AUSTRALIAN DENTAL ASSOCIATION INC.

Incorporated in the ACT ARBN 131 755 989

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All Correspondence to:
PO Box 520 St Leonards NSW 1590

28 January 2015

Manager
Insurance and Superannuation Unit
Financial System and Services Division
The Treasury
Langton Crescent
PARKES ACT 2600

Dear Sir,

Re: Private Health Insurance (Prudential Supervision) Bill 2015.

Thank you for the opportunity to provide input into the consideration of the Private Health Insurance (Prudential Supervision) Bill 2015.

ABOUT THE AUSTRALIAN DENTAL ASSOCIATION

The Australian Dental Association Inc. (ADA) is the peak national professional body representing the vast majority of Australia's 15,000 registered dentists as well as more than 3,000 dentist students. ADA members work in both the public and private sectors.

The primary objectives of the ADA are to encourage the improvement of the oral and general health of the public; to advance and promote the ethics, art and science of dentistry and to support members of the Association in enhancing their ability to provide safe, high quality professional oral healthcare.

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

PRIVATE HEALTH INSURANCE and DENTISTRY

Private Health Insurance (PHI) plays a minor role in the funding of dentistry, contributing a little less than 16% of total dental expenditure in 2012-13. The balance of the dental health expenditure is funded by Governments (25%) or individuals (59%)[1]. Funding for dental services accounts for the majority of payments made by private health insurers under their ancillary policies of insurance (63%)[2].

Pursuant to its object to ensure the improvement of the oral and general health of the public, the ADA takes an active role in reviewing the conduct of the PHI industry in an effort to ensure the public receive worthwhile benefits from their commitment to PHI. It sees the PHI entities maximizing profits at the expense of the PHI member. This is no better demonstrated than in analysing the premium income received by PHI entities and the return to policy holders under their policies. (See Table 1.)

[1] AIHW Report Health Expenditure Report 2012-13
[2] PHIAC Quarterly Statistics September 2014.

Table 1: Financial surplus achieved by PHIs since 2008/09

Year	Average weighted premium increase on 1 April	Annual CPI [Mar quarter]	General Treatment Fund Premium Revenue (000's)	General Treatment Fund Benefits (000's)	Surplus (,000's)	Percentage	Hospital Treatment Fund Premium Revenue (000's)	Hospital Treatment Fund Benefits (000's)	Surplus (000's)	Percentage
2008/09	6.02%	2.50%	$3,696,018	$2,869,540	$826,478	22.36%	$9,367,897	$8,316,804	$1,051,093	12.64
2009/10	5.78%	2.90%	$3,996,818	$3,052,757	$944,061	23.62%	$10,157,881	$8,989,906	$1,167,975	11.50
2010/11	5.56%	4.30%	$4,309,168	$3,209,104	$1,100,064	25.53%	$11,095,135	$9,769,293	$1,325,842	11.95
2011/12	5.06%	1.60%	$4,675,200	$3,536,925	$1,138,275	24.35%	$12,031,185	$10,618,227	$1,412,958	11.74
2012/13	5.60%	2.50%	$5,017,523	$3,908,684	$1,108,839	22.10%	$12,937,722	$ 11,504,346	$1,433,376	11.08
Total					**$5,117,717**				**$6,391,244**	

Source: Private Health Insurance Administration Council (PHIAC)'s Reports on the Operations of Health Funds

The ADA regularly submits to the ACCC on the conduct of Private Health Insurers. Major issues that it identifies include:

i. Lack of transparency by PHI entities in respect of PHI products and services;
ii. Inadequate provision of Policy information by Insurers -including access to Product Disclosure Statements and Policy Business Rules;
iii. Inadequate returns to Fund members under PHI policies – there has been no increase in rebates for dental services for the majority of contributors for 20 years;
iv. Inequity in payment of rebates for services that depend upon the identity of the provider of the service;
v. Conduct of PHI entities that are considered anti-competitive;
vi. Conflicts of interest created where PHI entities own health provider clinics, employ health providers, set premium levels for insurance, determine the price of the health service and then determine the amount of rebate to be paid under the PHI policy.

PRUDENTIAL REGULATION of PHI ENTITIES

The activities conducted by the Private Health Insurance Advisory Council (PHIAC) have been essential to enable the ADA to adequately assess PHI performance. The information and resources made available through its reporting role have been invaluable in enabling the ADA to analyse and report upon PHI behavior, to then inform members of PHI funds as to their rights and alert the public to some of the limitations of PHI cover.

PHIAC provided not only valuable information and resources about PHI but it also provided administrative oversight of PHI entities and provided consumers with an avenue through which to seek to have issues that confront policy holders dealt with in a way that empowers the consumer.

Consideration of the closure of PHIAC and the incorporation of its activities into the Australian Prudential Regulation Authority (APRA) cannot be looked at in isolation. The decision to also close the office of the Private Health Insurance Ombudsman (PHIO) and to incorporate its activities into the Department of Health also has to be considered.

The PHIO had the important roles of:

a. assisting health fund members to resolve disputes through our independent complaints handling service;
b. identifying underlying problems in the practices of private health funds or health care providers in relation to the administration of private health insurance;
c. providing advice to government and industry about issues affecting consumers in relation to private health insurance; and
d. providing advice and recommendations to government and industry about private health insurance, specifically the performance of the sector and the nature of complaints.

Whereas there were previously two specific agencies that dealt exclusively with PHI entities and PHI, these agencies have disappeared with their roles being assumed elsewhere. ADA can see the economic advantages for the merger of these entities with other authorities. However, both entities had very important distinct roles to perform. Both entities no doubt built up a considerable body of knowledge about PHI and had also accumulated staff who are experts in the complex area of PHI. Every effort needs to be made to ensure that the accumulated "corporate knowledge" is retained. The roles of both entities have to be maintained to ensure that the activities of PHI entities remain compliant with the Private health Insurance legislation and that consumers have a convenient organisation to approach to address their grievances.

Reports provided by PHIAC delivered accurate and important data for independent third party analysis. Health care provider organisations such as the ADA require accurate detailed analysis of all the registered health funds in Australia and to be able to continue to make precise analysis, the format of the reports must remain the same so that like with like comparisons can be made in the future.

RECOMMENDATIONS

What the ADA sees as essential in the new law is the necessity for APRA to remain diligent in all the activities that were previously conducted by PHIAC. However, the ADA's major concern with the closure of both PHIAC and the PHIO is that the experience and resources that were made available to both these entities may be lost or reduced with their merger into other sections of government. The focus that existed on the prudential management of PHI entities and the role played in the protection of the insured may be diminished.

While it would seem that what is proposed activities of APRA, as listed at page 10 of the Explanatory memorandum largely replicates the activities of PHIAC, the ADA calls upon government to ensure:

1. Retention and allocation of sufficient resources to ensure that the roles of both PHIAC and PHIO are maintained.

2. It addresses issues of concern regarding PHI entities such as those that have been raised by the ADA to ACCC as listed above.

3. That all the detailed publications and analysis (including the provision of statistical data) that has been carried out by PHIAC continue to be provided and conducted by APRA. The format, specificity and high standard of reporting by PHIAC with the production of the Annual Reports, "Operations of the Health Funds" and "Industry Operations" reports be maintained in the same format and be provided in a timely manner. Continuity of the format for these reports is essential so trend development can be analysed.

4. That APRA deal not only with the purely prudential role that it may assume for banks, credit unions, building societies, general insurance and reinsurance companies, life insurance, friendly societies,

and most of the superannuation industry but that it also maintains the focus PHIAC had in dealing with *"Protecting consumers of private health insurance by ensuring an industry which is competitive, efficient and financially sound."*[3]

5. That in carrying out its functions, APRA be provided with the ability to:
    a) regulate the PHI industry, and
    b) supervise and enforce PHI entities to compel compliance with the Private Health insurance Act 2007.

6. That APRA continues to act independently of private health insurers and conducts its activities with integrity and professionalism.

7. There is close liaison between APRA and that section of the Department of Health that will be assuming the role of PHIO. Each will identify issues that will be pertinent to the other and strong avenues of communication between the two must be developed.

Yours faithfully,

Dr Rick Olive,
President

[3] PHIAC Mission Statement- http://phiac.gov.au/