provider programs.**

3. Of key relevance to a number of the recommendations made by the ADA in this submission is the statistical information that we have previously discussed with regard to the enormous claiming pattern differences between this country's preferred and non-preferred providers in the use of certain procedures and item numbers.

4. I am surprised (as well as relieved) at the comments associated with recommendation #18, where the ADA goes on record saying that the preferred providers' standard over-servicing protocol "borders on fraud". This stance is very different from the one I encountered in my 2010 meetings with ADA representatives, including the schedules committee, who I felt did not want to confront this problem as it risked disenchanting a substantial component of our membership base.

It also leads to two simple, unpalatable conclusions:

a. When you consider the nationwide statistics I refer to in points 2 and 3 above, the problem of over-servicing (both administrative and physical) by preferred providers, rubber stamped by PHIs, is not restricted to a minor few rogue providers in these schemes.

b. **For the cases where the over-servicing is physical in nature, as per the comments made in the submission, PHI members seeing PHI-preferred providers indulging in these "inducements" face an immediate and definable risk. The public therefore needs to be warned; otherwise having this information and not divulging it makes us all complicit in the physical harm of our citizens.**

5. The inequity that was implicit throughout the submission document seemed to me to be the unlevel playing field on which preferred providers are competing against non-preferred providers directly as a result of the anti-competitive behaviour of PHI companies. Small and inexpensive changes within the electronic claiming process would all but eradicate over-servicing claiming patterns in our industry, creating a level playing field for the preferred providers and non-preferred providers. *A level playing field will then in turn make it a lot less attractive for dentists to join or remain on contracted PHI schemes.*

The current electronic claims protocols must strengthen the role of the patient as an active auditor of the claims process rather than make them a redundant bystander. As one of many examples of over-servicing methods that would be affected, the free dentistry inducements you refer to in your own submission would be wiped out as the gap payment would apply to each item number – including the OPG, which at present would be billed to the PHI through HICAPS but charged at the rebate-only amount to the patient.

Procedural changes to HICAPS that would reduce the incidence of anti-competitive behaviour by the health funds in support of preferred providers is an essential tool that forms the foundation of a level playing field.

Major health funds have previously sought my advice on the mechanics of the relationship between the funds and our industry. I would be pleased to share with my Association my insights about PHI and the PHI-preferred provider schemes. I am available to provide you with evidence pertaining to the statistical data I refer to in points 2 and 3, which can help quantify the level of anti-competitive behaviour the health funds are aware of but are turning a blind eye to. I also have available market research data on possible patient behaviours pertaining to some of the issues raised in your submission.

I hope to be of service to my Association, even at short notice, if I am called upon at any stage to discuss any matter contained in this letter.

I thank you for your time and look forward to your response.

Yours sincerely

Dr Kia Pajouhesh B.Sc., B.D.Sc. (Melb).

cc. Dr Shane Fryer (President – Federal ADA)

APPENDIX I

A Proposal to reduce health insurance fraud in Dental and other Ancillary Benefit Claims

Paper Prepared by:

Dr. Kia Pajouhesh B.Sc., B.D.Sc.(Melb)

1. Introduction

I am a dental surgeon and owner of a privately owned dental practice in Melbourne's CBD. The practice engages a total of 36 clinicians, including 11 dental specialists. I have lectured on dental practice management internationally, and provide ongoing coaching and advice to a number of dental practices across Australia, and have also consulted on policy development with major health funds. With this background, I have the unique experience and knowledge to intimately understand the activities of practitioners in the dental service industry.

I have for some time taken a keen interest in the ethics and technology of benefit claims and payments throughout the healthcare sector. In my interactions with the industry, I have observed a great many instances of behaviour that could best be characterized as misuse of the system of a significant scale above and beyond the recognized levels of overt fraud.

This paper documents examples of electronic claims misuse in the dental sector that I believe are common practice, and a proposal to change the system in order to significantly reduce if not eliminate these abuses entirely. The obvious effect of reducing misuse in the electronic system is of benefit to the public, the health funds, and the dentists upholding our brand reputation.

2. Background

2.1. The Health Insurance Sector

The Australian Private Health Insurance sector pays out some $10 billion each year in benefits, covering 9.5 million people, and providing a funding mechanism for hospitalization and ancillary health benefits such as dentistry, optometry and other therapies. By providing a privately funded supplement to the public hospital system, the private health insurance sector is a critically important component of the overall health system in this country. The importance of the sector is underlined by the tax rebate that the Commonwealth Government continues to provide as an incentive to private health insurance policyholders to continue their cover.

Benefits paid for non-hospital ancillary treatments such as dental services, optical services, physiotherapy, and other therapeutic treatments represent some $3.0 bn of the total benefits paid by the funds. Of these benefits, dental represents a little over half of the total, and is by far the largest single component of ancillary benefits paid.

For any insurer, the risks and additional costs posed by the incidence of fraudulent and misuse type activity is a significant cause of concern and a focus of management time. For the health insurance sector, where there is such a range of technically complex procedures that are carried out by various kinds of specialists in many locations, management of fraud has always been a major issue.

When the Australian health insurance system was first designed, one of its critically important components was the idea of a “co-payment” or “gap”, whereby the rebate to be paid against any given procedure was tightly defined and calculated in such a way that there was always a difference – the gap – between the total charge made by the provider and the benefit paid by the insurer. This gap had the effect of giving the patient a stake in the transaction and has two benefits – it sends a price signal to the patient to remind them that the cost of healthcare is not free, and, importantly for our purposes, it allows the patient to act as an involved auditor of the event, by giving them a hip-pocket incentive to check what services they are being charged for.

Of course, any such system was never going to be perfect, from a fraud prevention point of view. It would be unreasonable to expect that patients would always understand the complexities of dental and other procedures, or that they would necessarily grasp all of the subtleties of the funding system. Nonetheless, it is reasonable to assume that the existence of the co-payment gap has had a significant effect in reducing or eliminating the different forms of misuse and fraud.

Prior to the introduction of electronic claiming systems, health insurance claims were processed either by the patient taking the relevant account to a health insurance branch, or by submitting the claim by mail directly to the fund’s processing centre. Either way, the claim itself was subjected to expert human scrutiny, which acted as an important fraud control mechanism. Experienced and skilled claims processing staff were good at spotting incorrect or potentially fraudulent claims, and raising queries directly with the patient or the provider, before releasing the claim for processing and payment.

The downside, however, was that the funds had to maintain large and expensive branch networks and processing centres; in the understandable desire to keep operating costs as low as possible, when sophisticated electronic claiming technology emerged the

opportunity was taken to dispense with this infrastructure, and rely instead on a complex set of electronic business rules which would, in theory at least, emulate the fraud-detecting logic and skills of the people that the system replaced.

It is my fundamental contention that the introduction of electronic payment systems, while it has brought many important benefits to the health insurance industry, and no doubt has been a significant contributor to reducing costs in the system, has also fundamentally undermined the integrity of the gap co-payment system. I believe that this integrity can be restored by a simple business process change to the electronic claims process as outlined below.

The integrity of the system has also been undermined by the widespread adoption by the health insurance industry of preferred provider schemes of one kind or another. Essentially a marketing technique adapted from other industries, preferred provider schemes were originally intended to help the funds to cap benefits paid by offering marketing support to practitioners in exchange for a lower schedule of benefits, generally controlling the gap component and in turn the out of pocket expense to the patient. The efficacy of the preferred provider model depends entirely on the funds setting rebate levels such that the practitioner is fairly rewarded for the treatment carried out. If rebates are set too high, there are obvious consequences for the bottom line of the health fund; more problematic, however, is the risk that by setting rebates too low or proportionately favouring certain treatment modalities over others, the participants in the scheme will be forced to focus on maximizing their revenue by selectively managing the treatments they provide and, in some cases, by manipulating the claims system.

It is very difficult to ascertain directly the extent to which this chain of cause and effect is actually contributing to levels of fraud and widespread misuse in the system without having access to the detailed claims data held by the health funds, and they are not willingly sharing that information. I have challenged at least one of the major health funds to undertake an analysis of the claiming behaviors exhibited against commonly misused item numbers by preferred provider scheme members, and then compare those results against the general population of practitioners, a challenge that has in effect been declined. In all probability such analysis will only be undertaken or made available if there is pressure from government or other bodies to do so.

2.2. The Proposal in Summary

In the old manual system, as described above, any opportunity that providers may have had to intervene in the claim process was very limited. While they would no doubt have had a good understanding of the claiming processes and benefit payment rules of the various funds, the fact remains that the actual process of making a claim was very much in the hands of the patient, and that process was actively managed by the health fund. With the introduction of electronic claiming systems, where the payment and claim validation process takes place at the provider's premises, the opportunity arose for the provider to potentially manipulate the claims process in order to increase income revenue or to minimize patient out of pocket expense. Although the health funds clearly recognized this, and implemented quite extensive and complex automated business rules to attempt to combat any potential for fraud, it is nonetheless my contention that the fundamental flaw in the system is the fact that the principle of the gap payment as a motivator to keep misuse of the system has been undermined in such a way as to create incentives for providers and patients to collaborate, intentionally or otherwise, to defraud the funds.

I believe that there is a simple solution. The current payment systems (as detailed below) take the relevant claim information, process it through the health insurer's system, and then authorize a rebate, which is paid to the provider. Any gap payment is collected as a separate process, either by the provider issuing an account, or, more commonly, the patient paying the balance by cash, cheque, or credit/debit card on the spot. The important point to note is that *there is no connection between the approval of the rebate and the payment of any outstanding gap payment*. This means that the provider due to various motivations (detailed below) is in a position to manipulate the system in a variety of ways (examples of which are detailed below) without the patient having any involvement with the process. Given that such manipulation can also be presented to the patient as providing a monetary benefit to them, there is also the opportunity for a kind of passive collusion between patient and provider to defraud the health fund.

My solution is to modify the electronic payment systems to *insist that the patient actually pays the gap payment before the insurance rebate is released to the provider*. This removes many of the opportunities for the provider to manipulate the system, since it means that in many cases the patient would have to become actively complicit in the process, rather than passive or, more often, entirely ignorant of the fraud being committed by the provider.

Fundamentally, this process improvement, which is relatively simple to make, restores the role of the patient as an auditor of each transaction. It may be argued that in many cases patients do not have the technical skill to be able to make a distinction between a treatment that is deemed to be "correct" versus one that is fraudulent, or is a misuse of the

system, to take a kinder interpretation. However, I believe that in most cases a high level of knowledge is not required, and that in fact patients will be willing and able to audit the claims process almost without realizing that they are doing so. I have undertaken high quality research to demonstrate that consumers are attuned to these issues and are willing to act as an auditor in this way.

3. The Health Insurance Payments System

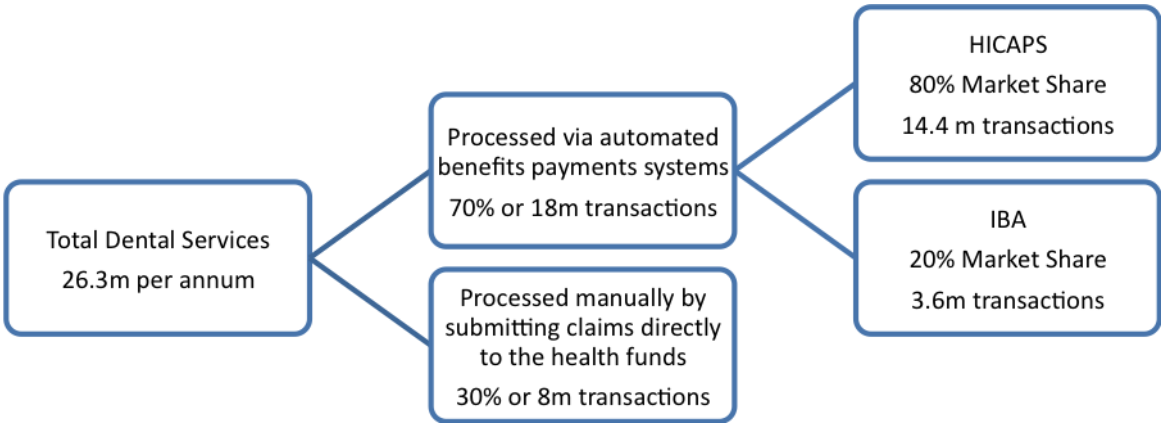
3.1. The Payment System Providers

Payment systems are provided to the health insurance industry by two providers:

Hicaps are a subsidiary of the National Australia Bank, housed within their NAB Health division. They are the dominant player in the private insurance sector, claiming better than 90% of the market. They provide services to 30 health funds, and over 23,000 providers use their system.

IBA Health is an Australian-based, global listed technology company who provide many technology products in the health care sector. In Australia, they are the principal provider of claims systems for Medicare, as well as having a small but growing presence in the private system.

The overall structure of the health benefits payment business as it applies to the *dental* industry is shown below.



As noted above, these numbers relate to the dental sector only. Discussions with Hicaps and IBA indicate that take up of electronic claiming processes in this sector are lower than for other ancillary benefits and therapies, where it is probable that closer to 90% of transactions are processed electronically.

For both providers, the health funds (and Medicare) are their principal customers. The funds pay them a fee, estimated at around 80 cents per transaction as an average, to provide the terminals and software to interface with the funds' own claims processing systems. This is partly recovered by the funds, who levy around 0.15% of the claim value as a settlement fee.

However, the payment system providers compete by getting dentists, optometrists, and other ancillary providers to sign up with them and use their machines. In order to compete successfully they have to have the ability to process payments on behalf of a large number of health funds, if not all of them, otherwise their services are not attractive to the provider networks.

3.2. The Health Funds

After recent mergers and other developments, the health fund landscape has changed considerably. The structure of the industry is essentially three-tiered, with two large players (Medibank and BUPA) accounting for around 60% of the market, three other funds (NIB, HCF and HBF) accounting for a further third, while the balance is held by 20 small funds. Medibank is government owned, BUPA and NIB are both commercial for-profit operations, while the balance is not-for-profit organizations.

The industry is highly regulated and supported through the health insurance tax rebate system introduced by the coalition government, and continued by the current government.

4. Fraud and Misuse in the Dental Sector

4.1. Motivations

It should be understood that while I do not imply that *all* practitioners are behaving badly, there are enough who do to have a significant impact on the industry as a whole. While it is certainly true that there are some practices who deliberately engage in dishonesty for their own gain, there are other motivational factors at work that encourage many otherwise honest practitioners to follow suit.

The most important of these is the operation of the various preferred provider schemes operated by the health funds. Under these schemes, providers are paid a fixed level of rebates for specific services, which is generally higher than the normal rebates offered by the fund, in return for the provider accepting restrictions on the level of out of pocket expenses that they can charge. These schemes obviously have considerable commercial appeal to the funds, and, it maybe contended, benefit the consumer by limiting out of pocket expenses. However, there are two pernicious side effects; firstly, when insurance funds control fee schedules, they become an integral player in the choices of treatment made by clinicians, and secondly, these schemes are by their nature attractive to practitioners who are marginally viable, because the promotional benefits are an attractive trade off against lower and controlled margins. Inevitably, such practitioners look for ways in which they can maximise their income while remaining within the rules of the scheme. One of the ways this can be done is by over-servicing in the ways that I have described in this paper. This over servicing can occur in the confines of the electronic claim or may extend onto actual work carried out on the public. *The evidence for this should not be far to seek – a comparison of claiming patterns between preferred provider scheme participants and other providers across commonly misused or what I term "high-risk item numbers" should make it obvious.*

There is, in fact, a belief in the community that your rebate is dependant on the "skill" of the receptionist driving the item numbers and the electronic claims machine. However, it is not the "skill" that is in question, but their willingness to bend the rules into misuse and fraud that determines the rebate figure. Three motivational factors exist for this behaviour, which is increasingly threatening the reputation of our industry.

1. **The "Robin Hood effect", as I like to call it, which legitimises in the minds of the clinicians and their management staff that it is fair game to rip off the faceless "big, bad" insurance firms to help the individual in their care with whom they have forged a strong bond.**

2. **To stay competitive in business, the clinicians are almost compelled to match the techniques applied in other practices to appease their patients or risk losing them.**

3. **The out-of-pocket expenses to the patient will determine how much they will choose to spend, and with increasing financial pressures on individuals in our community, the clinicians may turn to driving their electronic claims to favour the patient at the cost of the health funds.**

In light of the above three points, I believe that the same sequence of procedures carried out across, say, 10 practices around the country will result in as many as 5 to 6 greatly varying rebate figures. Therefore out-of-pocket expenses to the patient depend on the "driver" of the item numbers and the philosophy that the practice has instilled in that "driver".

4.2. Types of Fraud and Misuse

Example A: The practitioner undertakes services advertised as "free" – i.e., examinations, consultations, X-rays and free scale-and-clean in conjunction with other procedures such as teeth whitening – but will claim a rebate for these "complimentary" services from the insurance provider. Thus the service appears to be "free" to the patient with insurance, but not to the insurance provider, who is paying a rebate claim to cover the dentist's costs.

Rebate-only procedures are also often applied to retreatment of failed procedures and restorations where the dentist is not entitled to further funds but will charge the insurance provider "for his time" at no expense to the patient.

Rebate-only procedures are also used almost exclusively for family, friends, trading partners, and practice staff and their families. In the industry it is commonplace that staff and their families need to take out health insurance in order to have their dental care attended to by a rebate-only method. Rebate-only is not to be confused with the application of a discount, which is of course a legitimate business strategy.

It also has no boundaries in some practices, where it applies to wholesale batches of patients. In fact, some practices working in smaller migrant communities may market themselves as a rebate-only practice using the proposition that if you are paying for health insurance, dental care should be free!

Example B: Widespread item number misuse as an effort by practitioners and their auxiliary staff aimed at maximising the patient's rebate can take the form of the following practices:

(1) Up scaling procedures such as a "standard consultation" to an "extended consultation", or a "two surface" restoration to a "three surface".
(2) Splitting item numbers, for example by breaking up a large restoration into two smaller restorations.

Example C: Misuse of what I like to term "basic high risk item numbers", which are products or services that leave no trace in the mouth of the patient and pose little or no threat of incrimination to the clinician in question; thus they are *high risk* for the insurance provider, and *low risk* for the clinician misusing them. These products and services are often used with the explicit intention of increasing the health fund rebate to the patient, who may then be more receptive to additional treatment if the out-of-pocket figure is reduced to a minimum.

In dentistry, which is similar to general medical practice, these item numbers include, among many others - examinations, consultations, radiographs, study models, diagnostic tests, preventative procedures such as scaling and cleaning teeth, mouth guards, and night splints. With most levels of insurance cover, this shortlist can add up to several hundred dollars' worth of rebate. It is common for me to hear a patient complain that they received a lower rebate for a procedure at my practice than they have enjoyed at their previous dentist for an identical procedure.

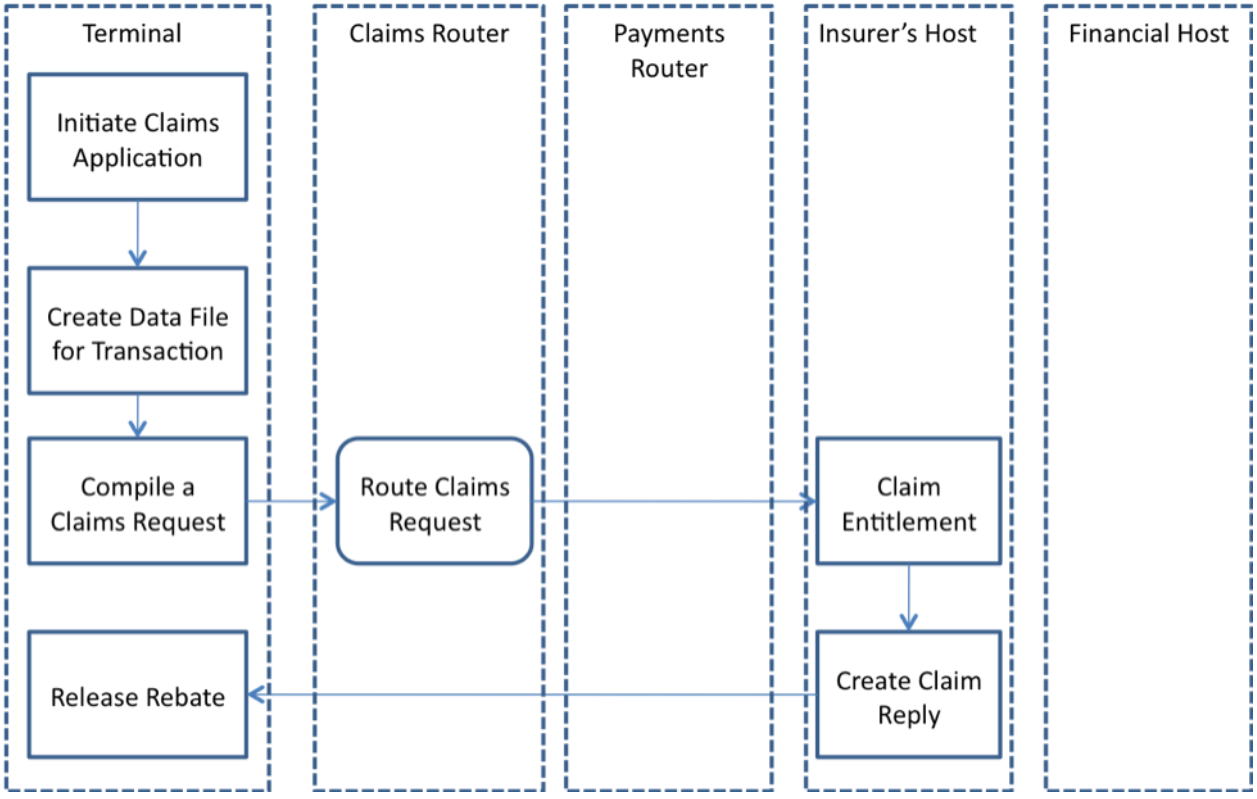
Example D: Loading up additional "complex high risk item numbers" that are also very difficult to trace. As one example, claiming a restoration under a new full coverage crown – there is no way of checking that the actual restoration was ever done, short of getting a patient to consent to having the crown removed, and even then there is little or no way one can prove that the restoration is an old one. Health fund experts writing endless business rules will argue that they have reduced many of these loopholes, however, it is my opinion that wholesale misuse still continues as the business rules are at best reactionary in nature and the complexities within the system harbour more loopholes than imaginable.

Example E: The provider, armed with the patient's existing health records and their health insurance card, can make regular claims, notionally on the patient's behalf, within the boundaries of the patient's condition to receive benefits in lieu of a past or pending procedure. The health fund releases the rebate without any gap payments being made. In some instances the provider is armed with the health cards of a large batch of his patients and uses the patients' health insurance cards to process claims so as to create a "deposit" (banking future benefit) in the patient's account to compensate for future treatment.

5. The Proposed Process Changes

5.1. The Existing Process

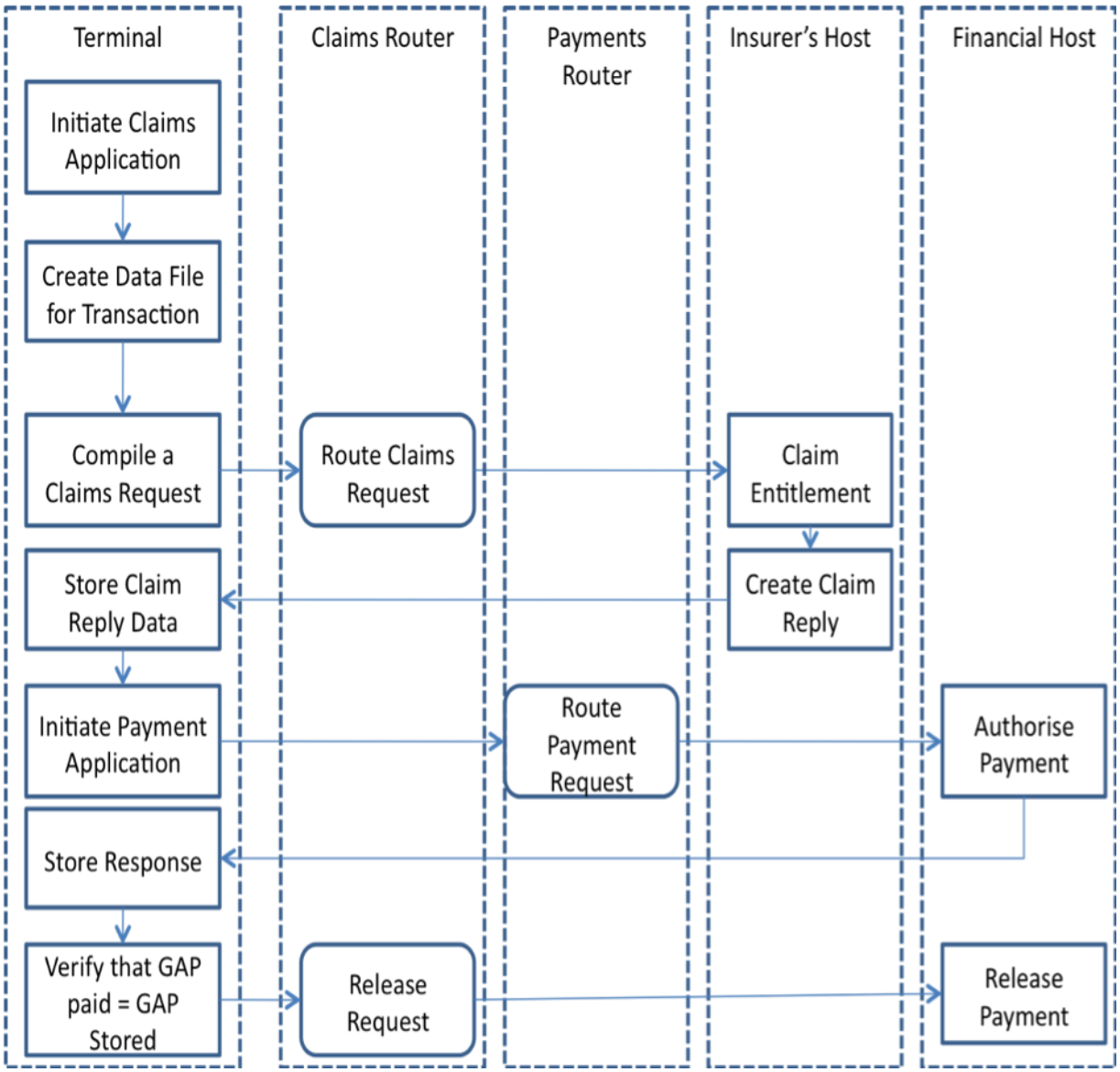
The current process for receiving and processing electronic health insurance claims is shown below in a simplified diagrammatic form:



The key point to note about this system is that release and approval of the rebate takes place without any verification that the gap has been paid, or even presented to the patient. The patient may pay the gap through an associated application, usually resident on the same terminal, but there is no loop back to the health insurer to tell it either the amount of the gap or that it has in fact been paid. Further, the system allows a practitioner to reprocess claims as often as required, without the patient having any interaction with the system.

5.2. The Proposal

My proposal involves a process for the payment of health insurance claims that would have the effect of closing this loophole by requiring the system to initiate and compile a record of payment of the gap before releasing the benefit, as described below.



The critical system change described in this diagram is that the system would require the practitioner to enter the gap payment as part of the initial claim request. Once the claim has been assessed by the insurer's system, a payment application is initiated, as part of which a check is undertaken to ensure that the gap payment actually being processed is in fact the same as the gap payment that was indicated in the initial request. Only if the two are the same would the claim be processed and the rebate released. In the event a patient chooses to pay the gap in cash or cheque, this is acknowldged by the practitioner therefore ensuring a paper trail is created for practitioners who may try and bypass the gap payment altogether.

6. How the Proposed Process Change would reduce fraud and misuse

The implementation of this process would have a significant effect on the way in which health insurance claims are processed through the electronic payments systems, and, crucially, the interaction that the patient has with the system.

Without going exhaustively through every example of fraud and misuse mentioned above, the following cases illustrate how the system change would alter patient and provider behaviour.

- **Rebate only claims for retreatment of failed procedures, marketing services as 'free' will have to be correctly claimed in every instance as the gap payment will be required to release the rebate figure.**
- **Up scaling procedures or splitting item numbers will be scrutinized by the patient when the integrity of gap payment is enforced.**
- **High risk item numbers can only be utilized if properly administered to the patient as the gap payment required to be paid for each of these item numbers will ensure they will not be misused**
- **Loading the invoice with additional item numbers in an effort to reduce the patient's out of pocket expense or to increase revenue will become a futile exercise as the overinflated gap payment with need to be paid before any rebate is released.**
- **Overt fraud by a clinician falsely claiming across multiple health insurance cards will cease, as the gap payment will not be collected and yet be registered as business income.**

7. Likely Consumer Behaviour

Clearly the whole hypothesis that I have developed here rests on the assumption that consumers are likely to be willing to act as auditors of the system if the integrity of the gap is restored. In order to test this proposition, I commissioned a research program to be undertaken by Forethought Research, a highly reputable and skilled market research company with experience in this field.

The research involved an internet survey of 66 respondents, broken down as follows:

- Aged 18 or more
- Private Health Insurance customers
- Visited a dentist within the past month
- Had their health insurance card swiped through an electronic payment terminal
- 59% male, 41% female
- 88% resident in the metropolitan area, the balance of 12% in rural areas
- Respondents were located predominantly in Victoria and NSW
- 59% of respondents were over 50 years of age

Based on normal field research techniques, this is a sufficiently broad and representative sample to be statistically valid given the nature of the research being undertaken.

Respondents answered a 10 minute online questionnaire which explored actual claims behavior, likely claims behavior in certain specific scenarios designed to mimic the changes I am proposing, and finally general patient attitudes to fraud and misuse in the health insurance system.

The key findings from the research are as follows:

- Patients demonstrated a sound understanding of the payments process, and were easily able to recall it when asked.
- Although only 41% actually examined the dentist's invoice during the process, there was clear evidence that they are more likely to examine the invoice under two sets of conditions:
    - If the size of the gap payment was relatively expensive (80% said they would examine the invoice in these circumstances)

    - If the gap payment was required to be settled on the spot (62% were likely to examine the invoice in these circumstances)
- Patients clearly indicated that they are prepared to question dental practice staff if they identify an inaccuracy on the invoice, and this increased from 50% to 71% if there is a relatively large gap. Further, 92% of respondents said they would be amenable to developing a greater understanding with respect to procedure codes and descriptions.
- Respondents generally displayed a concern for the impact of fraudulent behavior on the health insurance system. 83% said that "they cared about misuse of the health insurance payments system because it affects me", while 65% *disagreed* with the proposition that "misuse of the health insurance payments system only hurts insurance companies".
- Interestingly, patients responding to the survey clearly indicated that they are aware that the person operating the payment machine is able to influence out of pocket expenses (71% agreed with this proposition).

While the survey also indicated that most patients (88%) felt that it is hard to know whether the descriptions of the procedures shown on the invoice are correct or not, what the research does clearly show is that consumers are very conscious of the potential for fraud, are willing to act as auditors of the system, and that they are more willing to do so as the size of the gap increases. I recognize that this is not necessarily the last word on the subject and that many will argue with issues such as sample size and perhaps methodology, however I believe that this study provides substantial support for my position.

8. Estimated Benefits to the Health Insurance Sector

Based on the Private Health Insurance Administration Council (PHIAC) statistics for the period 12 months to March 2010, total benefits paid for dental services was almost $1.6 billion, across over 28 million services. All ancillary services benefits were around $3.0 billion, and almost 65 million services.

Based on my personal experience and knowledge of the industry, I have undertaken an analysis of the volume and value of probable fraud and misuse as described above. Because I do not have access to detailed statistics from the health funds, I am making educated guesses of the key variables (ie., the number of services that are assumed to be fraudulent, and the proportion of the total benefits paid that would be recovered under our proposed process).

Nevertheless, I estimate that fraudulent benefits recoverable for the *dental* sector is as shown below

	% of Dentists estimated to engage in this type of fraud	Number of Dentists engaged in this type of fraud	Total number of services carried out by these dentists	% of services that are assumed to be fraudulent	Total Benefits Paid on Fraudulent Services (through Automated System)	Assumed % of Fraudulent Benefits Prevented	Total Benefits Recovered
Category 1 Overt Fraud	3%	214	0.6m	10%	$3.4m	5%	$0.16m
Category 2 Covert Fraud	20%	1,427	4.3m	20%	$44.7m	30%	$13.4m
Category 3 Mild Misuse	50%	3,567	10.6m	25%	$139.8m	40%	$40.0m
Totals	73%	5,208	15.5m	23%	$187.9m	37%	$69.5m

This level of recovery represents some 6.4% of all benefits paid for dental services. At this point, I do not have any information on the likely fraud levels for other ancillary services funded by the Health Funds, and for that reason, I have assumed that fraud levels are relatively lower than dental. This is certainly likely to be true for the Optical sector, where levels of corporatization are higher, and therefore the incentive for fraud are lower. For the purposes of this paper, I have assumed overall fraud levels are around 2% of total benefits paid.

	Dental	Physio	Optical	Other	Total
Services pa	28.1m	8.4m	7.9m	20.9m	65.3m
Benefits Paid	$1,547m	$235m	$511m	$699m	$2,992m
Percentage Automated Payment	70%	90%	90%	90%	81%
Percentage Prevented	6.4%	2.0%	2.0%	2.0%	2.9%
Saving to Health Funds	$67.2m	$4.2m	$9.2m	$12.6m	$93.2m

As the table above suggests, the total potential benefit to the health insurance system of implementing our proposed process is over $93 million per annum, based on what I believe are reasonably conservative assumptions.

If more aggressive assumptions are made – for example by assuming that the percentage of benefits recovered in other ancillary service benefits is closer to 5% than 2% - the potential savings to the health funds might be as high as $150 million per annum.

I do not have access to market share data by ancillary benefit type, but if it is assumed that Medibank's overall share of the health insurance market of 30% is replicated for ancillary benefits, the potential direct saving to that organization is between $28 million and $45 million per annum, a saving that goes directly to the bottom line of that organization.

In addition, of course, the government has a direct stake in the potential savings that accrue to the other health funds, to the extent that they reduce the cost increases that must be applied for by the funds each year.

9. Progress to Date

9.1. The Health Payment Systems Providers

I have had several discussions with both Hicaps and IBA on the possibility of implementing the process directly. Both companies understood the potential benefits to the system as a means of reducing fraud and misuse, neither was prepared to proceed unilaterally. Both indicated that they would, however, be prepared to do so if requested by the health funds, although they also had the view that, for practical commercial reasons, it would be necessary for all of the health funds to participate in the change. They were skeptical that the funds could be brought to agree unanimously on making such a change of their own volition, given that the industry has no history of such voluntary cooperation.

Both Hicaps and IBA did suggest that, in the event that the funds did make a request for them to implement the system changes required, doing so would not be a complex or expensive exercise. That said, I did not arrive at any quantification of either the dollar or time investment required, since neither company had any interest in undertaking the necessary planning work in the absence of any pressure from the funds.

9.2. The Health Funds

Discussions have also been had over the last 18 months with various officials from the fraud prevention functions of the two biggest funds, Medibank Private and MBF/BUPA. These officials did, once it was explained to them, understand how the proposed process change could have a positive impact on fraud prevention, but were generally reluctant to progress the idea further. It is also my belief that the health funds run the risk of disenchanting their member's first providers by implementing a revised system that may unsettle their current electronic claiming habits.

10. Conclusions

I believe that, based on experience and what limited empirical data I have been able to access, there is a real case for the industry to embrace the changes to the health insurance payments system that I am proposing. Indeed, given the magnitude of the likely savings (and I believe my estimates to be conservative) it is almost incomprehensible to an outsider that the health funds have not chosen to move on this front of their own volition. The changes to the payment systems are, I am told, relatively simple and inexpensive, and have the potential to deliver substantial real benefits to the funds and to the profession. It is true that there may be some downside risks for the funds by way of a weakening of the preferred provider models, as practitioners motivated by avarice rather than patient needs exit the program; one would have thought, on the other hand, that this would ultimately be a net benefit to the funds and the public purse. And if the preferred provider schemes really do provide a marketing benefit to participants, they should be able to survive on that basis alone, rather than relying on manipulating the benefits approval process to maintain member numbers.

Overall, I would continue to encourage health funds, industry bodies, and the government to take this issue seriously and lend it support.

Project Smiles Report

Patient attitudes to misuse of the health insurance payment system and willingness to act as auditors of the system

Prepared for
Tony Wildman (Principal, Non-Executive Management)
Dr Kia Pajouhesh (Managing Director, Smile Solutions)

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Background

The most common method through which the ancillary health insurance claims are processed is through an electronic payment system known as HICAPS (Health Insurance Claims and Processing System). The process requires that the practitioner first relays the procedures performed and associated costs to the patient's nominated health insurance provider via the electronic system's interface. From this information, the health insurance provider calculates the proportion of the total cost to be paid to the practitioner (the benefit). The difference between the benefit and the total cost is charged to the patient (the gap).

Whilst the electronic payment system has increased the efficiency with which ancillary health insurance claims may be settled and despite the integration of computer based preventative measures into the system, it remains vulnerable to misuse by practitioners and patients. Misuse ranges from the manipulation of claims information to influence benefit payments, and subsequently gap payments, through to unrestrained fraud.

The client has patented an alteration to the electronic payment process that would require the patient to pay the gap before the benefit is released to the practitioner. It is believed that this requirement will encourage the patient to ensure the practitioner has correctly lodged the insurance claim and that they have been charged correctly by examining the invoice.

The efficacy of the proposed solution depends however on the willingness of the patient to act as an "auditor" of the transaction. The purpose of this research is to test that proposition.

Objectives

The present research project aims to provide directional insight into whether ancillary health care patients are willing and capable of acting as auditors of the electronic health insurance payment system. Specifically, the research project aims to:

1. Understand the attitudes of health insurance customers to health insurance fraud
2. To assess customer willingness to act as auditors of the health insurance payment system
3. To understand customers likely behaviour in specific payment scenarios

Research Methodology

A 10 minute online questionnaire, based upon discussion with the clients, was developed and distributed to an online panel. The questionnaire comprised of questions relating to:

- Actual patient claims behaviour
- Likely patient claims behaviour
- Attitudes to misuse of the electronic health insurance payment system

All respondents were registered with the online panel, aged 18 or more, private health insurance customers, visited a dentist within the past month and had their health insurance card swiped through the electronic payment system. The recency of the patient's experience was enforced as it increased the probability that recollections regarding the payment experience were accurate. Invitations reflective of ABS statistics (location, age and gender) were sent to the online panel from which 66 complete interviews were collected.

Please note that the sample size dictated that all results were directional in nature. Furthermore, whilst income, work status and relationship status were collected for a subset (n=23) of the sample of 66, no observable differences in behaviour or attitudes according to these variables were identified in the data. Consequently, results were discussed at the overall level only.

Patient Demographic Profile

Throughout the remainder of the report, respondents of the questionnaire will be referred to as patients.

Of the 66 patients that responded to the questionnaire, 59% (n=39) were male and 41% (n=27) were female.

With respect to geographic location, the patient sample breakdown is as follows:

- Victoria, 36% (n=24)
- New South Wales, 59% (n=39)
- Queensland, 5% (n=3)

- Metropolitan, 88% (n=58)
- Rural,12% (n=8)

Sample breakdown by age group shows that 59% of the patients that responded to the questionnaire were 50 years of age or older. The complete breakdown by age group is as follows:

Age group	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-74	75+
Percentage of total	10.6%	4.5%	6.1%	7.6%	4.5%	7.6%	13.6%	10.6%	13.6%	13.6%	7.6%
Number	7	3	4	5	3	5	9	7	9	9	5

Summary of Key Findings

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Actual Patient Behaviour

Patients demonstrated a relatively sound recollection and understanding of the payment process. Almost all patients were able to relay the order of events in which the process occurred and though there were several variations, the vast majority of payments were conducted in a consistent manner:

1. The patient presented their health insurance card to the staff member attending the desk. This was either the dentist or an administrative assistant.
2. The patient was told or shown (via the invoice) the gap amount they were required to pay. Patients noted that they were more often told than shown, suggesting that in a number of cases the invoice may not be presented to the patient until payment is made.
3. The patient paid the gap using either cash or a payment card.

With respect to variations on this process, in one example the patient was required to provided a health insurance and payment card simultaneously, therefore preventing an opportunity to view the invoice. In another, the dentist described the items claimed to the patient prior to payment. This enabled the respondent to verify the accuracy of the invoice and to gain a greater understanding of the procedure codes and descriptions presented on the invoice.

Patient responses also suggest sensitivity to the gap amount. Ninety percent (n=54) of respondents expected a gap payment and while the predominant reason for this was because they had previously experienced the scheduled procedure, 17% (n=9) indicated that their level of cover did not provide full coverage under any circumstances, 15% (n=8) of patients checked their health insurance benefit prior to visitation and 37% (n=20) were told to expect a gap by the dentist. Qualitative responses to the questionnaire also suggested that patients are somewhat keen to gain an understanding of the gap payment prior to visiting the dentist in order to ensure they will be capable of paying it.

Actual Patient Behaviour continued

However, while patients demonstrated an interest in the payment process and gap amount, only 41% (n=27) of patients examined the invoice on their most recent visit to the dentist. The same proportion, though not necessarily the same patients, reported a general preference to check the invoice at each visit to the dentist.

Given that 63% (n=20) of patients that examined the invoice stated that they did so because they *'prefer to check a document before they sign it'*, it is possible that the current payment process does not compel the patient to examine the invoice. Nevertheless, a substantial proportion of those that examined the invoice did so in order to verify its accuracy with 44% (n=14) wanting *'to make sure the procedures were correct'* and 28% (n=9) *wanting to make sure the out of pocket expense matched what they were told it would be'*.

Of the patients that examined the invoice, only 9% (n=3), however, explicitly examined the invoice due to being *'wary of fraud'*. Though this does not necessarily indicate a low awareness of fraud in ancillary health services, it may indicate that fraud is not presently a concern that drives patients to examine their invoices. In order to increase the propensity of patients to examine invoices closely and act as auditors of the system, it may be prudent to increase awareness of the possibility of health insurance payment system misuse. An increase of patient awareness may also lead to a reduction in fraudulent activity on behalf of the practitioner, as they become conscious of the potential for patients to question their modus operandi with respect to claims processing.

Of those that examined the invoice, 78% (n=25) examined the procedure descriptions, 47% (n=15) examined the procedure codes and 38% (n=12) examined their personal details. Of the 25 patients that examined the procedure descriptions, 80% (n=20) understood them, as did 67% (n=10) of those that examined the procedure codes. However, when asked whether it was *'hard to know whether the descriptions on the invoice were correct or not'*, 94% (n=62) of patients answered in the affirmative. This suggests that if patients were to be made auditors of the payment system, education regarding procedure codes and descriptions may be necessary. This finding is further discussed with respect to Potential Patient Behaviour later in the report.

Actual Patient Behaviour continued.

For patients that did not examine the invoice at their most recent visit to a dentist, or do not typically examine a dentist's invoice, an assumption that *'the procedures listed are correct'* was the most commonly (59%, n=26) cited reason for their behaviour. Second to this, 41% (n=18) of those that did not examine the invoice indicated that they did not do so because they *'expected the out of pocket expenses they were charged'*. Additionally, for those that did not examine the invoice, a *'substantial out of pocket expense'* was the most common factor (59%, n=20) that would cause them to examine an invoice in future. Second to this was *'a requirement that I pay on the spot'* (18%, n=6). This once again indicates that patients may be primarily driven by financial imperatives, rather than process.

Prior to completing the questionnaire, only 56% (n=37) patients were aware that the HICAPS claims form that they signed was a statutory declaration. Of the 29 patients that were unaware, 59% (n=17) indicated that they would subsequently alter their behaviour at the point of payment in light of their new found understanding.

Almost all of the patients that stated they would change their behaviour reported an intention to examine the claims form and invoice more closely prior to payment. This suggests that increasing awareness of the nature of the claims form may assist in altering behaviour at the point of payment and compel a greater proportion of patients to audit the invoice.

If an alteration to the electronic payment process were to occur, emphasising the fact that the claims form is a statutory declaration may further assist in driving behavioural change.

Potential Patient Behaviour

The likelihood that a patient would examine their invoice altered across two sets of conditions. First, patients were more likely to examine an invoice if a relatively expensive out of pocket expense was involved than if no out of pocket expense or a relatively cheap out of pocket expense was involved. This reinforces the suggestion that dentist's patients are sensitive to the out of pocket expenses generated by the claims process.

Gap size (holding requirement to pay on the spot constant)	% likely to examine the invoice (6-7 on the 11 point scale)	% highly likely to examine the invoice (8-10 on the 11 point scale)
No out of pocket expense	15% (n=10)	36% (n=24)
Relatively cheap out of pocket expense	20% (n=13)	42% (n=28)
Relatively expensive out of pocket expense	20% (n=13)	60% (n=40)

The second variable across which the likelihood to examine the invoice increased was the time of payment. Patients were more likely to examine in the invoice if forced to pay the out of pocket expense on the spot, rather than at a time of their choosing. This suggests that a requirement to settle the gap payment immediately following treatment is likely to increase the propensity of patients to examine the invoice more closely. Whilst a situation in which the patient is required to pay on the spot may not differ significantly from the present payment process, responses indicate that even inferring that payment is required immediately may substantially alter patient behaviour. It is therefore reasonable to conclude that an alteration to the payment process whereby the patient must pay prior to the benefit being released may result in an increase in the proportion of patients prepared to examine the invoice.

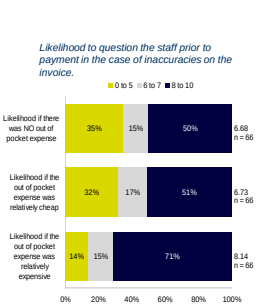
Time of payment (holding gap size constant at relatively cheap)	% likely to examine the invoice (6-7 on the 11 point scale)	% highly likely to examine the invoice (8-10 on the 11 point scale)
No requirement to pay on the spot	14% (n=9)	29% (n=19)
Requirement to pay on the spot	20% (n=13)	42% (n=28)

Potential Patient Behaviour continued

Patients also appear prepared to question practice staff in cases where they have identified an inaccuracy on their invoice. Even in a hypothetical situation in which there was no out of pocket expense, 50% (n=33) of patients were highly likely to question practice staff prior to payment. Though the proportion of patients highly likely to question staff only marginally increased as the out of pocket expense changed to a relatively cheap amount, it increased to 71% (n=47) as the out of pocket expense moved to a relatively expensive amount.

Whilst these results assume that patients are capable of identifying inaccuracies in the first instance, they suggest that if given sufficient opportunity to identify and define inaccuracies, patients may be prepared to directly challenge erroneous information at the point of payment.

Additionally, in light of the finding that 92% (n=61) of patients indicated that they would be amenable to developing a greater understanding with respect to procedure codes and procedure descriptions, it may be possible to increase the propensity of patients to audit the system through education or simplifications to procedure code and description nomenclature.



Patient Attitudes to Misuse of the Payment System

Consistent with the reported behaviour of patients during their most recent visit to a dentist, patient's stated attitudes indicate an understanding of the payment system and the potential for its misuse to affect out of pocket expenses. Indeed, 88% (n=58) of patients agreed that the *'types of procedures performed directly influenced my out of pocket expenses'* while 71% (n=47) of patients agreed that *'the person operating the payment machine is able to influence my out of pocket expenses'*. The second finding is particularly important as it indicates a possibility that the majority of patients are conscious of the ability of the practice to alter payment outcomes (i.e. conduct fraudulent activities). Though patients may not be frequently examining invoices in case of fraud overtly at present, they may be at least open to the concept.

With respect to misuse of the electronic payment system in particular, a high proportion of patients demonstrated concern for such activities when prompted with 83% (n=55) patients indicating that *'they cared about misuse of the health insurance payment system because it affected me'*. This was reinforced by the finding that 65% (n=43) of patients disagreed that *'misuse of the health insurance payment system only hurts insurance companies'*, and indicated that a high proportion of patients may intrinsically understand the impact that fraud has upon patient costs.

Patient responses indicate an open mindedness toward participation in the auditing of the electronic health insurance payment system with 94% (n=62) of participating patients agreeing that *'if I was able to prevent misuse of the health insurance payment system I would do it'*. While being amenable to the concept of contributing to the policing of fraud, 92% (n=61) of patients were interested in *'understanding more about the codes that identify procedures on the invoice'*. As has been previously mentioned within this report, this may indicate a willingness on behalf of the patient population to improve their ability to act as auditors of the system.

Patient Attitudes to Misuse of the Payment System continued

As 88% (n=58) of patients agreed that *'it is hard to know whether the descriptions of the procedures on the invoice are correct or not'*, the manner in which the information pertinent to the payment transaction is presented is crucial to developing the capability of patients to act as auditors of the system. Consequently, the knowledge of the patient regarding procedure descriptions and codes may act as a barrier to the installation of patients as auditors.

Additionally, patient attitudes suggest that a high proportion of patients may be inclined to divest the responsibility for preventing fraud to external persons or Governmental entities as 79% (n=52) of patients agreed that *'stopping misuse of the health insurance payment system is the responsibility of the dentist'* and 65% (n=42) of patients agreed that it was the *'responsibility of the Government'*. Perhaps prepared to abdicate responsibility, patients may need to be explicitly encouraged to participate in the auditing of the health insurance payment system.

Conclusions

Patient attitudes toward misuse of the electronic payment system in dentist's clinics suggest that while it was understood that the impact of fraudulent activities directly impacted out of pocket expenses, patients were unsure as to who was responsible for policing it. Indeed, though a substantial proportion of patients agreed that the prevention of fraudulent activity was the responsibility of the Government (79%, n=52) or the practitioner (65%, n=42), an overwhelming (94%, n=62) proportion of patients agreed to *'prevent misuse of the health insurance payment system'* if they were able to. Perhaps liable to abdicate responsibility, patients may need to be overtly encouraged to participate in auditing of the system.

Results also indicated that lack of patient knowledge may be a barrier to the successful implementation of patients as auditors of the payment system. With respect to awareness of misuse of the payment system, whilst a high proportion (83%, n=55) of patients indicated they *'cared about misuse of the payment system because it affected them'*, only 9% (n=3) of those that actually examined their dentist's invoice did so due to concern regarding fraud. It was possible that the gap between stated and actual behaviour was due to a lack of awareness regarding the incidence or potential for fraud in the ancillary health services.

Furthermore, a very large proportion (88%, n=58) found it difficult to gauge the accuracy of procedure codes. However, given the interest shown by patients (92%, n=61) in *'understanding more about the codes that identify procedures on the invoice'* patients may be amenable to acting as auditors of the payment system if empowered with the information necessary to understand procedure codes and descriptions. Alternatively, the information displayed on the invoice may be simplified to ease patient comprehension.

Conclusions continued

Nevertheless, irrespective of knowledge, a substantial proportion of patients were prepared to question what they believed to be erroneous information on an invoice. Despite there being no out of pocket expense, as much as 50% (n=33) of patients were highly likely (a rating of 8-10 on the scale of 0-10) to examine the invoice in the case of inaccuracies. The proportion of patients highly likely to examine the invoice remained the same (51%, n=34) in a situation where there was a relatively cheap out of pocket expense but rose sharply to 71% (n=47) when the patient was faced with a relatively expensive out of pocket expense.

In addition to highlighting a strong intention to question inaccuracies, these results also served to demonstrate patient sensitivity to price. Indeed, the proportion of patients highly likely to examine the invoice rose from 36% (n=24) in a situation where there was no out of pocket expense to 60% (n=40) in a situation where there was a relatively expensive out of pocket expense. Consequently, when provided with a financial incentive for doing so, patients may be more likely to act as auditors of the system.

APPENDIX K
Project Smiles market research report: points of note

- 74% of respondents will question items or procedures on the invoice that they do not understand or agree with.

- Since 67% of respondents believe that they understand the procedure codes, and 80% believe that they understand the procedure descriptions, the patient can be an effective active auditor of practitioner claims behaviour.

- 71% of respondents will speak up if they have any concerns about the invoice when there is a substantial gap.

- The likelihood of invoice scrutiny increases with the requirement of a larger gap payment. This explains what dentists know anecdotally: that a reduced or preferably nil gap or out-of-pocket expense for the patient in the instances of physical or administrative over-servicing forestalls questions or complaints in relation to the invoice.

- 71% of respondents believe that the person operating the electronic claims machine can influence one's out-of-pocket expenses. That is to say, more than two thirds of people believe item numbers can be manipulated by the health practitioner in a system that should be inherently black-and-white.

- 64% of respondents believe that private health insurance fraud reduction is the responsibility of the government, and 94% would prevent it if they could.

Conclusions

- Avoiding the need for a gap payment altogether, or minimising out-of-pocket expenses for the patient, decreases patient resistance to physical or administrative over-servicing.

- The current electronic processing of private health insurance claiming does not protect the need for a gap payment to be made. This can be changed with very minor alterations to the current sequence of steps in the electronic claims processing.

- In the CDDS, with no reliance on co-payment as an inhibitor of fraudulent behaviour, any reduction in physical or administrative over-servicing behaviours requires the assessment and input of the patient in scrutinising their own treatment plans before treatment begins, together with the careful attention of the referring medical general practitioner in the process.

- **Every time a no-gap claim is processed for a private health insurance ancillary claim, a discrepancy is created between the revenue figures collected by the private health funds and the actual figures lodged by the business to the ATO. As this is occurring across the ancillary health industry on a large and ever-growing scale, the figures provided by the health funds each year to the Department of Health are substantially flawed. The underlying reason for this is that the practitioner makes a full claim for all procedures carried out, then opts to accept the health-insurance rebate only without demanding a co-payment from the patient. Although the electronic claims terminal, and in turn the health fund is of the belief that the co-payment has been paid, this is not necessarily the case.**

- Health practitioner businesses providing no-gap or reduced-gap services are therefore running two sets of financial books, one being the auditable trail from their electronic claims terminal that the health funds and the government are relying on for policy development, and the other being the accounting numbers on their own computer software they are relying on to collate their true revenue figures for tax assessment each year.

APPENDIX L
The reduction of cost of treatment per patient in the Chronic Disease Dental Scheme

Comments in relation to article in SMH by Mark Metherell November 14, 2011 and Sue Dunlevy in The Australian December 21, 2011

The studies referred to in these news articles may be showing favourable statistics but what has been concluded from the data is, in my opinion, totally flawed.

As recently as a few weeks ago, we were hearing officials quoting average claim figures of $2200 per patient on the Medicare Chronic Illness dental scheme, but it seems this has now dropped to $1500, as cited by Professor Zoellner in the SMH report, and $1201 in the Dunlevy report

From this data you cannot form the hypothesis that patients across Australia are moving from the expensive, treatment-intensive phase to the less expensive maintenance phase of care and deduct new total dental Medicare spending budgets.

The underlying errors in the hypothesis are as follows.

1. It is a simple fact that almost all people with average to poor dental health (those this scheme has been targeting) can spend many thousands of dollars at the dentist before they can be put "on the shelf" as maintenance-phase patients. Evidence pointing to the fact that approximately one in two CDDS patients had an expensive crown inserted within the scheme, which in these cases would amount to almost all of the total claim points to the fact that one focal point or tooth in the mouth has been targeted, leaving the rest the mouth in the chronically ill patient in a state of disrepair.
2. The vast majority of the patients are new clients to the scheme as the $4250 limit applies to dental work carried out over two years before patients may be eligible to make further claims. So, in effect, new clients with similar mouths and dental problems are presenting in the current 12 months, as they were in the first, second and third 12 months of the scheme, but suddenly costing Medicare an average 30% less! To be sure of the maintenance phase kicking in, bringing down the cost of dentistry, the data would have to (a) show clearly that the drop has occurred in the patients reapplying to Medicare and seeking treatment in their second bi-annual period and (b) importantly, not include all the new patients to the scheme.

Finally, in relation to point 2, if a drop in figures is observed when comparing claims from patients new to the scheme with repeat claims from patients after the first two-year phase, one would need to check the drop-off of claim amounts in new clients vs. new clients as the baseline drop-off caused by other external factors. Only then, if there is an additional % reduction for clients claiming a second time round, could that reduction be genuinely attributed to maintenance-phase treatment kicking in. (This is just like when property capital gains tax is calculated as a gain above CPI so as to create checks and balances.)

It is my considered opinion that the brake applied to the claims patterns over the past 12 to 18 months was not due to maintenance-phase dental care kicking in.

Rather, I believe, the slowdown was due to the highly publicised Medicare audits of dentists not complying with legislation.

What these stats show is that Medicare's audits on dentists have bought the profession into line and put dentists willing to bend the rules on notice that they cannot get away with administrative claims over-servicing in the same way that they have with patients on private health insurance. In fact, the difference in cost to the public purse of $2200 and $1500 and $1201 per patient in the total bill to Medicare is, in my opinion, ***mostly a direct consequence of the reduction of physical and administrative over-servicing claiming patterns.***

I would be interested to find out if the total bill to Medicare for this scheme is also declining. This would be interpreted by vested interest groups as fewer dentists wanting to partake in the scheme due to Medicare's "bullying tactics", and yet the reduced claim amount per patient would debunk that theory.

Dr Kia Pajouhesh
B.Sc. (Melb) B.D.Sc. (Melb)
Dental surgeon

APPENDIX M

Proposed solutions for combating fraud in the Medicare Chronic Disease Dental Scheme (CDDS)

The problems described fall into three categories, under each of which I propose relatively simple solutions as follows.

Sequence of treatment and the importance of an itemised plan
The sequence of most treatment modalities follows an industry-accepted standard; hence, when an audit detects items charged for and performed out of sequence, these should be deemed suspect behaviour. As a simple example, all diagnostic measures, with related item numbers, are invariably carried out at the commencement of treatment, thus refuting any claims made by audit respondents that they have charged in advance for a diagnostic item number nearing the completion of treatment. This is something that can be assessed by a dental adviser.

Physical over-servicing
With respect to the dividing line between acceptable clinical variation and over-servicing, each industry peak body, such as the ADA in dentistry, should make available the industry standards they have in their possession, standards that will be based on scientific rationale and statistical data. ***This would place an onus on the health industry to become accountable to public health and the public purse in relation to the insidious problem of over-servicing.*** As an example, if the ADA deems the industry standard for OPG X-rays to be approximately 1 in 5 patients, then audits showing, over an extended period across a large sample of patients serviced, claiming patterns that are outside a dental industry–accepted level of variation can be seen to have detected physical over-servicing.

Administrative over-servicing
In each and every claim, an active auditor should be directly or indirectly appointed to scrutinize the claim. In claims where a gap or co-payment is required, the patient or client takes on this role as long as the claiming protocol ensures that the gap payment is made prior to any release of public funding. Where there is no gap payment, as with the Chronic Illness dental scheme, the processes in place for a GP and the patient to scrutinize the treatment plan before commencement of care must be rigorously defended and upheld for the sake of the public health and the public purse.

Installation of an out of pocket expense for the patient

An effective gap payment, albeit small is the most simple and efficient method to motivate a patient in becoming an active auditor of any claims process, whether it be private health insurance or a publicly funded Medicare scheme. Independent market research *(Appendices J and K)* has shown that patients are more likely to scrutinise treatment, and are more likely to speak up against any sign of administrative or physical over servicing when there is an out-of-pocket expense to be paid. In the event that a gap payment is required, the claims system whether it be electronic or manual must ensure that this gap amount is paid and not bypassed by the health provider to facilitate over-servicing behaviours.

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Dental surgeon

APPENDIX N
The Youth Dental Program failure – bad policy or something else?

Australia's $490 million Youth Dental Program is faltering because only 30% of the 1.2 million eligible teenagers used the program last financial year.

The Shadow Minister for Health and Ageing, Peter Dutton, has said: "While the Gillard Government is trying to tear down the highly effective coalition Chronic Disease Dental Scheme, which has provided more than 11 million services to needy Australians, its own dental health policies falter and fail."

Associate Professor Hans Zoellner, chairman of the Association for the Promotion of Oral Health and a University of Sydney dental expert, has said the program was a "bizarre act by the Labor government, which has invented new ways to humiliate poor people".

So why has one scheme been over-utilised and another under-utilised?

I believe it is because the CDDS gives carte blanche to over-servicing practices, making it possible for clinicians to carry out work well below their normal charge rates yet still gain financially from participating in the program; therefore they have embraced it. By contrast, the Youth Dental Program (YDP) is a $160 dead weight for the clinician and his/her business, so has largely been embraced with less vigour than the CDDS.

Conclusions

1. Fundamentally, ***a program's take-up rate depends on clinicians' endorsement of it based on its financial advantage to their business.***
2. The CDDS has been aggressively promoted by clinicians through various marketing methods, letter drops, website information and the like, whereas the YD program has been largely ignored.
3. The failure of the YDP relative to the success of the CDDS is not an indication of poor policy per se, because the CDDS is poor policy in many ways and the YD program is generally good policy. Rather, it is evidence of the opportunities a system with pre-set and limited fee schedules provides for administrative and physical over-servicing in order to give clinicians an opportunity to retain their business profitability.

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B.Sc. (Melb) B.D.Sc. (Melb)
Dental surgeon

Thursday 5 August 2010

Dr Kia Pajouhesh
Tony Wildman
PHIAC Ryan Sanderman

Melbourne VIC

A summary of electronic claims misuse and fraud by health care providers

Two broad categories:

1. Covert Misuse
2. Overt Fraud

- The current solutions provided by the health insurance companies to the endemic problem of covert misuse include auditing processes, business rules, and reduction of rebates of commonly misused item numbers. All these efforts are purely reactive in nature, slow, costly and collective punishment by nature.
- We need a one size fits all proactive solution to the problem that is "preventive" in nature.

"The gap" payment

Exists for a number of commercial reasons, however with regards to claims misuse prevention it plays this critical role:

- The patient is more likely to become a proactive auditor of the claims process and the health care professional's claims behaviour when it involves out of pocket expenses to them.
- The audit process becomes a functional and dynamic process as long as the integrity of the gap payment is maintained.

Our dilemma

The gap payment is an essential requirement to reduce health claims misuse and fraud.

However our current electronic claims process does nothing to protect its necessity. In fact, electronic claiming has further reduced the efficiency of the gap payment in protecting against misuse.

That is to say, electronic claiming has been an additional aid rather than a hindrance for a health provider willing to misuse the system.

The concept in its most basic form

1. Process the claim electronically as per usual
2. Determine the benefit amount as per usual
3. Request the gap payment to be paid first involving the patient as an active auditor of the claim
1. Release the benefit amount once gap payment is made

The Benefits

1. For the Health Insurer
2. For the Client/Patient
3. For the Health Provider
4. For the ATO by streamlining our audit trail

Benefits for the Health Insurer

Reduced claims misuse and fraud - better provision of service with more funds going to the clients and the fund rather than system misusing providers.

This can only mean happier customers, happier honest health care providers, and happier professional associations and Boards.

Benefits for the Client/Patient

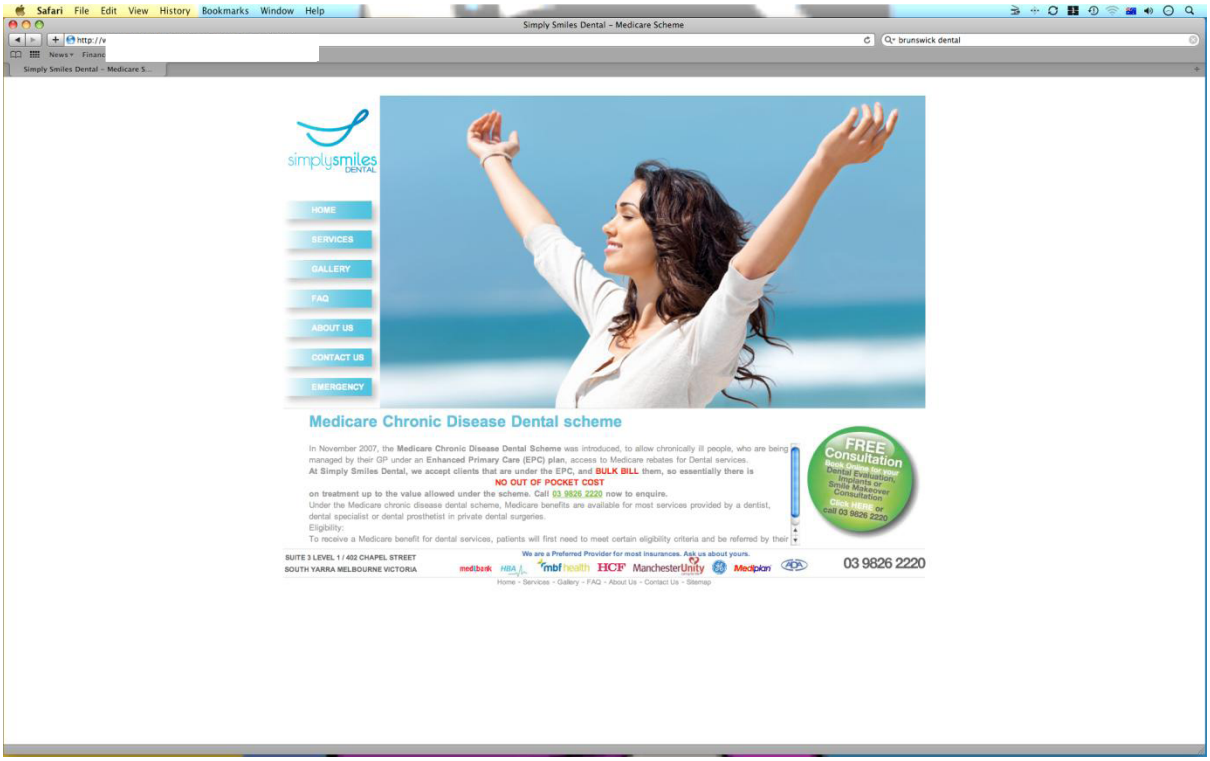
1. Increased claims benefit – as less funds are diverted into the pockets of fraudulent clinicians
2. Avoid being unwillingly manipulated into misuse of the processing system by not understanding the intricacies of the provider's misbehaviour when no gap or minimal gap care is on offer

Benefits for the Health Care Provider

1. Gap payment more likely to be paid - reducing bad debt
2. Removes the unfair advantage offered to dishonest health providers under the current processing system – thereby creating a more level playing field for all

In summary

- Happy Insurance provider
- Happy Consumer
- Happy honest Health care providers
- Unhappy dishonest Health care providers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Medicare Chronic Disease Dental scheme
In November 2007, the Medicare Chronic Disease Dental Scheme was introduced, to allow chronically ill people, who are being managed by their GP under an Enhanced Primary Care (EPC) plan, access to Medicare rebates for Dental services.
At Simply Smiles Dental, we accept clients that are under the EPC, and BULK BILL them, so essentially there is NO OUT OF POCKET COST
on treatment up to the value allowed under the scheme. Call 03 9826 2220 now to enquire.
Under the Medicare chronic disease dental scheme, Medicare benefits are available for most services provided by a dentist, dental specialist or dental prosthetist in private dental surgeries.
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The highly professional and skilled team at No Gaps Dental pride themselves on giving you the highest quality dental care in a comfortable and caring environment. We have a number of dentists to take care of your immediate needs and our staff are always keen to give new and existing patients a warm and friendly welcome.
Our patients know that we care about them and that we aim to offer a quality service at a very reasonable price. Your smile is important to us, so we will use our extensive experience to keep it beautiful and healthy. Once we determine your dental needs, we'll work with you to obtain the most feasible option whilst making treatment a positive and anxiety-free experience.
No Gap on General Dental Services
Our goal is not to let expense prevent you from benefiting from the quality of dental care you desire and need. Under our core No Gaps offering, our patients with dental cover with any Australian health insurer are offered many restorative and preventive dental services with no out-of-pocket expense. This includes your regular scale and clean, fluoride applications, x-rays and fillings.
Health Funds
→ MBF MemberCare
→ HBA/Mutual Community and BUPA Members First
→ Medibank Private Member's Choice Preferred Provider (Blacktown)
→ CBHS Preferred Provider
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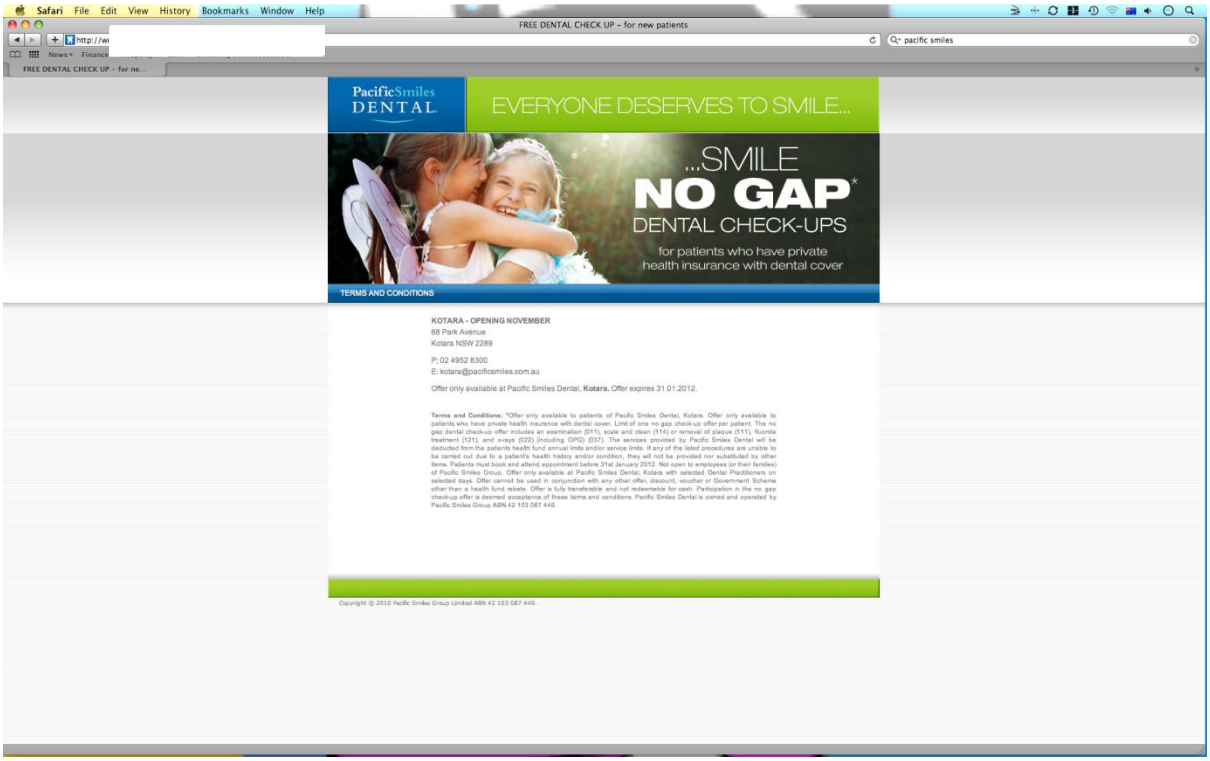
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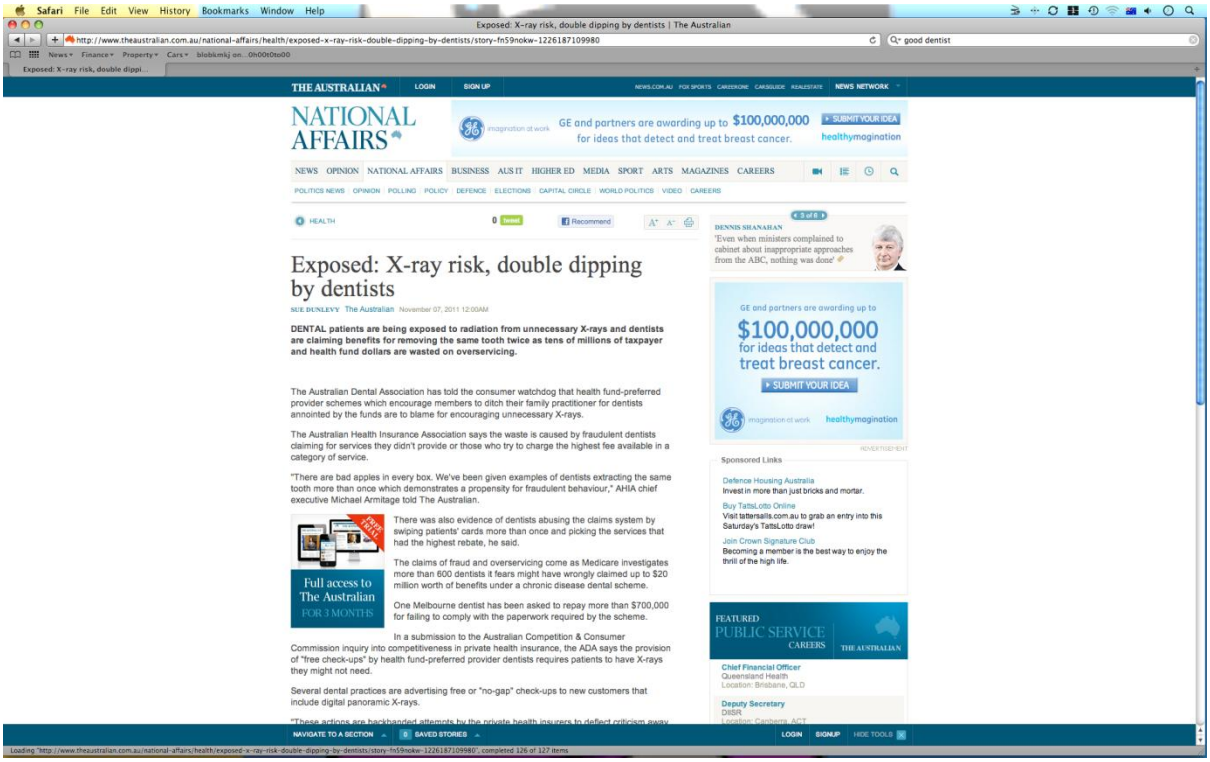
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HEALTH
Recommend
Exposed: X-ray risk, double dipping by dentists
SUE DUNLEVY The Australian November 07, 2011 12:00AM
DENTAL patients are being exposed to radiation from unnecessary X-rays and dentists are claiming benefits for removing the same tooth twice as tens of millions of taxpayer and health fund dollars are wasted on overservicing.
The Australian Dental Association has told the consumer watchdog that health fund-preferred provider schemes which encourage members to ditch their family practitioner for dentists annointed by the funds are to blame for encouraging unnecessary X-rays.
The Australian Health Insurance Association says the waste is caused by fraudulent dentists claiming for services they didn't provide or those who try to charge the highest fee available in a category of service.
"There are bad apples in every box. We've been given examples of dentists extracting the same tooth more than once which demonstrates a propensity for fraudulent behaviour," AHIA chief executive Michael Armitage told The Australian.
There was also evidence of dentists abusing the claims system by swiping patients' cards more than once and picking the services that had the highest rebate, he said.
The claims of fraud and overservicing come as Medicare investigates more than 600 dentists it fears might have wrongly claimed up to $20 million worth of benefits under a chronic disease dental scheme.
One Melbourne dentist has been asked to repay more than $700,000 for failing to comply with the paperwork required by the scheme.
In a submission to the Australian Competition & Consumer Commission inquiry into competitiveness in private health insurance, the ADA says the provision of "free check-ups" by health fund-preferred provider dentists requires patients to have X-rays they might not need.
Several dental practices are advertising free or "no-gap" check-ups to new customers that include digital panoramic X-rays.
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Australian Dental Association Inc.

ACCC Submission on Private Health Insurance

5 September 2011

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1. ABOUT THE AUSTRALIAN DENTAL ASSOCIATION

The Australian Dental Association Inc. (ADA) is the peak national professional body representing about 12,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers.

The ADA would like to thank the Australian Competition and Consumer Commission (ACCC) for the opportunity to respond to your letter of 10 August.

2. EXECUTIVE SUMMARY

Due to the deterioration in the behaviour of Private Health Insurers (PHIs) immediate remedial action is required to be undertaken to bring PHI into line with the health interests of their members. In responding to the ACCC's letter, the ADA has described conduct of PHIs and the impact that such conduct has on the consumer and in each context provides recommendations that will address the concerns identified.

The recommendations are:

1. PHIs to be brought to account to provide justification for the decline in payment of rebated benefits and if suitable explanation is not provided then remedial action be imposed through legislation to rectify this decline in real benefits.
2. PHIs to be brought to account to provide justification for the lack of increase in dental rebates across all dental services.
3. PHIs to increase dental rebates for all dental services annually.
4. PHIs be banned from actively and directly attempting to influence their members to receive treatment from the PHIs' contracted providers as it interferes with the patient/dentist relationship.
5. PHIs should cease to promote their contracted providers by use of terminology that potentially contravenes the Dental Board of Australia Guidelines and the "National Law".
6. PHI rebate structures for services must be designed with the health interests of the member as uppermost and should not be constructed to generate a profit for the PHI.
7. Health experts be engaged to assess the manner in which PHI rules governing utilisation and rebate levels for services are implemented to ensure that the health interests of PHI members are being correctly prioritised.
8. If there are to be annual limits imposed by PHIs (which is opposed by the ADA-see recommendation 11) then PHIs be required to provide to all contributors current details of such limits.
9. PHI be required to provide all general treatment policy holders with an itemised copy of current rebates for all general treatments.
10. There be some uniformity in business rules and qualifying periods in order that consumers can make valid comparison between PHI policies.
11. There be no annual or lifetime limits on dental rebates in PHI policies.

12. Where PHIs attempt to exercise derecognition action, the following must apply:
    - Provision of full and accurate disclosure of the PHI's reasons for such action to both the dentist and the patient;
    - Any communication between the patient and health fund regarding derecognition of the dentist be on agreed terms between the fund and dentist;
    - Rights of review of such decisions must be put in place – natural justice must apply;
    - There be procedural fairness in the derecognition process.
13. Enactment of legislation to prevent PHIs from purporting to "create" contracts where no consideration or meeting of minds between PHI and provider exists.
14. Discriminatory conduct in the payment of various rebates to members based on where services were received be declared illegal, as it is against the interest of the patient and undermines open competition.
15. When there is evidence of erroneous conduct by PHIs, immediate punitive penalties be imposed on PHIs and in the case of repeated infringements, loss of licence to operate as a PHI be imposed.
16. In the context of Preferred provider Schemes, the recommendations 4-11 above are repeated.
17. If the ACCC wishes to assist consumers with provision of information about the financial impact of receipt of healthcare then where services are rebated by PHI, the ACCC must demand PHIs publish clear, easy to comprehend rebate tables for each Policy of PHI provided. [See recommendation 9].
18. Inducements to receive free care where patients are required to undergo additional unnecessary services must be outlawed and appropriate legislation enacted.
19. The ADA calls for banning of social media sites that purport to assist consumers in identifying suitable health providers.

3. INTRODUCTION

There remains considerable disquiet being felt by both members of the public and the dental profession with regard to private health insurer (PHI) conduct.

The behaviour of PHIs appears focused primarily on a profit motive, at the expense of the health and welfare of their members. With the increase in market share of for-profit funds to approximately 71% of the market in 2010 (compared to 12.5% in 2000), the impact of this focus will only increase. This profit motive may be acceptable in more commercial arrangements but in the sphere of health, it is the interests of the patient (health fund contributor) that must be given the dominant place in the contractual arrangements that exist. Figures from the Private Health Insurance Administration Council (PHIAC) and highlighted in the Table below indicates there has been a steady but significant rise in the number of dental services provided to people with private health insurance in the past decade.

Despite the rise in dental services, the benefits returned to patients (relative to the cost of care) have declined over the past decade. As the table shows, the average benefit paid to patients as a percentage of the cost of care for dental services has fallen from 54.5% in 2000 to 48.73% in 2010. This is more than a 10% decline. There is no evidence to suggest why this diminution in benefits to members has arisen.[1]

PRIVATE HEALTH INSURANCE - Benefit paid as a percentage of the cost of service for Dental Services 2000 to 2010						
Year	**Number of services**	**Fees charged (cost of the service)**	**Benefits paid for services**	**Average cost of service**	**Average benefit paid to patient**	**Benefits paid as % of cost of services**
2000	16,224,856	1,255,697,000	686,873,894	77	42	54.50%
2001	19,923,999	1,575,518,000	876,464,773	79	44	55.70%
2002	21,501,375	1,771,760,000	965,563,252	82	45	54.80%
2003	21,837,694	1,886,382,000	993,246,116	86	45	52.30%
2004	22,756,855	2,082,321,000	1,051,117,913	91	46	50.50%
2005	23,297,702	2,230,007,000	1,098,089,121	96	47	48.90%
2006	23,999,526	2,414,322,000	1,187,205,239	101	49	48.50%
2007	25,072,735	2,638,144,000	1,283,302,782	105	51	48.60%
2008	26,687,191	2,925,375,186	1,414,241,884	110	53	48.34%
2009	27,739,510	3,118,928,845	1,509,763,524	112	54	48.41%
2010	28,829,591	3,295,090,696	1,605,632,781	114	56	48.73%

Source: PHIAC - Statistical Trends in Membership & Benefits Data Tables December 2010.

Given that the rising cost of healthcare is promoted as the principle explanation for rising health insurance premiums, the ADA believes it is important for health funds to ensure that benefits paid as a percentage of the cost of care do not continue to decline, as they have done over the past decade.

It is very apparent that in the last decade PHI has used general treatments [formerly referred to as ancillary services] as a means of generating enormous surplus in funds. This is clearly indicated in the table below.

[1] **See Tables relating to Premiums, rebates and cost increases (Attachment 1).-Available at** http://www.ada.org.au/private_health_insurance/cpi.aspx

Year	Ancillary Income	Ancillary payout	Surplus	Percentage
2000/01	$ 1,920,519,000.00	$ 1,533,122,000.00	$ 387,397,000.00	20.17%
2001/02	$ 2,121,529,000.00	$ 1,900,328,000.00	$ 221,201,000.00	10.43%
2002/03	$ 2,371,360,000.00	$ 2,043,440,000.00	$ 327,920,000.00	13.83%
2003/04	$ 2,556,786,000.00	$2,117,299,000.00	$ 439,487,000.00	17.19%
2004/05	$ 2,724,385,000.00	$2,239,925,000.00	$ 484,460,000.00	17.78%
2005/06	$ 2,857,096,000.00	$ 2,276,743,000.00	$ 580,353,000.00	20.31%
2006/07	$ 3,049,798,000.00	$2,454,356,000.00	$ 595,442,000.00	19.52%
2007/08	$ 3,433,908,000.00	$ 2,656,255,000.00	$ 777,653,000.00	22.65%
2008/09	$ 3,696,018,000.00	$ 2,869,540,000.00	$ 826,478,000.00	22.36%
2009/10	$ 3,996,818,000.00	$ 3,052,757,000.00	$ 944,061,000.00	23.62%
Total	**$ 28,728,217,000.00**	**$ 23,143,765,000.00**	**$ 5,584,452,000.00**	**19.44%**

Source: PHIAC

In the 10-year period depicted in the table a surplus of in excess of $5.5 billion has been achieved in comparing Ancillary income with payouts. It would appear that PHIs are using the surplus from ancillary to support [subsidise] their other insurance products as the declared overall profit of PHI does not reflect these massive profits from ancillary. The ADA believes that the health fund contributors are not informed of this massive surplus. In real terms it means that contributors to ancillary services are not getting full value in rebates as significant amounts are being used to offset other aspects of the PHI business. This is of great concern to the ADA as the Private Health Insurance Administration Council (PHIAC) figures indicate about 51% of the ancillary expenditure is for dental services.

Furthermore, some health funds have not had across-the-board rebate increases since 1994. Despite the few dental rebate reviews that have occurred, rebate increases have not kept pace or even approximated the annual PHI contribution increases.

The PHI annual contribution increases have with regular monotony been well in excess of CPI.

Recommendation:

1. The ADA calls for PHIs to be brought to account to provide justification for this decline in rebated benefits and if suitable explanation is not provided then remedial action be imposed through legislation to rectify this decline in real benefits.
2. The ADA calls for PHIs to be brought to account to provide justification for the lack of increase in dental rebates across all dental services.
3. The ADA calls for PHI to increase dental rebates for all dental services annually.

4. ACCC LETTER OF 10 AUGUST 2011

In responding to the letter from the ACCC, the ADA will confine its responses to those questions that are of relevance to the Association, its members and the patients our members treat. For completeness, it has been necessary to reiterate certain points made in the Submission when responding to some questions. This is because some of the issues raised require response on more than one occasion.

Question 1. CONTRACTING ISSUES

- *The ACCC seeks comment on any developments or trends in the sector in 2010-11 that have impacted on these contractual arrangements*

As mentioned in the Introduction to this submission, there has been a significant increase in both the number of dental services provided to people with PHI over the past few years and the premiums paid for PHI. Despite this, benefits returned to patients (relative to the cost of care) have declined over the past decade. The inherent reluctance of PHI to regularly implement rebate increases is a concern to the ADA and must also be of concern to the contributors of the health funds. It would not be unreasonable for contributors to expect annual rebate reviews reflecting increased rebates at least commensurate or equal to CPI. Annual premium increases to PHI are nearly always in excess of CPI.

Health funds are often profit driven and their business rules are designed to maximise their profits. One method of achieving this is by placing a limit on their rebates to their contributors (annual limits), i.e. an annual limit. PHIs not only do not increase dental rebates but they do not on a regular basis review the annual limits. Further, PHIs also place restrictions on the number of services that are eligible for rebate. For example they may only permit payment of a rebate on a limited number of services each year [e.g. only allow one dental crown per annum] or may impose life-time limits on some procedures [e.g. orthodontic banding]. The creation of such limits is arbitrary and has no relationship to dental needs of the patient. These limitations are not well explained by PHIs, if at all, to their contributors and often the first time the contributors are made aware of these restrictions is after the event, i.e. after having the dental service provided and then attempting to make a claim for rebate.

The impact that this can have on the dental health of the patient and the clinical independence of dentists is inappropriate in that it restricts services that are necessary for the contributor.

The ADA sees health funds as increasingly interfering with the delivery of dental healthcare by:

1. Seeking to influence patients in the selection of their dentist for treatment.

Continuity of treatment is vital in the proper care of patients. Bonds and confidences are developed over time between patient and practitioner that are invaluable. These should not be interfered with. This is even more so in dentistry where often phobias or dislike of treatment can be a relatively common occurrence.

Examples of this are many and varied and set out below are instances of such conduct:

a) There is evidence available that some health funds are using the opportunity of discussing written estimates of costs of treatments with their members to deliberately attempt to redirect patients to the funds' contracted (preferred provider) dentists. This behaviour by health funds is not in the patient's dental health interest and is unfair to the treating practitioner and in fact lessens competition. This practice amounts to an effort to discourage patients from using their dentist of choice. It is an underlying principal of PHI that one of the prime reasons for taking out PHI is to be able to attend the provider of choice. It is contrary to the patient's dental health interests and is really a backhand and deliberate attempt by the funds to deflect criticism away from them for their failure to have rebates keep pace with premium increases and the higher 'gap' for the provision of dental services that arises.

b) There is an increasing trend detected by the ADA and displayed in PHI advertising where patients are often advised by health fund staff to seek treatment from practitioners who are 'preferred providers' of a particular fund. Quite erroneous reasons for this advice are provided to the patient by the fund. The manner in which this is presented or advertised is often seen by the patients as indicative of inferior performance by the 'non-preferred provider' practitioner when that is not the case. This practice is most unfair to those dentists who choose not to enter into a contractual relationship with a health fund and has the effect of creating an uneven field of competition. (See also later under Question 2)

c) There is evidence of PHIs refusing to accept additional healthcare providers as preferred providers. Reasons given by the PHIs are varied:

- There are too many preferred providers in the same area as the applicant;
- The applicant's fees are too high even though there are already contracted providers who have a much higher fee base; and
- The volume of dental services output is too high.

d) Further, the PHI preferred provider schemes offer substantially higher rebates for services provided by the 'preferred provider'. This is most discriminatory and provides an unfair advantage to the contracted provider.

Some schemes have fees set by the PHI which seems contrary to National Competition Policy and raises the spectre of a cartel arrangement or a contract arrangement that lessens competition. In some of the schemes with fees set by the PHI, the patients seen by the preferred provider have zero out-of-pocket costs but the non-preferred provider's patient, even if the fee charged is identical gets a much lesser rebate. This punitive discrimination is anti-competitive.

e) Other schemes have contracted agreed fee arrangements that cannot be increased without PHI agreement. The preferred provider patients receive substantially higher rebates depending upon which table they are in.

There are cases where the non-preferred providers' entire fee is less than the rebate offered to the preferred provider's patient yet because the out of pocket expense is less, the PHI's staff promotes the preferred provider as being cheaper. This is clearly not the case and is misleading and deceptive.

f) PHIs often advertise "free services" or "no charge" services by preferred providers. Quite clearly the provider is paid for their service and the patient pays via their contributions. This is misleading and deceptive. There is lessening of competition as the non-preferred providers patients are not offered these "free" services.

In all of the above examples the patients are paying the same contribution rates yet if the patient chooses the provider of their choice they are punitively discriminated against by the differential rebate. This lessens competition.

The inference associated with the use of the term 'preferred provider' which is promoted and advertised by health funds is that dental providers not listed as preferred providers are perceived as 'not preferred' or 'not approved'. This also creates a misleading perception in the public's mind that these uncontracted dental providers have inadequate or lesser qualifications or provide substandard levels of care. This is both a deceptive and misleading activity by the health funds.

Use of such terminology to describe a practitioner with a contractual relationship with a PHI is contrary to the Dental Board of Australia's (DBA) Advertising Guidelines.[2] These guidelines "apply to advertising of regulated health services." As such, they apply to the promotion of one health provider over another and as such are applicable to PHI activity where they promote or advertise the services of preferred providers. The Guidelines are breached if advertising is "misleading" or can create an "unrealistic expectation" about service to be delivered. Use of such titles as "preferred provider" or the like also breach Section 6.4. 1. of the Guideline which prohibits a practitioner "taking or using any title that could reasonably be understood to induce a belief" that a person using such a title ('preferred provider' or 'approved provider') carries skills or expertise that sets them apart from other practitioners. Utilisation of such terminology therefore exposes a practitioner to an allegation of inappropriate professional conduct and a risk of deregistration as a health practitioner. Use of such titles by PHIs and the consequent use of the title by health practitioners place them in potential breach of the DBA Guidelines and must therefore be stopped.

Recommendation:

4. PHIs should be banned from actively and directly attempting to influence their members to receive treatment from the PHIs' contracted providers as it interferes with the patient/dentist relationship.
5. PHIs should cease to promote their contracted providers by use of terminology that contravenes the Dental Board of Australia Guidelines and the "National Law".

[2] http://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx

2. *Creating fund business rules relating to rebates payable that result in patients sometimes not opting for a course of treatment that is best suited to them.*

Some funds adopt a concept of a 'reasonable utilisation level' which, through imposition of financial limitations on payment of rebates, imposes a constraint upon the way in which treatment should properly be delivered to patients. In some cases, a practitioner's mode of practice and delivery of proper dental care to the patient is adversely affected because of the utilisation level. These practices constitute interference in the delivery of proper dental care.

Such utilisation levels are based on economic parameters and are not based on sound clinical evidence applied to individual patients.

Where utilisation levels interfere with the delivery of proper healthcare they should be disregarded and the PHI obligated to meet, in part, the fees incurred for the optimal treatment.

PHI place annual limits on services provided and in most cases the contributor is unaware of the restrictions imposed and has not had this clearly explained in the policy of insurance. The ADA is concerned that the term 'insurance' is used in connection with PHI when what is provided is not insurance in the real sense. In no other area of insurance are such limitations imposed. In motor vehicle insurance for instance there are no policies that limit cover to only two wheels, one door and three windows per year. Utilisation of the term "insurance" in itself when related to PHI is misleading. Where PHIs apply lifetime limits on what services will be rebated as a "business rule", the contributors often elect to not proceed with necessary treatment if there is no rebate available. For example in some difficult orthodontic cases it may be necessary to apply orthodontic bands (fixed appliances) sometime after the initial course of orthodontic treatment. Because the orthodontic rebate has been claimed previously there is no further rebate available under lifetime cover. Furthermore, even when the life-time limit has been received for a particular service, the PHI continues to receive premiums from the contributor for such 'Major Dental' entitlements knowing the contributor cannot claim for such services again. This is deceptive and misleading as contributors are often not aware of the particular business rule that would disqualify them for benefits in the future.

Lifetime cover and annual limits are not applicable to medical cover. There is no uniformity in PHI business rules, rebates per service, annual limits, lifetime limits and qualifying periods. No other aspect of insurance has such impossible parameters for direct comparison of levels of cover and premiums. This does not occur with household, car, boat or any other form of insurance. It effectively lessens competition between health funds as it is impossible to make direct comparison of what is covered.

Recommendation:

6. PHI rebate structures for services must be designed with the health interests of the member as uppermost and should not be constructed to generate a profit for the PHI.
7. Health experts be engaged to assess the manner in which PHI rules governing utilisation and rebate levels for services are implemented to ensure that the health interests of PHI members are being correctly prioritised.
8. If there are to be annual limits imposed by PHIs (which is opposed by the ADA-see recommendation 11) then PHIs be required to provide to all contributors current details of such limits.

9. PHI be required to provide all general treatment policy holders with an itemised copy of current rebates for all general treatments.

10. There be some uniformity in business rules and qualifying periods in order that consumers can make valid comparison between PHI policies.

11. There be no annual or lifetime limits on dental rebates in PHI policies.

3. *Recognising some dentists as unacceptable providers (both non-contracted and contracted dentists) so their patients will not receive a health fund rebate.*

The ADA objects to the manner by which health funds communicate to a dentist's patients the fund's decision to no longer recognise claims made by patients if they are treated by a particular dentist. Being deemed unacceptable means that patients of that provider receive zero rebate for dental services to that private health insurer's member. Removal of recognition is often based on non-compliance by the dentist with certain unilaterally imposed fund requirements. Such non-compliance does not equate with any form of improper conduct by the dentist or delivery of inferior care. All too often, we are advised by our members that when the fund communicates advice to a patient of termination of its recognition of a dentist or makes critical comment about a proposed treatment plan of the provider, the obvious inference drawn by the patient is that the dentist has been providing inappropriate, improper or dishonest treatment. Such comments are clearly outside the area of competence of a fund and the suggested motive for such comments can only be presumed to be in order to influence the patient to change to a preferred provider of the fund.

Strict conditions on the exercise of such rights must be legislated. Not only does this conduct constitute the creation of a false and misleading perception in the mind of the patient it is contrary to competition policy as it effectively removes a practitioner from treating a PHI member.

Recommendation:

12. Where PHIs attempt to exercise derecognition action, the following must apply:
    - There be full and accurate disclosure of the PHI's reasons for such action to both the dentist and the patient;
    - Any communication between the patient and health fund regarding derecognition of the dentist be on agreed terms between the fund and dentist;
    - Rights of review of such decisions must be put in place – natural justice must apply;
    - There be procedural fairness in the derecognition process.

4. *Recognising some dentists as a recognised provider without the dentist's agreement to a contract with the health fund.*

Some funds have sent correspondence to dentists suggesting that the dentist is a 'recognised provider' of their fund, even though there is no contractual relationship between the two. The claim by the fund that a contractual agreement is now in place binding the treating dentist to the rules and regulations of that health fund is made simply on the basis the dentist has treated a patient who has insurance cover from the fund concerned. Once this unilateral 'recognition' is provided the PHI then seeks to impose certain conditions/rules to ensure the provider's patient receives benefits. These rules may entail using a fund's 'provider number' or similar imposition. This unilateral application of requirements on the provider, when no relationship (contractual or otherwise) exists between the two, is inappropriate and the ADA says it is improper for such requirements to be arbitrarily imposed. Non-compliance with the fund's unilateral provision of this requirement causes inconvenience to the patient and is often used as an opportunity for the fund to recommend to the patient a change of practitioner to one of the fund's actual preferred providers. It is in the ADA's view an unfair exploitation of market position by the funds.

Recommendation:

13. Legislation be enacted to prevent PHIs from purporting to "create" contracts where no consideration or meeting of minds between PHI and provider exists.

5. *The provision of higher rebates to a patient that is treated by a 'preferred' or 'contracted' provider of a fund is discriminatory to fund members.*

As all members of a fund will pay identical premiums, for the same level of cover, eligibility for rebates should also be identical. To increase a rebate available to one member who chooses to use a preferred provider discriminates financially against the member who chooses to maintain a dentist-patient relationship that may have existed for years. To place financial incentives to break down that trust is contrary to the provision of quality dental care.

Recommendation:

14. Discriminatory conduct relating to the payment of rebates based on where services were received be declared illegal as it is against the interest of the patient and undermines open competition.

6. *Repayment of erroneous claims by service provider.*

Often when PHIs claim there is over-servicing, overpayment or errant claims, the PHI demands repayment of the rebate from the provider of the service. The provider is not insured with the health fund – it is the patient who is insured and it is the patient who ought to be refunding the rebate. The contract of service is between the dentist and the patient. The contract of insurance is between the patient and the health fund.

In the case of an error in account to the patient the provider should refund the fee to the patient if that is the agreed outcome. The rebate issue is between the PHI and the contributor.

7. *The erroneous interpretation of dental item numbers by PHIs.*

The *Australian Schedule of Dental Services and Glossary*[3] is prepared by the ADA and provides numbers and descriptors for various dental services. PHIs, with increasing frequency, are placing their own interpretation on dental item numbers. The *Australian Schedule of Dental Services and Glossary* is a copyright-protected document. It has been accepted by the National Coding Centre as the definitive and authoritative descriptor of dental services. PHIs are invited to contribute submissions to the review of the *Australian Schedule of Dental Services and Glossary*.

The accusatory nature and invariably inaccurate ways in which PHIs make claims that the incorrect item number has been used are destructive to dentist-patient relationships. They often amount to no more than an attempt by PHIs to deny legitimate rebates. The ADA is unsure how it is that PHIs believe it is their domain to make such rulings on dental procedures. For all concerned there must only be one interpretation of item numbers. It is inappropriate for PHIs to attempt to interpret correct usage of item numbers, and where questions may arise, reference must be made to the ADA's expert committee for guidance.

8. *PHIs refusing to rebate for dental services carried out over multiple appointments until the services have been completed.*

Some PHIs on a regular basis, but at their discretion, refuse to rebate for dental services carried out over multiple appointments until all the services in a treatment have been completed. This particularly relates to crown and bridge work. These procedures are usually carried out over at least two visits.[4]

The *Australian Schedule of Dental Services and Glossary* clearly defines the accepted protocol of billing for such procedures at the first visit. These protocols are based on common law contract principles. PHIs refuse to accept this protocol.

This is contrary to how PHIs deal with general treatment rebates for other providers and is conduct clearly discriminating against the contributor for legitimate dental services provided. The same PHIs who do not rebate the crown or bridge at the preparation date will rebate optical services at the issue of the prescription for the lenses even though not yet provided and will rebate for orthotics merely at the impression-taking stage. Unlike the crown preparation, neither the optical nor the orthotic treatments are invasive or irreversible procedures. PHIs remain inflexible in their attitude to this and incorrectly inform patients on a regular basis that it is the dental provider who is at fault and refuse to rebate on presentation of the account even if the patient has paid for the said service in full.

[3] The *Australian Schedule of Dental Services and Glossary* has been published by the Australian Dental Association since 1986. Since its inception, it has been accepted as the definitive coding system of dental treatment and endorsed by the National Coding Centre.

[4] The first involves the preparation of the tooth/teeth which is an invasive and totally irreversible procedure. It also involves impression taking, temporisation, haemostasis, extensive laboratory procedures and is usually conducted under local anaesthetic administration. Prior to the next visit the crown or bridge is constructed. The second visit involves the fitting of the crown or bridge.

9. Manipulation of the dental market to the detriment of the community.

There is a maldistribution of dentists in Australia with the ratio of dentists per head of population in rural and remote areas well below in metropolitan areas. Workforce maldistribution is demonstrated by the following:

- Major cities – 58.6 dentists per 100,000 population
- Inner regional – 34.6 dentists per 100,000 population
- Outer regional – 28.5 dentists per 100,000 population
- Remote/Very Remote – 19.8 dentists per 100,000 population.[5]

Evidence is available of PHIs trying to convince rural patients to attend a dentist other than the one in their town (the patient's normal treating dentist) as they are not contracted preferred providers and suggesting to the contributor they attend a contracted preferred provider dentist either in an adjoining town or in the CBD. Such conduct is not only manipulative of the market but impacts adversely on delivery of dental services in rural and remote communities. There is already an issue with the survival and viability of remote practices and these actions by PHIs are reprehensible and unnecessary.

There is also evidence one PHI refusing a dentist the ability to be a contracted preferred provider in a rural township as there was already a contracted preferred provider in the town. Such conduct is clearly a restraint of trade and as such is anti-competitive.

There have been instances where a contributor has been referred to a particular dental speciality by their usual dental provider only to have the PHI advise them to see a contracted preferred provider who has limited their practice to this field of dentistry but is not a registered specialist in this field. ADA would deem this as misuse of market power.

Such examples are instances of a restraint of trade and a misuse of market power.

Recommendation:

15. When evidence of conduct described in paragraphs 6, 7, 8 and 9 arises immediate punitive penalties be imposed on PHIs and in the case of repeated infringements loss of licence to operate as a PHI be imposed.

Question 2. PREFERRED PROVIDER SCHEMES

- *Provide views you/your organisation may have on third line forcing as it applies to preferred provider schemes.*

[5] AIHW DSRU Dental Labour Force data collection 2005 in Australian Institute of Health and Welfare 2008. Australia's health 2008. Cat. no. AUS 99. Canberra: AIHW.

The ACCC states:

> *"Under the CCA third line forcing involves the supply of goods or services on condition that the purchaser buys goods or services from a particular third party, or a refusal to supply because the purchaser will not agree to that condition. The ACCC is of the view that private health insurers through their preferred provider arrangements are unlikely to be engaging in conduct in contravention of the CCA".*

The ADA is concerned that in making this statement the ACCC is already of the opinion that PHIs are not contravening the Competition and Consumer Act. The ADA is of the opinion that the ACCC must adopt a more open mind on this issue.

The ADA suggests that examples of third line forcing by PHIs are:

- Provision of higher rebates for dental services to PHI members **only** if the services are purchased from a PHI contracted dental provider.
- **Refusal to supply** a higher rebate to PHI members for dental services if they attend a non-PHI contracted provider.
- Provision of free check-ups to PHI members **only** if the service is purchased from a PHI contracted dental provider.
- **Refusal to supply** a free check-up to PHI members for dental services if they attend a non-PHI contracted provider.
- Provision of free scale and clean treatments to PHI members **only** if the service is purchased from a PHI contracted dental provider.
- **Refusal to supply** a free scale and clean to PHI members for dental services if they attend a non-PHI contracted provider.
- Provision of 'zero out-of-pocket expenses' to PHI members for dental services **only** if provided by a PHI owned dental clinic. The ADA has an additional concern with this issue in that the insurer is providing the service for which the insurance is offered and thus a conflict of interest is created.
- Restriction of acceptance of preferred providers to those that are contracted to HICAPS.

Aside from the issue of third line forcing, the creation of 'preferred providers' in dentistry undermines significant features of 'best practice' in delivery of dental care to patients. While it is argued that such providers may encourage competition, this is at the significant cost of a reduction in quality of care delivery.

This impact occurs in the following ways:

Continuity of treatment is vital in the proper care and treatment of patients. Bonds and confidences are developed over time between patient and practitioner that are invaluable. This is even more so in dentistry where often phobias or dislike of treatment can be a relatively common occurrence.

Utilisation of the terms "preferred provider", "participating provider" or "members choice provider" by PHIs can be seen by patients as indicative of inferior performance by their treating ('non-preferred, non-participating or non-members choice provider) practitioner.

The inference attaching to being a health fund contracted provider, promoted and advertised by health funds, is that the dental providers not listed as preferred providers are perceived as 'not preferred' or 'not approved'.
This creates a misleading perception in the public's mind that these uncontracted independent dental providers have inadequate qualifications or provide substandard levels of care. This is both a deceptive and misleading activity by the health funds. In fact, evidence exists that there are more complaints registered against health fund contracted providers than non-contracted providers.

Provision of cost comparisons by PHI staff when discussing claims with patients and by this means deliberately attempting to redirect patients to the PHI's contracted (preferred provider) dentists is not in the patient's dental health interest and is unfair to the treating practitioner. This practice is discouraging patients from using their dentist of choice. There is evidence that some contracted providers' fees are substantially higher than non-contracted providers yet contributors are openly touted by PHI to attend the contracted provider. The contracted provider is deemed to have a competitive advantage as the rebates for the contracted provider are higher than for the non-contracted provider and also benefit from the extensive PHI advertising campaigns.

Use of terms such as a 'recognised provider' by PHIs in an effort to involuntarily recruit a practitioner into some sort of contractual relationship with a PHI continues to occur. PHIs attempt to create this 'relationship' on the basis the dentist has treated a patient who has cover with a particular PHI and a claim made by the patient has been met by the PHI. The fund seeks to have the provider comply with certain directions/rules to ensure the provider's patient receives appropriate benefits. The rules imposed may entail using a fund's 'provider number' or similar imposition. This unilateral application of requirements on the provider, when no relationship exists between the two, is inappropriate and it is thus improper for such requirements to be imposed. Non-compliance with the fund's unilateral provision of this requirement causes inconvenience to the patient and is often used as an opportunity for the fund to recommend to the patient a change of practitioner to one of the fund's actual preferred providers. This is an unfair exploitation of market position by the funds.

These actions are a backhanded attempt by the PHIs to deflect criticism away from them for their failure to have rebates keep pace with premium increases and the resultant higher 'gap' for the provision of dental services that arises.

Provision of 'free check-ups' by preferred providers occurs, in which health funds may be complicit, whereby some preferred provider dentists offer inducements to patients to receive 'free check-ups'. The 'fine print' in the inducement offered for the free service in fact requires the patient to undergo other procedures for which no gap fee is charged but which the PHI will rebate to the practice. These procedures can entail undergoing OPG radiographic examinations and other (perhaps unnecessary) treatments. (See also at Question 3).

Preferred Provider Arrangements (PPAs) connected to the preferred providers have the effect of limiting dental services provided. PHIs have increased rebates for PPAs at a higher rate than for non-PPAs services and this exacerbates the discriminatory approach by PHIs to non-PPAs. In fact some funds have not increased rebates across the board for dental services provided by non-PPAs for over sixteen years. Yet, these same funds have had significant increases in premiums. Patients view this conduct as restrictive and this prevents them from having their complete course of treatment.

Furthermore, the PPAs have had the effect of directing treatment patterns which advantage the health funds financially and are detrimental to the prescribed best practice course of treatment for the patient.

Such conduct is grossly inappropriate as it: seeks to break or undermine the bond developed between patient and the normal treating dentist; seeks to coerce the patient to become a patient of the preferred provider for further services; unfairly exploits the relationship between preferred provider and PHIs to secure more advantageous financial results for the fund in respect of future treatment provided and delivers unnecessary services that may be both harmful or inappropriate.

Recommendation:

16. The ADA repeats the recommendations 4-11 above.

Question 3. INFORMED FINANCIAL CONSENT

- *any trends in the private health insurance sector affecting informed financial consent in the 2010-11 period*

In the ACCC letter, there is the comment:

> *"Private health insurance sector participants have a duty to inform their patients about the cost of the services they provide. This allows consumers to give their informed financial consent regarding the net costs of medical services after benefit payments, particularly those involving more than one provider."*

It is not clear from this statement as to precisely who "Private health insurance sector participants" are. If it is intended to include the health practitioner providing the service then any obligation to provide "informed financial consent" (IFC) should solely be restricted to provision of informed consent as to the actual service charge between practitioner and patient.

It is the PHI, not the providers, responsibility to inform the patient as to what the rebate for the dental service will be. PHIs do not issue to their contributors a list of rebates for dental services and nor is it easily accessible. [See recommendation 9].

The subject of IFC[6] has long been an issue for the ADA and its membership. The ADA recognises that the health provider has an obligation to provide IFC vis-à-vis the patient/dentist relationship but that obligation extends no wider.

It is important to recognise that when patients have PHI cover, they have a direct contractual relationship with their PHI. The health provider is not a party to that contract and therefore has absolutely no obligations under that PHI arrangement. If the patient wishes to know what out of pocket expenses are to be incurred (i.e. expenses over and above the rebate received from the PHI) then the determination of that information is a matter between the Patient and PHI.

[6] ADA Policy 5.16- Informed Financial Consent. (Attachment 2)

The health provider, being external to the insurance contract, has no obligations to either the patient or PHI to advise on the financial impact of PHI cover on the cost of services.

The ADA advocates the issuing of written and detailed treatment plans outlining proposed treatments and fees. Patients are encouraged to present these to the PHIs to ascertain their rebate. ADA policy is:

> *"It is not the responsibility of dental practitioners to know the difference between their dental fees and the rebates payable by private health funds. Advice about that difference cannot be considered part of informed financial consent."*

The reasoning for such policy is that with around more than 37[7] different PHIs with each having some three or more different levels of rebate for dental cover and differing levels of annual limits based upon which table of cover and length of membership, there are many hundreds of permutations of rebate levels. Determining the level of rebate is also contingent on the consumer knowing exactly which table of cover, the balance of annual limit, the length of time in the fund and whether there are imposed limits on particular services. This is even further complicated by some PHIs having a different scale of fees for every contracted PPA. See previous comments on non-disclosure of business fund rules at Recommendation 9. Compliance with this recommendation would not only promote true open competition amongst PHIs based upon quantum of premiums rather than ambiguous and deceptive policies which leave consumers unable to make direct comparison but also clarify for patients exactly what benefits are available.

It is the ADA's experience that regularly when patients present their proposed treatment plans and fee estimates to the PHIs, PHI staff are instructed to opportunistically use this information to try and force the patient to see their contracted providers. This is done utilising discriminatory rebates that favour PPAs. The underlying philosophy of private health insurance is that the patient has the right to choose the provider of their choice. This is the fundamental difference between public and private services. PHIs through PPAs are eroding this choice.

Patients understandably have a low awareness of PHIs/ PPAs contracting issues, but the level of rebate does have the potential to impact adversely on their entitlements under their health insurance merely based upon which dental provider they wish to attend. The patient does not have the choice of a lower premium if they choose to attend a non-PPA. One PHI has a PPA scheme based upon different fee levels for each PPA. The dental provider is only accepted by that health fund if their range of fees is acceptable to that fund. This fund rebates 60, 70, 80 or 90% of the agreed fee. The issue at hand is that there are dental providers who are not contracted to this fund. Their entire fee for some dental services is less than the 90% rebate of some contracted providers yet their patients receive much lower rebates and have a health fund generated gap of some 40-50% of the fee, when, if rebated the same amount as the contracted provider, there would have been zero gap. This is anti-competitive.

[7] PHIAC 2009/2010 Report

The ADA continues to recommend that dentists ensure treatment plans, preferably written, are offered to their patients prior to the course of treatment being undertaken. The ability to give IFC is an important consumer right and is supported and practised by dentists.

Recommendation:

17. If the ACCC wishes to assist consumers with provision of information about the financial impact of receipt of healthcare then where services are rebated by PHI , the ACCC must demand PHIs publish clear, easy to comprehend rebate tables for each Policy of PHI provided. [See also recommendation 9]

QUESTION 3 (CONTD) ACCC LETTER:

- *Have you identified any trends in advertising private health insurance during the 2010-11 period? If so, please provide details.*

Free Check-ups:

The ADA sees regular promotion of 'free check-ups' by preferred providers. This appears to be advertising in which health funds may be complicit. Some preferred provider dentists offer inducements to patients to receive 'free check-ups'. The 'fine print' in the inducement offered for the free service in fact requires the patient to undergo other procedures for which no gap fee is charged but which the PHI will rebate to the practice. These procedures can entail undergoing OPG radiographic examinations and other (perhaps unnecessary) treatments. Advertising of such "free" services is misleading and deceptive. In some cases provision of these additional services may be detrimental to the health of the patient as the patient is required to undergo services that may not be required.

This conduct borders on fraud. It amounts to exploitation of the patient by the PHI in an effort to induce the patient to receive treatment from a preferred provider.

Recommendation:

18. Inducements to receive free care where patients are required to undergo additional unnecessary services must be outlawed and appropriate legislation enacted.

Question 4. DEVELOPMENTS

Further information and comment on any initiatives or developments over the 2010-11 period including:

- *the development of industry-run online tools allowing consumers to find and compare healthcare specialists in their local area;*
- *the development of private health insurance comparison tools to compare the cost and terms and conditions of private health insurance policies.*

Social Websites:

NIB Insurance sought to introduce a website that would provide information to the public as to the 'quality of services' provided by a dentist and the fees charged. The site did not proceed to final publication as nib had apparently utilised data about practitioners from information provided by Medicare Australia. Closure of the site only occurred through the actions of the ADA and other professional associations in establishing the utilisation of such data.

What was of concern to the ADA was that this site and/or any similar site based upon the same premise could:

- Contravene advertising requirements of the Dental Board of Australia – these preclude the use of "testimonials or purported testimonials" about the practitioner.[8]
- Have the potential for misleading impressions to be conveyed and are therefore dangerous.
- Provide 'impressions' as to quality of care delivery when patients may not be able to properly judge such matters.
- Have the potential for biased comments to be posted without adequate scrutiny being imposed.

Such sites provide little reliable or valuable information to users. For further comment view the ADA's July *National Dental Update* on the issue of Websites on Healthcare professionals.[9]

Recommendation:

19. The ADA calls for banning of such sites.

PHI Business Rules.

The manner of application of PHI Business Rules is contrary to fundamental contract law. How PHIs are able to apply such Rules when premium-paying members are not provided with details of them contradicts any basic tenet of contract law.

In early 2010, the ADA wrote to 36 health funds requesting details of their business rules. None of the funds provided their business rules to the ADA. Following this, in May 2010, the ADA wrote to the Private Health Insurance Ombudsman (PHIO).

[8] Section 4-DBA- Guidelines for advertising of regulated health services

[9] http://www.ada.org.au/publications/natdentup11.aspx (Attachment 3)

The ADA asked the Ombudsman to require:

i. Private health insurers to make the existence of business rules known to prospective and actual members of funds.

ii. Business rules be made publically available – either in documentation or via website.

iii. Copies of business rules to be made available to members of funds at the time of:

   a. Initially entering into the contract of private health insurance;
   b. Annual renewal;
   c. Any change to the business rules.

iv. Members of funds be given the ability to cancel a contract of insurance at any time there is a change to business rules (iii above) and another fund be obligated to accept that person (changing funds) as a member with the equivalent restrictions (if any) on benefits that may have applied under the original contract of private health insurance.

The response was that the Private Health Insurance legislation allowed PHIs to not publish such Rules. The PHIO indicated that publication of the rules is not required due to their inherent complexity. Non-disclosure of the rules (either to the ADA by the funds or to their members and providers) is a cause for concern. All financial products require the publication of product disclosure statements and PHI should be no exception. Why funds are not prepared to disclose their rules supports the concerns that have been raised already: that the profit motive is more important than the rights of their contributors. As the rules are only publically disclosed when a dispute arises, one has to question whether the rules are being modified where convenient to account for claims that have fallen outside the anticipated claims' experience of the fund. Profit incentive over health improvement seems to be the motivating factor.

These rules should be open to public scrutiny and available to not only educate and inform the fund member but also members of the public who wish to compare policies prior to signing up for private health insurance.

Recommendation:

20. Legislation should be introduced to repeal those sections of PHI legislation that permit non-disclosure of PHI business rules and legislation passed that require PHIs to publish clear, simple, easy to understand, and publically available business rules. This is essential.[10] It is in fact the very reason these business rules need to be published. This is a basic tenet of contract law. Any legislative exclusion permitting such conduct must be removed.

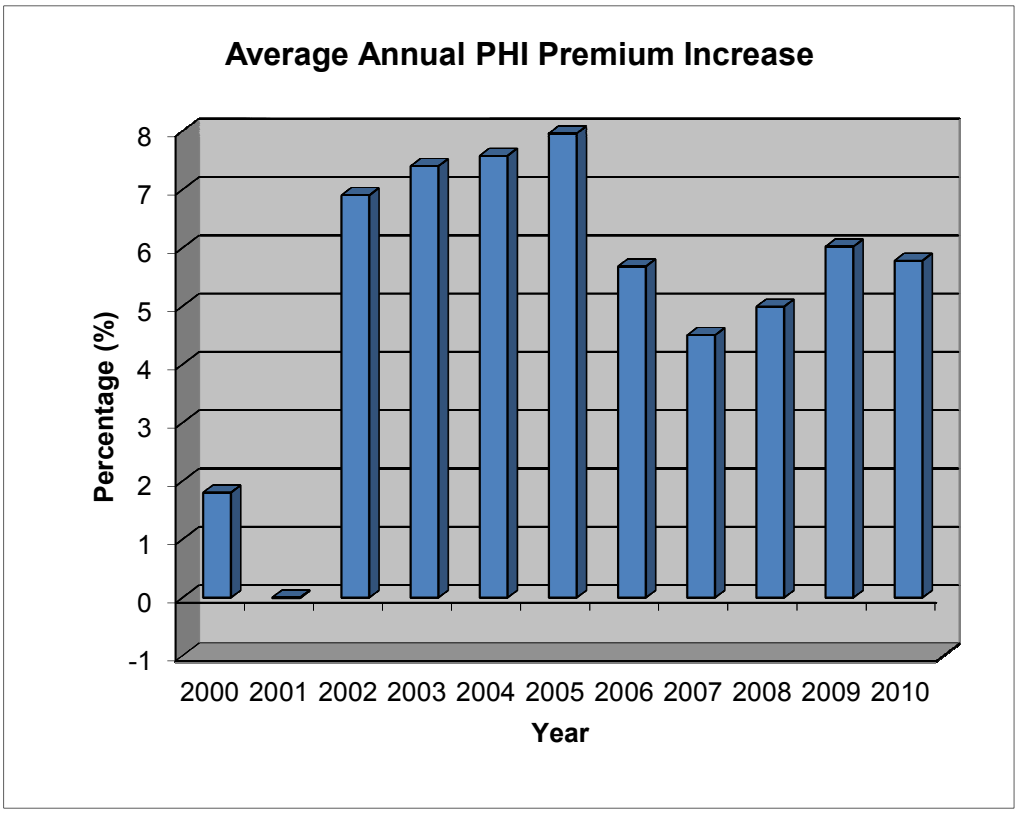
[10] In 2009, private health insurance benefits for dental services amounted to $1.5 billion compromising almost 52% of general treatment expenditure. These figures highlight the need to provide more information to consumers about these charges.

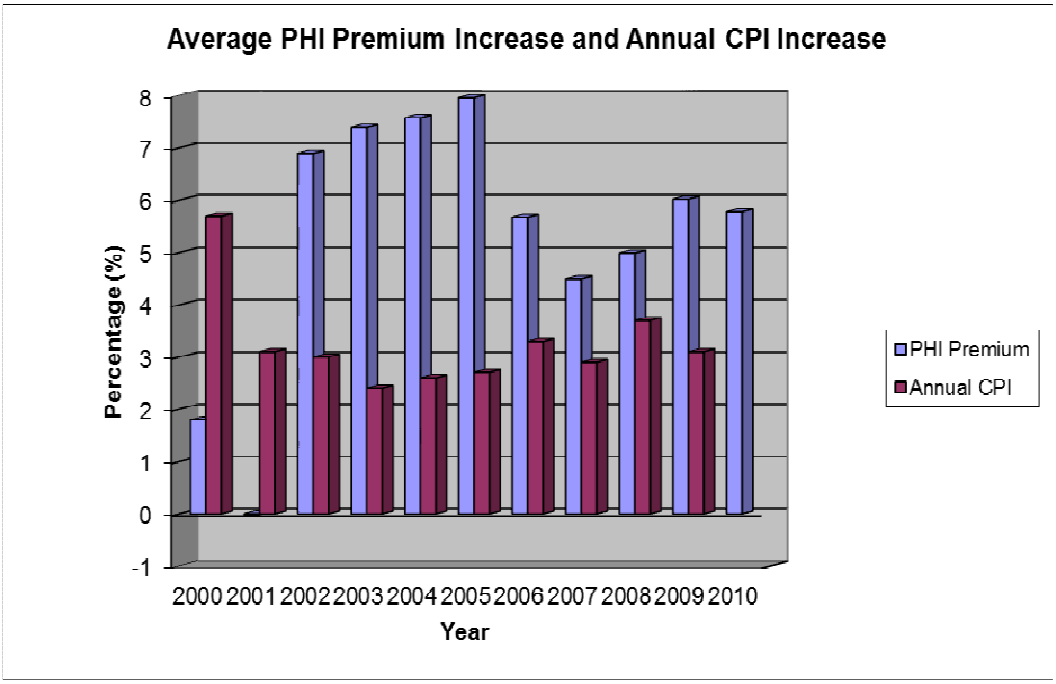
Question 5. ACCC STAKEHOLDER ENGAGEMENT

The ADA remains concerned that issues raised by it in previous submissions have been ignored. PHI behaviour requires significant reform. It is evident that PHI behaviour has deteriorated markedly over the last few years. Immediate steps must be taken to make PHIs accountable to consumers in the interests of fair financial accountability and more importantly, their health interests.
Adoption of the recommendations made in this submission must occur to achieve this end.

Dr F Shane Fryer
President
Australian Dental Association Inc.
5 September 2011.

Attachment 1





Attachment 2

INFORMED FINANCIAL CONSENT[1]

1 Introduction

1.1 The principle that no patient should be provided with health treatment without first having provided consent, and having had the opportunity to inform themselves of the risks and consequences of the treatment, has long been recognised in dental practice. In some jurisdictions, Boards have created Codes of Practice, which have identified requirements for the obtaining of patient consent to treatment.

1.2 Government agencies have published reports urging health care practitioners to obtain informed financial consent from patients before proceeding with a course of care.

1.3 There are more than 30 separate health funds with no consistency of dental rebates, and each has a range of tables defining corresponding terms of dental cover provided for their members. Many health funds do not publish their rebate levels and only 14% of the cost of dental services is funded by them.

1.4 **Definitions**

1.4.1 BOARD is a Federal, State or Territory dental registration board.

1.4.2 FUNDING AGENCIES are third parties, which make contributions to the payment of the fees charged by dentists.

1.4.3 INFORMED FINANCIAL CONSENT is consent given to the dentist by a patient [or the parent, guardian, or other legally responsible person] to the fees to be charged for treatment agreed to be performed.

2 Principles

2.1 The clinical relationship between a dentist and a patient is independent of the source of funding for the patient's treatment.

2.2 Any rebate for the services from third party funding bodies is a matter between the patient and the funding body.

2.3 The provision of written material to the patient regarding dental fees will reinforce the patient's awareness of the treatment cost.

2.4 The provision of information about dental fees should ideally be available to patients prior to their treatment.

2.5 Informed financial consent is sound ethical professional practice. This is also good business practice and will result in fewer disputes over accounts, lower debt recovery costs and fewer bad debts.

[1] This Policy Statement is linked to other Policy Statements: *5.5 Funding Agencies, 5.8 Dental Acts and Boards, 5.14 Dentistry and the Legal System & 5.23 Regulatory Authorities,* and the ADA Guidelines for Good Practice *"Consent for Care in Dentistry"*.

2.6 Many patients will be unfamiliar with what is involved with their dental procedure. In some instances, patients may have wrongly assumed that the fee for the dental service is fully covered by their health fund.

2.7 Patients may be apprehensive over the pending dental procedures. They may be unwell, distressed, disoriented, or affected by more than one of those conditions. Discussing financial implications with some patients at this time may be impractical and unworkable.

2.8 Dental fees may be based on an itemised schedule of treatment or on the time taken to complete the dental procedure. Accordingly, the dentist may only be able to estimate a range of fees based on the expected time to undertake the procedure. Similarly, if the planned procedure is changed during surgery, due to unforeseen circumstances, this may also result in a change to the final fee charged by the dentist. Of course, any such change should be advised at the appropriate time.

3 Policy

3.1 It is not the responsibility of dental practitioners to know the difference between their dental fees and the rebates payable by private health funds. Advice about that difference cannot be considered part of informed financial consent.

3.2 The estimated cost of treatment involving multiple visits should be provided in writing.

3.3 Any information about expected charges, provided to the patient prior to treatment, should include advice that the estimate is not guaranteed and the cost to the patient may increase if the planned procedure takes longer than expected or other procedures are required.

3.4 Dentists should ensure that patients are in a fit state to give informed financial consent.

Policy Statement 5.16

Adopted by ADA Federal Council, November 15/16, 2007.

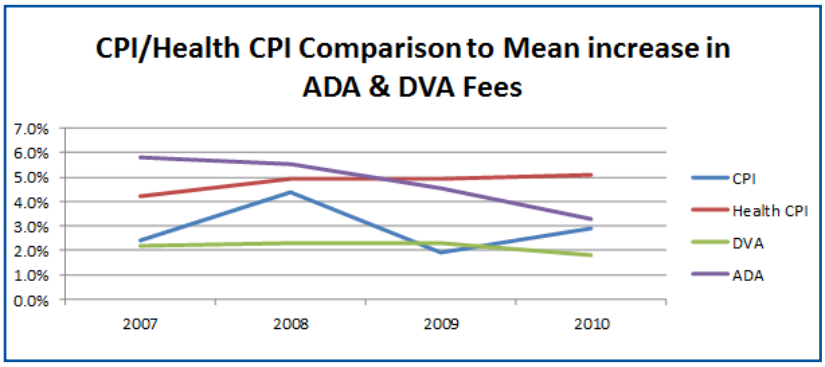
AUSTRALIAN DENTAL ASSOCIATION INC.

NATIONAL DENTAL UPDATE
APRIL 2011
www.ada.org.au

Attachment 3

PRIVATE HEALTH INSURANCE PREMIUMS – DENTAL REBATES

The average cost of health insurance increased by 5.56% on 1 April this year following the approval of health insurance premium adjustments by the Minister for Health and Ageing, The Hon Nicola Roxon MP. This increase is only marginally less than the previous year's increase of 5.78%.



"Once again, the gap between dental fees and average benefits paid to patients will widen," commented Dr Shane Fryer, Federal President of the Australian Dental Association Inc. (ADA). "Despite substantial increases in the premiums charged over the last ten years, health insurers fail to pass on appropriate rebates as a percentage of cost of care to its customers. This situation must be rectified."

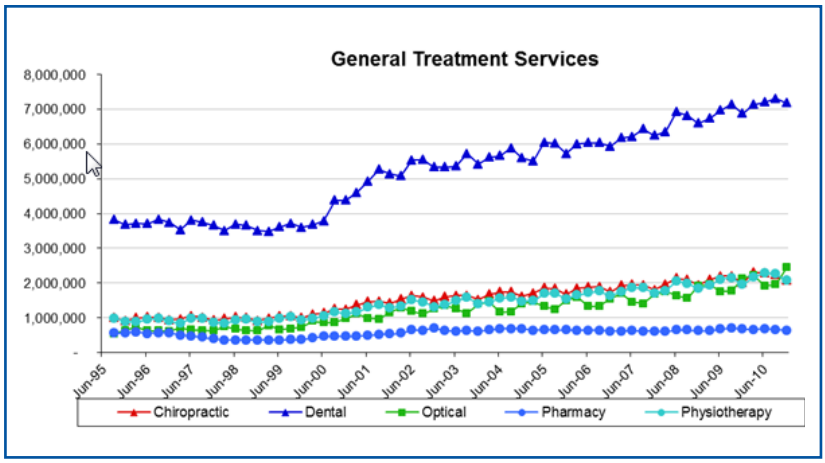
Dr Fryer also questioned the insurance premium increase being set substantially higher than the health index increase which has remained below 5% over the last few years.

"The 2010 ADA Dental Survey Fees Report demonstrates that the mean fee charged by dentists is being maintained well below the health services index (the measure of inflation for the health industry) at a rate of 4.8%", Dr Fryer reports.

The picture is similar with the rebates offered for services provided to Veterans and their families. Average increases in the Department of Veterans' Affairs schedule of fees for dental services remain steady at 2% – less than average CPI, let alone the health index over the same period.

"The ADA is worried dentists won't be able to service veterans and their families if this discrepancy continues. Dentists are doing their bit to ensure that the Australian public has access to quality oral health services, it's time that the Australian Government and health insurers did likewise," added Dr Fryer.

Figures from the Private Health Insurance Administration Council and those highlighted in the diagram below show there has been a significant rise in the number of dental services provided to people with private health insurance over the past few years.



Despite the rise in dental services, the benefits returned to patients (relative to the cost of care) have declined over the past decade. As the table (see overleaf) shows, the average benefit paid to patients as a percentage of the cost of care for dental services has fallen from 54.5% in 2000 to 48.73% in 2010. This is more than a 10% decline. There is nothing that can justify this.

Given that the rising cost of healthcare is the principal explanation for rising health insurance premiums, the ADA believes it is important for health funds to ensure that benefits paid as a percentage of the cost of care do not continue to decline as they have over the past decade.

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Tel: 02 9906 4412 Fax: 02 9906 4736 Email: adainc@ada.org.au

PRIVATE HEALTH INSURANCE - benefit paid as a percentage of the cost of service for Dental Services 2000 to 2007						
Year	Number of services	Fees charged (cost of the service)	Benefits paid for services	Average cost of service	Average benefit paid to patient	Benefits paid as % of cost of services
2000	16,224,856	1,255,697,000	686,873,894	77	42	54.50%
2001	19,923,999	1,575,518,000	876,464,773	79	44	55.70%
2002	21,501,375	1,771,760,000	965,563,252	82	45	54.80%
2003	21,837,694	1,886,382,000	993,246,116	86	45	52.30%
2004	22,756,855	2,082,321,000	1,051,117,913	91	46	50.50%
2005	23,297,702	2,230,007,000	1,098,089,121	96	47	48.90%
2006	23,999,526	2,414,322,000	1,187,205,239	101	49	48.50%
2007	25,072,735	2,638,144,000	1,283,302,782	105	51	48.60%
2008	26,687,191	2,925,375,186	1,414,241,884	110	53	48.34%
2009	27,739,510	3,118,928,845	1,509,763,524	112	54	48.41%
2010	28,829,591	3,295,090,696	1,605,632,781	114	56	48.73%

Source for CPI/Health CPI Comparison to mean increase in ADA and DVA fees: ADA Dental Fees Survey 2010; Department of Veterans' Affairs (2010) Fee Schedule of Dental Services for Dentists and Dental Specialists (Effective 1 November 2010), Australian Bureau of Statistics, CPI Tables December 2010

Source for General treatment services: Source: PHIAC - Statistical Trends in Membership & Benefits Data Tables December 2010.

Source for Private health insurance – benefit paid as a percentage of the cost of service for Dental Services: PHIAC - Statistical Trends in Membership & Benefits Data Tables December 2010.