Submission
No 263

INQUIRY INTO DENTAL SERVICES IN NSW

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Theme:

Summary

INQUIRY INTO DENTAL SERVICES IN NSW

SOCIAL ISSUES COMMITTEE
PARLIAMENT OF NEW SOUTH WALES

Hearing: 16 February 2006

SUBMISSION

BY

AUSTRALIAN HEALTH INSURANCE ASSOCIATION

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1. ***Could you describe the activities of your Association and its membership? Is membership compulsory for private health insurers? How is the industry regulated?***

Answer

The Australian Health Insurance Association (AHIA) is the major industry association for private health insurance firms in Australia. The Association represents 26 registered health benefits organisations (RHBOs) which together cover 93 per cent of the privately insured population in Australia. The members of the Association are listed in **Appendix 1**. The Association was established in 1971. Its principal objective is to advance the interest of all its members in relations with governments, the media, contributors and other organisations involved in the health care field.

The Association also provides an information and advisory service to members in relation to issues affecting their operations. In addition, the Association has a role in coordination of industry activities and in education through the organisation of national conferences and industry meetings.

The role and objectives of the Association are:

- To foster and promote the principles, practice, development and philosophy of voluntary health insurance as the best method of financing the costs of health care;

- To make representations and submissions where deemed necessary or desirable to the appropriate persons or authorities in respect of any matter affecting the interests of members or any member of the Association, subject to prior consideration by the members; and

- To provide a medium through which opinions of members may be ascertained or expressed;

Membership of the AHIA is voluntary for private health insurers. In addition to the AHIA, the Health Insurance Restricted Membership Association of Australia (HIRMAA) is an industry association representing 14 health funds, primarily smaller restricted membership funds.

Private health insurance firms are regulated by the federal government, through the Australian Government Department of Health and Ageing and the Private Health Insurance Administration Council (PHIAC). There is also a Private Health Insurance Ombudsman. Regulation of private health insurance is largely through the *National Health Act, 1953.*

2. ***How many people have private health insurance in New South Wales? What percentage of those customers have some form of dental coverage? Has there been a noticeable increase or decrease in that number in recent years?***

Answer

As at September 2005, a total of 3.7 million people in NSW (52 per cent of the population) had some form of private health insurance.

Table 1, Coverage of Private Health Insurance, in Appendix 2, provides quarterly data on ancillary coverage in the NSW and Australian populations, quarterly data on total persons covered with private health insurance, and the proportion of the population with private health insurance coverage who have dental coverage.

From September 1999 to September 2005, there has been an increase in the proportion of the privately insured population with dental coverage of from 73 per cent to 79.5 per cent in NSW, and from 74.1 per cent to 80.5 per cent nationally. Hence there has been a noticeable increase in this proportion in recent years.

All the persons shown in **Table 2** below have dental coverage as part of their product given existing product design features except for a small percentage who have an ambulance only product. There has been a 10 per cent increase in ancillary coverage in NSW and the ACT over the period July 1999 to July 2004.

Table 2: PHI Ancillary Coverage NSW & ACT

Persons and Proportion of the Population with Ancillary Cover

Quarter		NSW & ACT
June	Coverage '000	2,288
1999	% of Population	34.0%
June	Coverage '000	2,870
2000	% of Population	42.2%
June	Coverage '000	2,929
2001	% of Population	42.5%
June	Coverage '000	3,017
2002	% of Population	43.4%
June	Coverage '000	3,077
2003	% of Population	43.9%
June	Coverage '000	3,115
2004	% of Population	44.1%
June	Coverage '000	3,171
2005	% of Population	44.6%

Please note that the % of Population may vary from previously published figures due to revisions of the population base by the ABS

This table shows all ancillary membership including ambulance only cover

Source PHIAC Annual Report 2005 Part B

In addition, the age and gender distribution of those covered for ancillary insurance in Australia as at June 2005 is shown in **Figure 1**, Appendix 2.

Figure 2 (Appendix 2) provides the proportion of the NSW Insured Population with Some Form of Dental Cover from September 2000 to September 2005.

3. ***Is dental coverage a motivating factor for people to take out private health insurance? How important is dental coverage to customers of private health insurers?***

Answer

The fact that 3.2 million people in NSW take out ancillary cover (45.1% of the population in December 2005) shows that they value their purchase. The ancillary product covers more than just dental care, however we draw your attention to the fact that dental benefit payments make up more than 50 per cent of the total ancillary benefit payments.

4. ***How much does an average insurance premium, with hospital and ancillary cover, cost per year? How much of that constitutes dental coverage? Could you describe the varying levels of dental coverage?***

Answer

The cost of an average hospital and ancillary premium in NSW is $1,521 for a single membership and $3,042 for a family membership. The cost of an average ancillary premium in NSW is $528 for a single membership and $1,055 for a family membership. These figures are for the full premium cost prior to the application of the 30 per cent rebate. Hence, the rebate assists Australian families in making private health insurance coverage affordable.

The insurance premiums will differ between funds, State, product, product features, and will be based on health funds' own actuarial assessments about service utilisation, provider charges, changes in clinical treatment and technology, and appropriate benefit levels. Those factors will have a different weighting depending on whether it is a combined hospital and ancillary product as opposed to an ancillary only product.

Health fund premiums are priced by reference to, and weighted according to, individual modalities, their utilisation levels, and their benefits paid level, and annual benefit limits.

Information on the varying levels of dental coverage is provided in the answer to Question 5 below.

5. ***Could you explain how private health insurance works in relation to oral health services? What types of dental treatments are covered by private health insurance? Are any services limited or excluded?***

Answer

Health funds may have several 'Tables' covering the ancillaries area (including dentistry). Different tables usually provide for different levels of coverage, and different annual financial limits. For example, a basic plan might cover only general dental care – not major dental, and may target young singles. For each fund, the higher cost tables provide more comprehensive dollar coverage.

Coverage of general dental services may include the following:

- diagnostic procedures (consultations, X-rays, etc.)
- preventative procedures
- oral surgery
- endodontics (root canal therapy)
- restorative services

Specialist dental services coverage may include the following:

- periodontics (specialist root planing)
- oral surgery
- endodontics (root canal therapy)
- general services
- high cost dentistry, eg, crowns/bridges/dentures; and orthodontic.

There are a number of health fund approaches to payment of dental benefits. Some approaches are as follows:

- a fixed dollar benefit per stipulated service (eg, a dollar amount per consultation, or up to a specified amount);
- a benefit as a percentage of the dentist's fee;
- a combination (eg, a percentage, but up to a dollar limit);
- there may be limits on coverage of particular services (eg, two examinations per person per year);
- financial year limits per person, or per policy; there may be different separate limits for general dentistry, specialist dentistry and high cost dentistry. The orthodontic financial limit may be per lifetime.
- some funds may give a maximum combined limit for two consecutive years;
- some funds offer an increase in the annual $ limit via a 'loyalty bonus'.

Some health funds also have dental networks, and through these networks they can assist in access to health care in specific locations for their members, and, in addition, may apply limits to maximum charges for reimbursement to dentists.

Increasingly preventative dental items have been reimbursed at a higher level than other dental services. The funds are guided in what they do by the rules inherent in

the Australian Dental Association's Dental Schedule about what is clinically appropriate.

It should be noted that in addition to ancillary coverage for out of hospital dental services, hospital insurance will also cover oral health services provided on an inpatient basis, whether for overnight services or day hospital services. Such oral health services provided for inpatients are usually aggregated with inpatient statistics, rather than with ancillary statistics.

6. ***How much do private health insurers pay out per year in benefits with respect to dental services, nationally and in New South Wales? How does this compare to benefits paid out for other medical services?***

Answer

In 2004-05, private health insurers paid out $1.079 billion for dental benefits on a national basis, and $418.9 million on dental benefits in NSW and the ACT. In NSW and the ACT, expenditure on dental benefits was 52 per cent of total expenditure on ancillary benefits by health insurers. (Source: PHIAC, Annual Report, 2005)

7. ***What effect did the Commonwealth Government's introduction of the 30% rebate have on the uptake of private health insurance? What do you think would happen if that rebate were removed?***

Answer

The private health insurance 30 per cent rebate was introduced on 1 January 1999. On April 2005, a higher rebate was introduced for older Australians. This rebate is 35 per cent for persons 65-69 and 40 per cent for persons 70 and over. The impact of the rebate on the take up of hospital insurance can be seen in **Figure 3A and Figure 3** in Appendix 2. By December 1999, prior to the introduction of the 30 per cent rebate, hospital insurance coverage had declined to close to 30 per cent. With the introduction of the rebate, combined with the Life Time Health Cover policy, hospital coverage increased to 45 per cent in December 2001.

Figure 3 also shows the estimated impact of the removal of the rebate on coverage levels. Due to the detrimental financial impost on NSW families, the removal of the rebate would obviously lead to a substantial decline in private health insurance membership for all types of coverage, not just dental coverage. Removal of the rebate would have a substantial impact on family budgets and particularly on the elderly cohort with private health insurance coverage. It is estimated that the impact of removal of the rebate on ancillary coverage would be similar to the removal of the rebate on hospital coverage, and that 35 per cent of members would also drop ancillary coverage.

The AHIA notes that ancillary health coverage includes not just dental coverage, but also supports other key services including optical, physiotherapy, home nursing, pharmacy, podiatry and psychology services, etc.

8. ***How much does the Commonwealth Government pay with respect to dental services per year under the 30% rebate?***

The 30 per cent rebate is a benefit directly to the members via reduced premiums. The Australian Government does not pay anything directly in respect of dental services for those with private health insurance. The rebate is applicable to the total health insurance premium and cannot be apportioned.

9. ***Could you comment on the proposal that health insurers should provide a basic dental-only cover to allow lower-income earners to have access to dental services?***

Answer

It should be noted that under the *National Health Act, 1953,* community rating must be applied by health funds. That is, health funds must charge the same premium to all for the same product, regardless of health risk, age or level of income. For each health fund it is a matter of making their own actuarial calculations to assess whether a product will be affordable or attractive for that specific market segment. Factors that would be taken into account would be likely utilisation by service and charges likely to be levied by dentists.

The charges for dental services are relevant to this question. Of significance, the last 10 years in NSW have seen an increase in dentists' charges of 129 per cent, and utilisation increases of 50 per cent.

In addition, one issue that has been raised by consumers with the Private Health Insurance Ombudsman relates to the experience of consumers where dentists have not provided **Informed Financial Consent**. There is a clear need for improvement in the provision of Informed Financial Consent to consumers by dentists.

At least one health fund does provide a 'dental only' product, but this is in association with taking out private hospital coverage with the same fund.

A number of health funds operate their own dental centres in NSW as follows:

- HCF: Sydney CBD, Parramatta, Chatswood, Hurstville, Bondi Junction, Brookvale, Blacktown
- AHMG: Haymarket, Parramatta, Wagga Wagga
- NIB: Sydney, Newcastle

These dental centres generally provide a range of no gap services to fund members.

10. ***Do you think that Medicare should be extended to cover oral health services and why, or why not?***

Answer

Policy matters regarding Medicare and its extension are a matter for the Australian Government.

11. Has the Association considered any other ways in which private insurance could be made more affordable to low income earners?

Answer

The rise in the dental segment of the Health Price Index (which is greater than the CPI) over the period September 1995 to June 2005 was 60 per cent (132.2 to 215.4). This has to be factored into any product design. Funds alone do not determine price as the underlying costs are set by dentists.

All health funds are concerned that their premiums are as low as possible so that more Australians can afford private health insurance. Individual funds may develop products to attract different segments of the market, including, say a less comprehensive lower-cost ancillary product. However, funds cannot control dentists' charges and, in the end, it is often the health funds that wear the brunt of criticism on the impact of charges over which they have no control. In that regard, funds are already paying back 90 per cent of their premiums to their members as benefits.

Having said that, those who tend to take out ancillaries coverage, including dental coverage, are generally those who expect to use the product in the near term – unlike normal insurance, eg fire, house, car, etc.

Further, given that funds are bound by the rules of community rating, there is no possibility to risk adjust premiums thereby reducing the premiums for some potential contributors.

It is noted that the network arrangements that have been introduced by some health funds, not only assist in providing access to dental treatment, they also provide certainty regarding the cost to members. Hence, such network arrangements can assist in ensuring access to affordable dental care.

In Conclusion

The AHIA thanks you for the opportunity of appearing before the Committee on behalf of private health insurers. Through its provision of dental coverage to contributors, private health insurance makes a significant contribution to the dental health of a very substantial proportion of the NSW population.

APPENDIX 1

AUSTRALIAN HEALTH INSURANCE ASSOCIATION LTD

MEMBERS LIST

1. Acorn Prudential Ltd
2. Australian Health Management Group Ltd
3. Australian Unity Health Ltd
4. BUPA Australia Health Pty Ltd
5. CBHS Friendly Society Ltd
6. Cessnock District Health Benefits Fund Ltd
7. GMHBA Ltd
8. Grand United Corporate Health Limited
9. HBF Health Funds Inc.
10. Healthguard Health Benefits Fund
11. Health Insurance Fund of WA
12. Health-Partners Inc
13. Hospitals Contribution Fund of Australia Ltd
14. Latrobe Health Services Inc
15. Manchester Unity Australia Limited
16. Medibank Private Ltd
17. MBF Alliances Pty Ltd
18. MBF Australia Ltd
19. Mildura District Hospital Fund Ltd
20. NIB Health Funds Ltd
21. Queensland Country Health Ltd
22. Queensland Teachers' Union Health Fund
23. St Luke's Medical & Hospital Benefits Association Ltd
24. United Ancient Order of Druids Friendly Society Ltd
25. Westfund Ltd

(Nationally Registered Health Funds at 1 February 2006)

APPENDIX 2

Table 1 COVERAGE OF PRIVATE HEALTH INSURANCE

	Ancillary Persons Covered (Excl Ambulance Only)		Total Persons Covered		Proportion of PHI Population having Dental Coverage	
	NSW	**AUST**	**NSW**	**AUST**	**NSW**	**AUST**
Sep-99	2,009,958	5,574,273	2,752,585	7,521,641	**73.0%**	74.1%
Dec-99	2,032,497	5,647,070	2,775,901	7,596,123	**73.2%**	74.3%
Mar-00	2,089,066	5,785,139	2,835,140	7,746,916	**73.7%**	74.7%
Jun-00	2,613,238	7,022,304	3,511,229	9,490,952	**74.4%**	74.0%
Sep-00	2,719,628	7,365,913	3,633,043	9,950,229	**74.9%**	74.0%
Dec-00	2,704,833	7,357,889	3,605,374	9,878,282	**75.0%**	74.5%
Mar-01	2,714,463	7,398,781	3,563,995	9,836,294	**76.2%**	75.2%
Jun-01	2,724,190	7,447,927	3,550,449	9,826,832	**76.7%**	75.8%
Sep-01	2,750,213	7,526,127	3,561,347	9,855,621	**77.2%**	76.4%
Dec-01	2,771,583	7,600,281	3,575,013	9,889,318	**77.5%**	76.9%
Mar-02	2,786,814	7,635,114	3,585,484	9,893,376	**77.7%**	77.2%
Jun-02	2,792,906	7,655,539	3,586,591	9,880,360	**77.9%**	77.5%
Sep-02	2,813,709	7,706,853	3,606,212	9,907,960	**78.0%**	77.8%
Dec-02	2,830,171	7,755,387	3,618,312	9,930,300	**78.2%**	78.1%
Mar-03	2,839,660	7,776,946	3,623,909	9,929,784	**78.4%**	78.3%
Jun-03	2,834,078	7,752,139	3,613,499	9,878,620	**78.4%**	78.5%
Sep-03	2,847,569	7,794,634	3,627,690	9,898,117	**78.5%**	78.7%
Dec-03	2,863,180	7,838,063	3,642,768	9,934,736	**78.6%**	78.9%
Mar-04	2,861,905	7,850,913	3,639,384	9,933,848	**78.6%**	79.0%
Jun-04	2,872,072	7,860,988	3,634,184	9,916,328	**79.0%**	79.3%
Sep-04	2,891,675	7,924,204	3,654,433	9,974,699	**79.1%**	79.4%
Dec-04	2,906,701	7,972,564	3,669,377	10,017,254	**79.2%**	79.6%
Mar-05	2,914,954	8,001,734	3,675,620	10,034,775	**79.3%**	79.7%
Jun-05	2,920,283	8,020,353	3,679,948	9,999,253	**79.4%**	80.2%
Sep-05	**2,942,434**	8,101,351	**3,701,357**	10,061,695	**79.5%**	80.5%

Figure 1

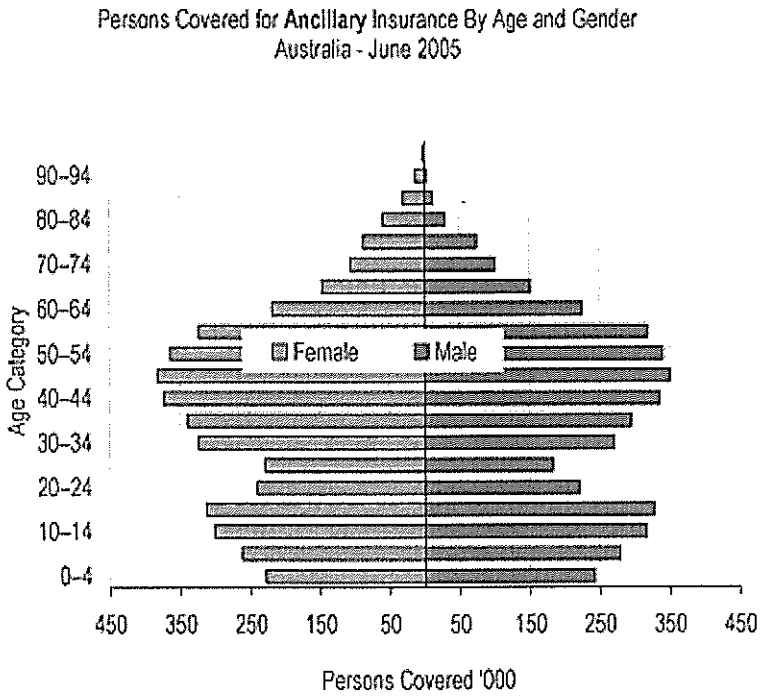
Persons Covered for Ancillary Insurance By Age and Gender
Australia - June 2005
90–94
80–84
70–74
60–64
50–54
40–44
30–34
20–24
10–14
0–4
Age Category
Female
Male
450
350
250
150
50
50
150
250
350
450
Persons Covered '000

Figure 2:

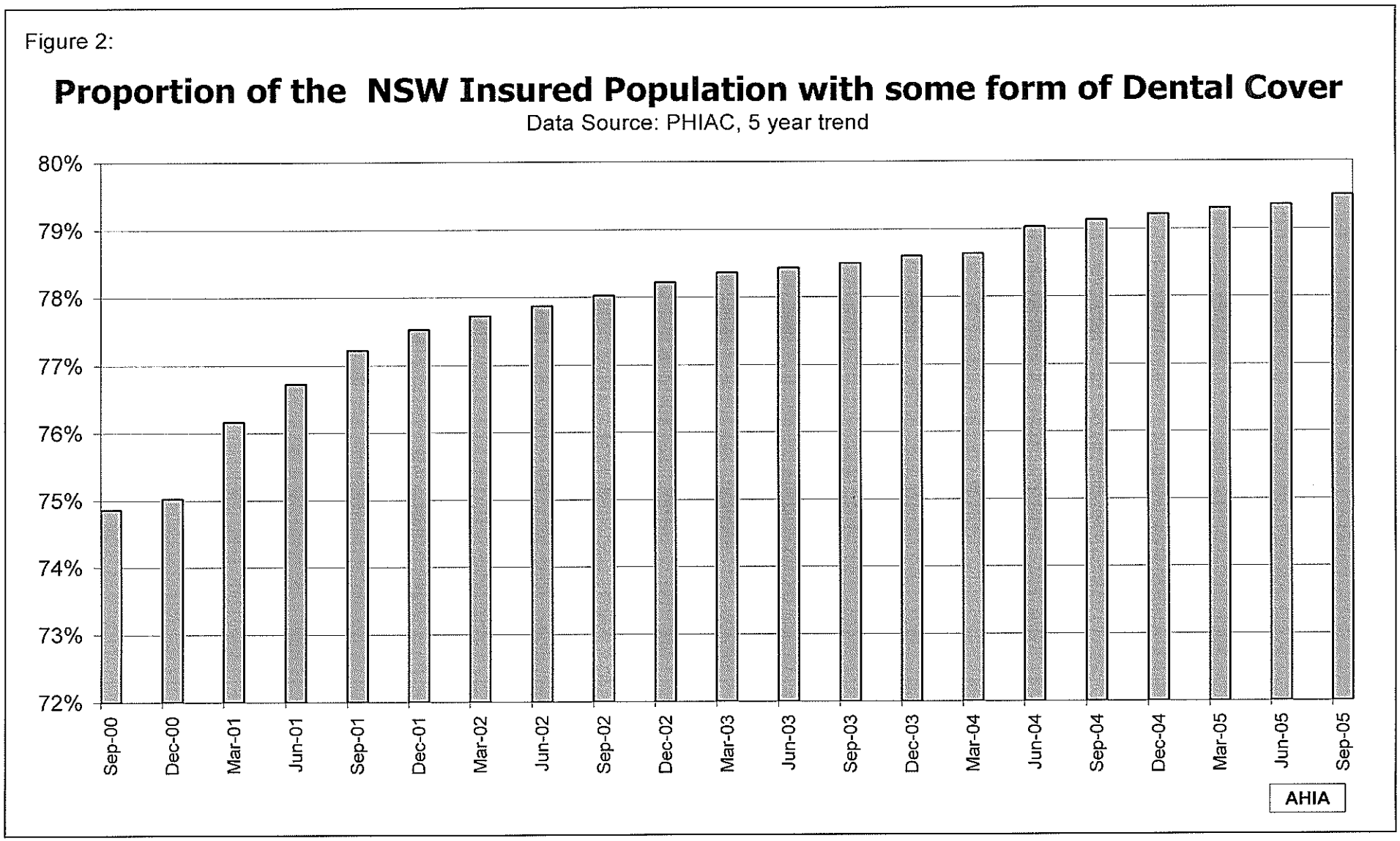
Proportion of the NSW Insured Population with some form of Dental Cover
Data Source: PHIAC, 5 year trend
80%
79%
78%
77%
76%
75%
74%
73%
72%
Sep-00
Dec-00
Mar-01
Jun-01
Sep-01
Dec-01
Mar-02
Jun-02
Sep-02
Dec-02
Mar-03
Jun-03
Sep-03
Dec-03
Mar-04
Jun-04
Sep-04
Dec-04
Mar-05
Jun-05
Sep-05
AHIA

Figure 3a:

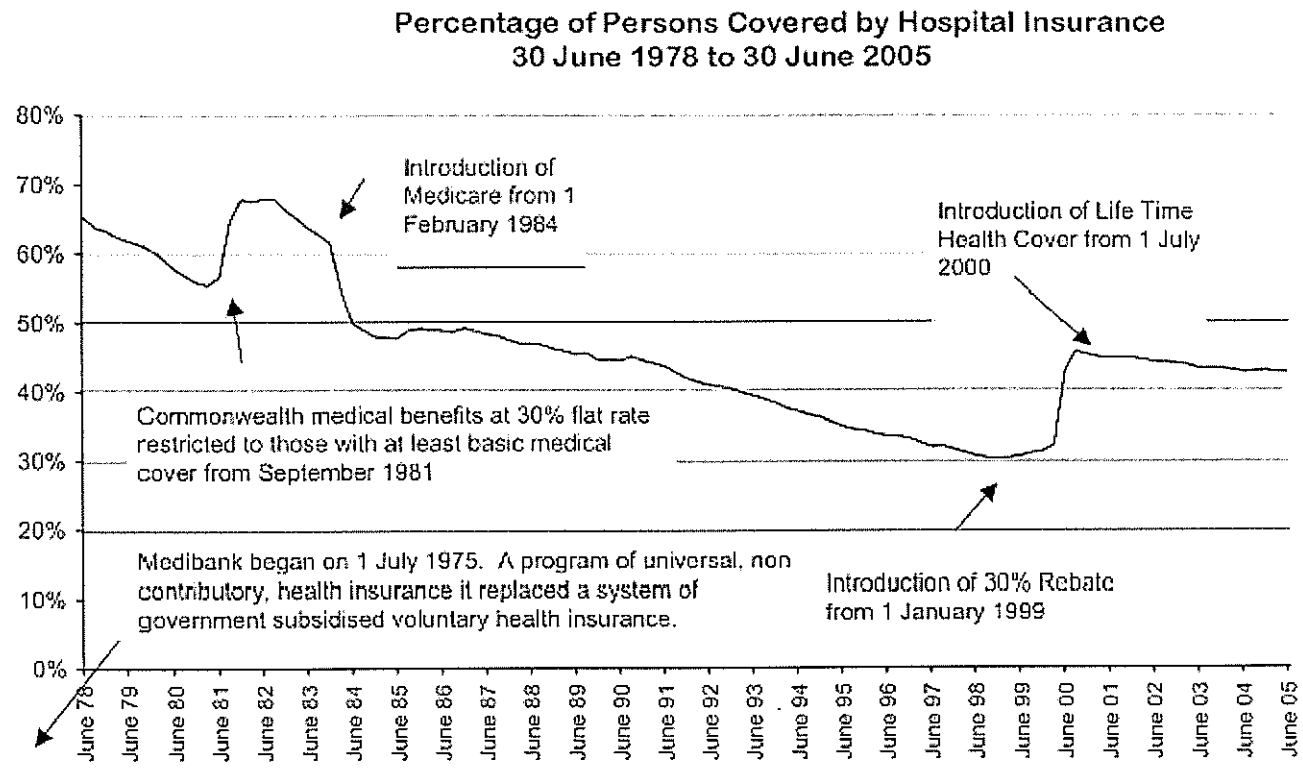

Figure 3: