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General Manager
Market and Competition Policy Division
The Treasury
Langton Crescent
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By email: competition@treasury.gov.au

Dear Treasury,

Re: Submission in relation to the Options to strengthen the misuse of market power law Discussion Paper

The Australian Dental Association (**ADA**) welcomes the opportunity to be involved in the consultation on the *Options to strengthen the misuse of market power law* Discussion Paper (**Discussion Paper**) dated December 2015. The ADA is the peak national professional body representing the vast majority of Australia's registered dentists and dentist students. ADA members work in both the public and private sectors.

While the ADA will respond to the corresponding questions raised, it essentially seeks to make two overarching recommendations:

1. The government should adopt a hybrid of Options D and E.

   The new section 46 of the *Competition and Consumer Act 2010* (CCA) should:

   a. Remove the 'taking advantage' component;
   b. Include an effects test;
   c. Include mandatory factors for the courts' consideration;
   d. Make Authorisation available. However, in a sensitive area of commerce such as the supply of health services, there needs to be rigorous testing by the Australian Competition and Consumer Commission (**ACCC**) in any Authorisation process, of the benefits to the public and the detriments resulting from any restrictive policies or arrangements in the event that authorisation is made available for conduct that may otherwise be prohibited by section 46 of the CCA; and
   e. Include ACCC issued guidelines regarding its approach to the amended provision.

2. Government should retain unamended the existing provisions related to third line forcing (s47(6) and s47(7)) and again provide for rigorous testing of the benefits/detriments associated with Notification made to the ACCC seeking immunity for restrictive arrangements relating to health markets.

1. ***What are examples of business conduct that are detrimental and economically damaging to competition (as opposed to competitors) that would be difficult to bring action against under the current provision?***

Small business is unlikely to have the resources to launch large legal actions generally

The role that the independent dentist plays in the dental health sector and the economy more broadly is a significant one. Dental care in Australia is primarily provided by practitioners in small to medium sized businesses operated by either sole practitioners or partnerships. Based on the ADA's survey conducted in September 2013:

- ADA members operate in excess of 7,500 dental practices which, in addition to delivering oral health care to the Australian public, generate significant employment opportunities for many Australians including those in regional and rural Australia; and

- The average dental practice employs a total of 4.8 staff which represents a work force of approximately 36,000 people.

Section 46 of the CCA is intended to constrain the activities of those with substantial market power from taking advantage of that power for the purposes proscribed in that section. ADA agrees with the general proposition that competition laws aimed at the general welfare of all Australians should focus on prohibiting conduct that is damaging to competition and not individual competitors.

Having said that, in the context of dentistry services (and other ancillary health services) the business conduct that is often detrimental to competition often involves restrictive, exclusive and/or preferential arrangement by larger private health insurers (**PHIs**). There needs to be a realisation that it is small businesses, such as individual dentists, that are harmed at the outset by such practices (and thereafter, ultimately patients/consumers). Further, the economic reality is that these small businesses generally do not have the resources dedicated to launching and running legal actions in response to such anti-competitive arrangements by large market participants. The risk of legal actions being unsuccessful, and the associated time and cost impacts is prohibitive to small business seeking redress through the courts relying on provisions such as s46. Nor do these small practices have the resources to compete with the marketing of PHIs.

We recognise that the ACCC may in some circumstances take legal action to restrain any such actions. However, whether it be the ACCC or individual business taking action in response to perceived anti-competitive conduct by businesses having a significant market position, section 46 should therefore be reformed in such a way as to provide specific guidance as to what is, and what is not permitted, and it should act as a real deterrent and disincentive for those with market power from acting inappropriately; ideally without having to seek the provision to be enforced by the courts at all.

Background to examples of conduct that has difficulty being addressed under the current s.46

As stated above, the particular examples of conduct that affect competition in the supply of dentistry services to patients is the conduct of the larger PHIs.

Dentists (as well as most other suppliers of ancillary health services) have very significant interactions with PHIs. The primary reason for this interaction is that a large proportion of patients of dentists have private health insurance and seek to claim a rebate from the PHI for services performed by a dentist.

Research Paper 1 June 2015 published by the Commonwealth Government Statutory Authority, Private Health Insurance Administration Council (**PHIAC Report**) states that, as at the date of the report, there were 13.2 million Australians covered by private health insurance.[1]

The fact that such a large proportion of Australians have contracts with PHIs means that private health insurance policies have a very large influence on which health practitioners consumers can see, although ostensibly the primary purpose of private health insurance is for the consumer to receive their health care (dental) services from the provider of their choice. This choice underpins the entire reason for having private health insurance.

The PHIAC Report further states that at a national level, the market for private health insurance is "significantly concentrated",[2] with the two largest insurers, namely BUPA and Medibank Private accounting for in excess of 56.2% of policies.[3] It also states that a more regional segmentation by State shows more stark shares by the largest PHIs, with:

- BUPA having 52% share of policies in South Australia, 38% in each of the Northern Territory and Tasmania and 34% in Queensland;
- Medibank Private having 44% in the Northern Territory, 36% in Victoria, 35% in Queensland, 33% in Tasmania and 32% in the ACT; and
- HBF having 54% in Western Australia.[4]

While this influence and the market power of the larger PHIs is not per se problematic, the ADA has over the years raised concerns with the ACCC about conduct by larger PHIs which has substantially damaged small business dental practices commercially to the detriment of patients/consumers in terms of access to quality healthcare of their choice and costs.

In addition to the prohibitive costs issues referred to above, the constraints of the current 'taking advantage' and 'purpose' requirements in section 46 are a very significant deterrent to the ability of small business dental practices from launching any legal action against PHIs when faced with anti-competitive conduct by the larger PHIs. This has been canvassed thoroughly by the Discussion Paper.

The view consistently conveyed to the ADA by the ACCC has been that provided PHI practices lowered the price per unit of care for some consumers, *ipso facto* consumer welfare was enhanced. This approach reflects a disregard for section 46 which requires that damage is what in fact is occurring to the competitive process, by way of damage to small business dental practices; as a result of the larger PHIs' use of their substantial degree of power. Any cost amelioration that could theoretically occur would unlikely be maintained over the medium to long term as the damage to the competitive process and the corresponding increase in market consolidation and

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1 Private Health Insurance Administration Council, *Research Paper 1: Competition in the Australian Private Health Insurance Market*, June 2015, 30.
2 Id., 32
3 Ibid.
4 Id., 32-33

market power of these larger PHIs means that the commercial pressures to deliver dividends to shareholders will increase. It is highly likely that consumers over time will be subject to a combination of higher costs for their private health insurance policies, as well as a reduction in the ability for their policies to assist them in accessing the care they need.

As s46 is presently drafted, damage to competitors arising from such behaviour, which in our view is not in the interests of consumer welfare, is arguably not considered as a contravention of s46, primarily due to the difficulties of the "taking advantage" limb of the provision.

For example, some of the conduct we refer to below such as preferred provider agreements (**PPAs**) is entered into by both smaller and larger PHIs – which "presents" problems from the perspective of the "taking advantage" limb of the contravention. However, such conduct by the larger PHIs, together with other conduct referred to below, has a very significant impact on the ability of dentists that are not "aligned" with, or preferred or contracted by, the larger PHIs to compete, which then has a significant effect on both price and non-price competition. More generally from the perspective of consumer welfare, there is no evidence that the conduct of the PHIs in relation to the provision of dental services has resulted in a lowering of costs for dental services and the ADA's analysis suggests that the 'benefits' to consumers/patients provided under policies which purport to include "free services" (such as x-rays) are illusory in that the premiums paid for these far exceeds what the average costs for those services would be if the consumer/patient was uninsured. Furthermore, consumers feel enticed by such offers, demanding dentists perform these "free services" when it may not be clinically necessary.

Further, the ACCC does not more closely assess the full impact of private health insurers' 'lowering of price' via providing higher rebates for patients attending dentists that are contracted to that private health insurer. The facts are that there has been no reduction in cost of the service at all.

Additionally, the ACCC has not considered the fact that the practices of the PHIs unfairly withholds the full benefits of a health insurance policy and penalises consumers who receive the same services but choose to attend a non-contracted provider yet that consumer pays the same premium for that same policy.

The particular conduct of concern involves the larger PHIs, that in the ADA's views already possess substantial market power:

- Opening PHI owned clinics, thus vertically integrating and becoming head-on competitors with dentists; and

- Entering into PPAs with particular dentists and as a corollary, 'steering' members to particular dentists or more recently steering members who have previously attended PPAs to their own clinics; interfering in patient's continuity of care.

Against this background:

- ***The larger PHIs have access to sensitive commercial data and practices of their competitors.***

The vast majority of private health insurance claims are processed through the HICAPS system which is the processing and payment system of choice by PHIs. One of the main reasons for this is because private health insurers can access data about the charging practices of individual practitioners and practices across different practices. Where the PHIs are operating 'owned' practices they have the advantage of granular sensitive information of the pricing practices, and

clinical practices of their competitors (where the PHI's members have attended the 'other' practice and are making a claim following that visit). **This places the PHI in an unique position of being privy to the actual prices of its competitors; knowing which services are being provided and the busyness of those practices thus being able to vary its own prices having regard to this information as well as 'steer' customers to the PHI owned dentist either by way of pricing signals such as level of rebate/level of out of pocket expenses or contractually in the terms and conditions of policies. They are also privy to the busyness and volume of trade so may consider establishing a clinic nearby.**

- A genuine and contemporaneous example is as follows:

  Item no 615 is the provision of a porcelain fused to gold crown. Dr John charges $1580 for this service. PHI ABC rebates $680 for this service on the premium general treatment. The out of pocket (OOP) expense is $900.

  PHI ABC has a PPA with Dr Brian and has a negotiated fee with Dr Brian for ABC contributors for item 615 of $1680 and offers 80% rebate ie $1344. The OOP expense is $336. The cost of the service is actually $100 more expensive.

  Dr John has applied to ABC to become a PPA but ABC has refused Dr John becoming one as ABC do not want any more PPAs in that area.

  Furthermore Dr Jeff is employed in an ABC owned clinic. They see other PHI patients as well as uninsured patients and patients of other insurers are charged $1480 for item 615 as ABC is aware of Dr John's fee scale.

  PHI ABC are aware of what other PHI rebates are for item 615 giving them other PHIs' privileged data.

This conduct has a materially detrimental effect on competition as the PHIs are privy to the commercially sensitive data of their competitor dentists and PHI and have the ability and incentive to utilise this information to their advantage and to thereby skew the competitive process.

The vertically integrated PHIs also have additional information advantages vis-a-vis other PHIs. See Dr Jeff example. On occasions patients attend PHI owned dentists but are insured by other PHIs. In such circumstances (assuming the use of the HICAPS system), the PHI will have data on the rebate amounts provided by the other PHI for those services. Over time, the vertically integrated PHI can build their database of rebates from their competitors.

- ***PHIs' conduct following entering into PPAs amount to imposing discriminatory rebates:***

This behaviour steers consumers to providers who are contracted to private health insurers (or to PHI owned clinics). Where this is the operating approach of a larger PHI, it has the potential to significantly affect non-preferred providers' revenue streams thus raising the overall costs (across the number of patients at the practice) of non-preferred/non-owned dentists and affecting their ability to compete. This can have a significant effect on competition, particularly in non-major metropolitan areas where there are more limited number of practices and where volumes may be materially affected by the practices of the PHIs where they have significant share of policies in that region.

In the above instances, in addition to the anti-competitive effect there is a loss of consumer welfare in that the conduct simultaneously interferes with consumers' continuity of care and

access to their healthcare provider of choice; risking reducing the quality of care available to them. Continuity of care is fundamental to ensuring that the patient receives the most suitable treatment for their circumstances.

Dentists like other health providers are happy to compete on price as well as quality of service and care. However, discriminatory rebate practices do not provide the level playing field nor does it constitute pro-competitive or neutral competitive business practice. Rebate differentials risk unfairly giving an impression that the non-contracted dentist is charging more for their services than is actually the case. It substantially lessens competition within dental markets on an unfair basis and not on the basis of quality of product or efficiency of services.

In addition there is a loss of consumer welfare and a lessening of competition as a result of the changing incentives of PHIs.

- One particularly striking case study of how the above combines to substantially lessen competition is Bupa in South Australia. The majority of dentists in South Australia are contracted providers. One reason that some dentists chose to be a contracted provider with Bupa (and self-impose certain controls on how much they could charge for dental services) was a belief that they could benefit from the marketing that Bupa engaged in;

  While contracted dentists are free to negotiate with Bupa the level of fees they could charge for services, Bupa is the sole arbiter of the fee agreed. The ADA objects to Bupa's discriminatory fee structure and discriminatory rebate practices. Bupa provides a lower rebate to consumers who go to non-Bupa contracted dentists even though they have the same policy, undergo the same services and pay the same premium as consumers who go to Bupa's contracted dentists. This is unfair competition that discriminates between consumers and also substantially lessens competition between dental care providers in a manner that is by virtue of providing a quality service or genuine efficiencies.

  Further, Bupa is engaging in actions which are suggestive of a misuse of its market power and its changed incentives as a vertically integrated business. Bupa previously engaged in marketing activities marketed on behalf of its contracted providers. It is now changing its approach. It has now reduced its marketing efforts towards contracted providers considerably, instead, aggressively marketing its own dental clinics and directing patients to attend Bupa owned clinics.

  ADA understands that Bupa has the right to suspend promotion of its contracted providers for any reason without notification. Further, Bupa reserves the right to unilaterally terminate contracts it has with its preferred providers for any reason with 60 days' notice. There is a real risk that Bupa will eventually withdraw support for its contracted providers altogether as it continues to steer consumers to Bupa's own clinics; which the ADA considers to be a misuse of market power.

  It is highly likely that Bupa will use these mechanisms to reduce competition against its 'owned' practices by reducing the number of contracted providers and dental practices generally. There will be more corporate owned and run clinics in South Australia which have their own risks due to the inherent conflict of interest (employing the service provider, setting the fee for the service provider as well as the rebate level that will be given to the policyholder and charging the contributors a fee to be insured in the first instance). The consumer's ability to maintain continuity of care with the practitioner of their choice will be largely impacted.

The ADA does not begrudge the role of competition within the dental sector, far from it. However, the practices outlined above illustrates a misuse of market power that substantially

lessens competition and penalises those consumers who do not attend a contracted provider yet pay the same premium for the same policy.

What should also be kept in mind is that these issues that are impacting on dental care also apply to all other ancillary providers in South Australia (and nationally) for which a general treatment/ancillary policy provides such rebates to patients. Examples are physiotherapists and optometrists to name two.

The ADA also has examples of instances where the above advantages have also resulted in conduct which may allegedly breach section 46 as well as other provisions of the CCA. The vertically integrated PHIs have information advantages about the fee rates of competitor dentists and set the rates of their employed dentists. They have used this information to communicate with non-preferred dentists about their rates, essentially seeking to affect their rates.

2. ***What are examples of conduct that may be pro-competitive that could be captured under the Harper Panel's proposed provision?***

The ADA is agnostic when it comes to PHIs' use of contracted dentists per se. The misuse of market power that substantially lessens competition comes from the larger PHIs' use of consumer and practitioner wide market information as well as the discriminatory rebate practices on the basis of whether a patient sees a contracted dentist or not.

Take advantage

3. ***Would removing the take advantage limb from the provision improve the ability of the law to restrict behaviour by firms that would be economically damaging to competition?***
4. ***Is there economically beneficial behaviour that would be restricted as a result of this change? If so, should the scope of proscribed conduct be narrowed to certain 'exclusionary' conduct if the 'take advantage' limb is removed?***
5. ***Are there alternatives to removing the take advantage limb that would better restrict economically damaging behaviour without restricting economically beneficial behaviour?***

As referred to above, removing the 'take advantage' limb is appropriate. The ADA agrees with the reasons outlined by the Harper review about the benefits of such a change. The ADA however does not believe it is necessary to narrow the scope of proscribed conduct to certain 'exclusionary' conduct. In the event that certain of the above conduct is undertaken by smaller PHIs, they will not meet the 'substantial market power' threshold and as such, the conduct is unlikely to be impugned.

Purpose or effect (or likely effect)

6. ***Would including 'purpose, effect or likely effect' in the provision better target behaviour that causes significant consumer detriment?***

Including both purpose and the effects test would *prima facie* better target the behaviour outlined above that has been having a negative impact on competition as well as consumers over the years.

7. ***Alternatively could retaining 'purpose' alone while amending other elements of the provision be a sufficient test to achieve the policy objectives of reform outlined by the Harper Panel?***

The ADA disagrees that 'purpose' alone should be retained. It inappropriately narrows the scope of attention to explicit intentions. While the courts are able to infer intentions or an entity's purpose, the law should provide the effects sought to be achieved (**intentions**) the requisite authority for the court and regulators to correct practices that have or are likely to have a deleterious effect on competition.

Substantially lessening competition

8. ***Given the understanding of the term 'substantially lessening competition' that has developed from case law, would this better focus the provision on conduct that is anti-competitive rather than using specific behaviour, and therefore avoid restricting genuinely pro-competitive conduct?***

9. ***Should specific examples of prohibited behaviours or conduct be retained or included?***

Beyond the existing exclusive dealing provisions and third line forcing restrictions (in section 47) which should be retained unamended, the focus of the provision on conduct that is anti-competitive, or that 'substantially lessening competition' is appropriate. At this stage there is no other range of specific behaviours that need to be prescribed as being unacceptable in the CCA.

10. ***An alternative to applying a 'purpose, effect or likely effect' test could be to limit the test to 'purpose of substantial lessening competition'. What would be the advantages and disadvantages of such an approach?***

The ADA does not support limiting the test to 'purpose of substantially lessening competition'. Please refer to our response to Question 7. Considering that the Harper review noted that over the past 15 years, only seven cases by the full Federal Court or the High Court have considered the existing s46, limiting the scope to consider purpose alone (whether its purpose to damage a competitor or the competitive process) would very likely reduce the range of future cases lodged or threatened, to the detriment of competition more generally

Mandatory factors

11. ***Would establishing mandatory factors the courts must consider (such as the pro- and anti-competitive effects of the conduct) reduce uncertainty for business?***

12. ***If mandatory factors were adopted, what should those factors be?***

The ADA supports mandating consideration of a range of pro and anticompetitive factors on the basis that such a list would not be exhaustive. It would be a useful way to guide not only practitioners but business more generally.

In terms of mandatory factors to consider, the ADA would suggest:

- Whether the behaviour restricts or limits benefits to be provided to a portion of consumers even though they have provided the same consideration for the same good/service. If this is the case, further consideration should be made as to whether:

- The behaviour in turn substantially lessens competition within a market that is either the one in which the good/service is provided, or on a related market for which the good/service is related.

Authorisations

13. Should authorisation be available for conduct that might otherwise be captured by section 46?

The considerable limitations in the Notification process that will be outlined in the case study below, suggests that while Authorisation should be available for conduct that might otherwise be captured by s46 (and related conduct that may otherwise be captured by the existing section 47) given the sensitivity of, and complexity of, health markets, the ACCC must ensure that it undertakes a vigorous review of the benefits to the public/detriments that flow from the conduct including ensuring that it notifies all affected and likely interested persons including representative and peak bodies. The expectation that a review by the ACCC may be "picked up" without proactive publication of the review being undertaken by the ACCC (as occurs with the Notification process) is fanciful.

One additional concern is that even though it is likely that such authorisations for s46 conduct would receive greater attention compared to other conduct (and so it should), small businesses are not in a position to be able to dedicate resources to provide the monitoring, research of case studies and economic and commercial analysis to mount a response to such applications.

Case study: Third line forcing Notification process

As outlined above, the ACCC's response to the ADA's concerns illustrates a tacit permissiveness of PHI behaviour that substantially lessens competition and negatively impacts on consumer choice and continuity of care. Third line forcing and the authorisation process is one example. This already 'soft touch' approach to enforcement of already existing provisions of the CCA risks discrediting the whole competition law regime and should cease.

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

Health insurance policies which breach these sections are a feature of the private health insurance industry and likely to continue to expand.

Recently, Bupa was granted an exemption from compliance with the provisions of sections 47(6) and 47(7) CCA in respect of a New Youth Policy.[5] This policy only pays benefits on a health service, including a dental visit, if a policyholder seeks care at a *Members First network* provider including dentists contracted to Bupa. Policyholders who seek oral health care from *non-Members* providers do not receive any benefits under this policy.

Correspondence available on the ACCC website concerning this notification indicates that the notification was issued to Bupa without a full inquiry by the ACCC. The ACCC did not attempt to

[5] The ACCC Exclusive dealing notifications register Bupa Australia Pty ltd – Notification – N97766 available at http://registers.accc.gov.au/content/index.phtml/itemId/1181381/fromItemId/113339 accessed 8 May 2015

ascertain what the impact of such a policy may have on health care delivery relying almost entirely on the representations of Bupa. This is unsatisfactory. The ACCC in its role as the protector of the interests of the consumer should have investigated in some depth the ramifications of this Bupa policy.

The above Notification provided immunity under the CCA for a participant in the private health insurance industry taking away the right of a policyholder to choose their own treating practitioner without significant oversight. Continuity of care and choice of provider, well-respected concepts, has been cast aside and the health consequences to the consumer ignored.

The ADA submits that this approach by BUPA and the ACCC indicates that without the prohibition of section 47(6) and (7), BUPA and other large participants in the PHI industry will, without any material oversight at all, increasingly require policyholders to acquire medical care, including dental care from nominated contracted dentists. This will result in a situation where the PHI industry is permitted carte blanche to engage in anti-competitive practices which:

- Explicitly direct patients to seek care away from their customary treating provider to a provider contracted with a private health insurance industry fund; and
- Continue to reduce the amount of the rebate or alternatively not pay any rebate when patients exercise their own choice and continue to obtain oral health care from their treating health care provider; and
- Involve the insureds' not being well informed of the exclusionary clauses and in most instances only understanding their effect once they attempt to make a claim.

Currently, the existing third line forcing provisions provide the best and least costly protection against such anti-competitive practice of Bupa and any other participants in the private health insurance market (notwithstanding the abovementioned limitations). If sections 47(6) or 47(7) CCA are either qualified or repealed in their entirety, the approach of Bupa and other participants in the private health insurance industry in directing patients to contracted dentists will continue to expand. This is a threat to the importance of continuity of care and has the potential to result in adverse health outcomes for patients to deteriorate.

This case study is one example why the ADA urges that provisions relating to third line forcing (as well as exclusive dealing more generally) be retained. Furthermore, when it comes to s46, while an authorisation process should be provided for, given the sensitivity of, and complexity of, health markets, the ACCC must ensure that it undertakes a rigorous review of the benefits to the public/detriments that flow from the conduct including ensuring that it notifies all affected and likely interested persons including representative and peak bodies.

Other issues

14. If quantitative data on the regulatory impact of alternative options on stakeholders (including the methodologies used) can be provided.

15. Are there any other alternative amendments to the Harper Panel's proposed provision that would be more effective than those canvassed in the Panel's proposal?

Specific options

16. ***Which of options A through F above is preferred? What are the relative strengths and weaknesses of each option? What information can you provide regarding the regulatory impact of each option on businesses?***

17. ***Are there any other options (not outlined above) that should be considered?***

The ADA's proposal

Ideally the ADA recommends a combination of certain features of Options D and E.

The new section 46 should:

a. Remove the 'taking advantage' component;
b. Include an effects test;
c. Include mandatory factors for the courts' consideration;
d. Make Authorisation available. However, in a sensitive area of commerce such as the supply of health services, there needs to be rigorous testing by the ACCC in any Authorisation process, of the benefits to the public and the detriments resulting from any restrictive policies or arrangements in the event that authorisation is made available for conduct that may otherwise be prohibited by section 46 of the CCA; and
e. Include ACCC issued guidelines regarding its approach to the amended provision.

Further, existing provisions related to third line forcing and exclusive dealing be retained unamended.

This model of a new s46 provides a more appropriate scope to redress the misuse of market power that has the effect of substantially lessening competition. Mandatory factors support this test by providing a baseline from which the anticompetitive effects of misuse of market power can be assessed. ACCC guidelines would similarly provide clarity on what market participants can expect to be addressed. Noting already the limited resources for small business to seek enforcement of the law through the courts, it is correspondingly critical that the ACCC assumes greater responsibility for monitoring and assessing crucial markets such as private health insurance and the healthcare sector.

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Thank you for considering this submission. If you have any questions please contact Mr Robert Boyd Boland, Chief Executive Officer of the ADA at ceo@ada.org.au.

Yours faithfully,

Dr Rick Olive AM
Federal President
Australian Dental Association