AUSTRALIAN DENTAL ASSOCIATION INC.

Submission to the Productivity Commission

On

Review of National Competition Policy Arrangements.

June 2004.

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EXECUTIVE SUMMARY:

This review of competition policy provides the Government with a significant opportunity to evaluate the Government's effectiveness in delivering the objectives competition policy was designed to create.

More importantly, not only does the review enable this but it also creates the opportunity for Government to consider what steps it can now take to assist in achieving these objectives. The Australian Dental Association Inc. (ADA) believes that there are initiatives available to the Government that will not only assist in improving competition but also in improving the quality of the dental treatment available and also improve the overall oral health of the Nation.

The key points made by the ADA in this submission are:

1. There is no point in introducing measures increasing competition if, in doing so, the delivery of dental care to Australians suffers. Any measures introduced must have as their objective the improvement of the quality of dental services to and the oral health of the community. Introduction of competitive measures for competition's sake is not suitable if in doing so, quality of care suffers.

2. The "*corporatisation*" of dentistry, as with all health providers, would mean that the primary obligation of the participant (the dental surgeon) in the provision of health services would be to the business that employs the provider, rather than the provision of the optimum service to the recipient of that service – the patient.

3. Dentists receive extensive training on professional and ethical standards. Their focus is always their patient's oral health. Dentists therefore approach their practice in a different way than would a non-health related owner of a practice.

4. It is more likely that corporate owned practices will focus on lucrative facets of dentistry. It will therefore become difficult to find dentists prepared to provide services under government sponsored schemes or for the financially disadvantaged.

5. Consolidation of dental services in some areas may lead to non-competitive markets being created.

6. Non-dentists who own dental practices will not be, and are not, subject to the same standards of professional practice and codes of conduct. Health professionals have a higher obligation to their patients than would a business owner. Dentists risk breaching professional standards and loss of registration and ability to practice, if they do not adhere to certain levels of conduct. Non-dentists involved in dental practice are not subject to the same accountability mechanisms.

7. If the Federal Government truly wishes to increase competition in the dental healthcare sector and, at the same time, improve delivery of dental care universally across the country, it should initiate steps to increase the number of dental students and dental graduates to service those areas of the country where delivery of dental services suffers through lack of a workforce.

8. Increased mobility within the Nation ought to be facilitated by easing some of the administrative burden involved in the State/ Territory registration process.

9. The ADA submits that any such funds that State and Territory Governments receive as a result of the perceived increase in competition in the dental profession should be quarantined for use exclusively to improve dental health.

10. The ADA endorses the Federal Government's steps in attempting to restrict the circumstances in which successful claims for compensation can be brought and also endorses action taken and proposed action to be taken to restrict damages in such cases, so that compensation payable in such cases is in line with that available in many statutory schemes in Australia.

INTRODUCTION

The Australian Dental Association Inc. (ADA) represents approximately 8,500 registered dental practitioners within Australia. This constitutes well over 90% of all dental practitioners in this country.

The primary object of the ADA is to encourage the improvement of the health of the public and to promote the art and science of Dentistry.

In 1995 State and Territory Governments agreed to the introduction of reforms to competition policy in Australia. The changes extended the restrictive trade practices provisions in Part IV of the *Trade Practices Act* 1974 to all people engaged in business. The ADA notes that the underlying notion of the reform is the promotion of greater competition which it is suggested will create incentives for improved economic performance. It is noted that the reforms are designed "significant public benefit"[1]. The Productivity Commission is currently reviewing the impact of the National Competition Policy arrangements.

The reforms to competition policy can affect the dental profession, and thereby the public, in a number of ways. Whilst the ADA agrees with the motives of the Government in attempting to increase competition with a view to providing better performance, it must be appreciated that, in dentistry, the paramount interest of the dentist is, and must remain, the health of the patient.

TERMS OF REFERENCE.

The Productivity Commission has been asked by the Government to report on:

a) The impact of NCP and related reforms undertaken to date by Australian, State and Territory Governments on the Australian economy and the Australian community more broadly. To the extent possible, such assessment is to include:

   i. impacts on significant economic indicators such as growth and productivity, and to include significant distributional impacts, including on rural and regional Australia; and

   ii. its contribution to achieving other policy goals.

b) at the Australian, State and Territory level, areas offering opportunities for significant gains to the Australian economy from removing impediments to efficiency and enhancing competition, including through a possible further legislation review and reform programme, together with the scope and expected impact of these competition related reforms.

In examining new areas, the Commission is to have regard to the Government's desire to focus new reform activity where there is clear evidence of significant potential gains, through improvements to Australia's international competitiveness and the efficiency of domestic markets.

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Impact of Competition Policy Reforms on Rural and Regional Australia
Inquiry Report: 2 April 2002.

THE UNIQUE NATURE OF THE HEALTHCARE SECTOR

Increasing competition in the health services area must always be balanced against the interests of the patient and the community. A purely economic approach to reform is not suitable to the healthcare sector. The primary consideration in healthcare must always be the health of the patient and any proposed initiative that impinges on this primary objective has to be disregarded.

There is no point in introducing measures increasing competition, if in doing so, the delivery of dental care to Australians suffers. Any measures introduced must have as their objective the improvement of the quality of dental services to the community. Introduction of competitive measures for competition's sake is not suitable if in doing so, quality of care suffers.

Uppermost in any reform process in this area must be the improvement of dental service delivery to patients

The ADA contends that for reform to be effective it must satisfy the basic premise that the reform must as a consequence of its adoption, achieve the improvement in the delivery of dental care. If this is not achieved by any measures proposed then it is the ADA's view that there would be no benefit obtained by their introduction. This submission will address a number of issues relating to the delivery of dental care in the context of competition reform and in so doing express the ADA's view as to whether the measure being considered achieves this objective.

1. CORPORATE OWNERSHIP.

It is often felt that the incorporation of dental practices or the ability to open up the ownership of dental practices may have some "public benefit." The reasoning is that the eligibility of persons to enter the practice of dentistry will be extended beyond the bounds of registered dental practitioners to the wider community and that this widening of eligibility will increase competition and cause a reduction in the cost of delivery of dental service to the community. The ADA accepts that for many business enterprises this may be true but says that in the delivery of health services this proposition is not universally correct.[2]

The ADA in this submission will identify why this proposition does not apply to the delivery of dental services and indeed may be contrary to the "public interest."

a). Corporate duty.

For example, Section 181 of the Corporations Act provides:

"(1) A director or other officer of a corporation must exercise their powers and discharge their duties:

*a) in good faith **in the best interests of the corporation;** and*
b) for a proper purpose."

[2] See Schedule 1-ADA Policy Statement on Corporate ownership.

A clear statutory obligation is therefore imposed on officers of companies to act in "***the best interests of the corporation."***

The "*corporatisation*" of dentistry, as with all health providers, would mean that the primary obligation of the participant (the dental surgeon) in the provision of health services would be to the company that employs the provider, rather than the provision of the optimum service to the recipient of that service – the patient. The ADA believes there is no more important role for the health care provider than the delivery of care to the patient. It therefore does not believe that care delivery would be anything other than compromised by the granting of corporate ownership for dentistry.

b) The primary relationship in dentistry must be between the dentist and patient

Dentists receive extensive training on professional and ethical standards. Their focus is always their patient's oral health. Dentists therefore approach their practice in a different way than would a non-health related owner of a practice.

The ADA believes that it is not in the public interest for non-dentists to own and manage dental practices. It is concerned that such ownership of dental practices will result in an increased **emphasis on profit** and, in turn, result in reduced servicing standards.

As stated, directors of companies have a duty to act in the best interests of the company. In corporate owned dental practices the duty to the company's shareholders will dominate over the dentist's duty and responsibility to their patient. The dentist's relationship with their patient will become secondary. The same would hold true for the non-dentist owned practice.

Health funds provide a useful example of the issues which arise when a third party (such as a corporate dental practice or non-dental owner - hereinafter referred to as "corporate" owners) intervenes in the relationship between the dentist and the patient. Health funds are obligated to primarily consider the interests of their shareholders/members over the interests of the individual dental patient. For example, in some cases, financial considerations cause health funds to prefer certain types of treatment over others. Adoption by the patient of a treatment plan with the most attractive rebates may result in compromised care delivery. The better treatment might be clearly another option but the payment of lower rebates by the fund under that option may mean compromised care delivery. All this has done is lead to complications in the patient's treatment and has not contributed to an increase in productivity. The same situation could arise in the delivery of treatment by a "corporate" dental provider. Primary consideration would be given to profitability rather than proper delivery of the treatment.

c) Profit motive paramount.

Whereas the focus of dental practices that are owned by dentists is the oral health of patients, in corporate owned practices the focus will inevitably be swayed towards profit and cost cutting. Corporate practices could, by virtue of their duty to the shareholders or co-investors, be placed under added pressure to over-service or use techniques and materials that are not the optimum but result in an economic saving. As such they may not provide the same level of care for the patient that a more effective but more expensive treatment might provide. Shorter term cheaper options may not be in the long term interests of the patient but may be in the immediate financial interests of the corporate-run practice. It is possible that standards of service, such as standards of infection control will fall, as dentists come under pressure to increase profits in these businesses. Members

of the public have become expectant that the materials and equipment used in dental practices are of a very high standard and are selected on a cost/benefit basis and not on cost alone. This may be threatened if considerations of profit dominate in dental practices.

d) Focus on profit driven work

Some aspects of dental practice are more lucrative than others - this may depend upon the capacity of the patient to pay or to pay promptly. It may well depend on whether the work is done under a government scheme. It is more likely that corporate owned practices will focus on these lucrative facets of dentistry and, if practices are to be incorporated, it may become difficult to find a dentist to provide other services.

In Schedule 2 of this submission, a comparison is provided between the Department of Veteran's Affairs (DVA) scale of fees currently allowed for dental services and the average 2002 fees for the equivalent items of dental treatment charged by private practices[3].

This table illustrates that the level of fees paid by the DVA scales means that for DVA treatment the differential between gross income and overheads is effectively increased from 64% to 90%. This is a large reduction in the dentist's profit margin.

Corporations and non-dentist owners of practices would not participate in work of this kind. After payment of wages and other overheads the return on investment would be well below the cost of capital contributed by the shareholders/proprietors and performance of such work would, in their interests, have to be avoided. A liability would fall on directors and officers of companies that participated in such work if the doing of that work led to liquidation of the company.

The ADA has received information which suggests that existing corporate owned dental practices (which currently exist in some States) do not participate in government schemes, nor do they waive fees. Corporate practices will also not be concerned with the public interest, public sector work or with servicing the regional and remote areas. Such work would therefore place additional pressure on an already over extended dental workforce to attempt to do such work.

d) Competition may increase inappropriate demand creation

The profit motive that will drive a corporate practice to satisfy the demands of its shareholders/co –investors will, in turn, drive that practice to concentrate effort in demand creation. A corporate owned dental practice is therefore more likely to promote the advancement of profitable types of treatment than perhaps focus on basic, less remunerative dental work such as preventative measures designed to avoid the necessity for treatment in the future.

Demand creation in health, not only in dentistry, is the one major threat to the continuation of an effective health service for the community. Increasing resources are currently being devoted to profitable, but unscientific or even "unnecessary" therapies. It is expected that this will only increase if the number of corporate owned dental practices increases. Strong professional ethics and associations tend to dampen this demand creation on the basis of personal professional integrity.

As the provision of dental care universally across the country is under strain, due to lack of resources, any reform that allows focus and utilization of valuable resources for the sole pursuit

[3] The average fees are obtained from the 2002 ADA National Dental Fees Survey.

of profit at the expense of the overall dental health of the population has to be opposed as not being in the "public interest."

Attention is drawn to the section of this submission below that deals with "Advertising". The ADA suggests that demand creation is one focus of advertising and, as such, is an expense that could well be saved and the saving directed to overall improved dental delivery. (See below).

e). Economies of scale

An often presented argument is that fees charged for dental services may be lower when ownership restrictions are lifted, as the business is more likely to achieve economies of scale. The ADA contends this does not apply in the delivery of health services.

For example, Mayne Health's foray into private hospitals epitomises the myth of the argument of economies of scale, in that it has not delivered universal savings to the community. Anecdotally, it has been reported that, in fact, many patients are reluctant to utilise services in such practices due to the "de-personalisation" of the relationship that occurs, which of course can then result in inferior quality service delivery. Also the experience of MIA Group Limited (where a number of radiologists grouped together to form a corporate enterprise) is worthy of note. MIA Group Limited has a network of over 170 clinics in Australia and the United Kingdom[4] but its creation has reportedly done nothing to either increase competition in radiology or lower fees for service.

Savings on overheads in the operation of such businesses may well occur but if there is no requirement for those savings to be passed on, then all that has occurred is an increase in profits for the shareholder.

f). Corporate owned practices may affect referrals

There is also concern that commercial arrangements between corporate entities will replace the existing referral service. There may be, in the environment where the pursuit of benefits to the shareholder is the primary aim, commercial reasons and incentives for referring their patients to certain service providers over others, should some commercial benefit ensue to the referrer. Instead of focusing on referring patients to practitioners who are best able to assist them, the motive may become one of referral where the better more lucrative return may eventuate.

g). **Corporate owned practices may reduce competition in some areas.**

Corporate owned practices may, in fact, reduce competition, especially in regional and remote areas (an area of specific concern for dental service - see above). Consolidation of dental services may lead to non-competitive markets being created. For example, the incorporation or joinder of the only 2 dentists in a rural community would allow that practice to effectively monopolise dentistry in that area. As this is the area where the delivery of dentistry is at its worst due to limited resources, protection of the population is essential. As emphasised at the outset, any alteration to the existing framework of dentistry in Australia, should only occur if benefits are achieved. The ADA maintains there are no advantages emanating from such change in this area.

[4] www.mia.net.au/about/welcome.asp - accessed 1 June 2004.

h). Dentists are held to high professional standards

Dentists must meet high standards of professional conduct in order to be registered to practice. Their membership of this Association and membership of the profession imposes ethical standards upon their mode of practice[5]. This is a very valuable requirement in the effective delivery of dental care. Non-dentists who own dental practices will not be, and are not, subject to the same standards of professional practice and codes of conduct. Health professionals have a higher obligation to their patients than would a business owner. Dentists risk breaching professional standards and loss of registration and ability to practice if they do not adhere to certain levels of conduct. Non-dentists involved in dental practice are not subject to the same accountability mechanisms. In corporate practices they will actually have a higher obligation to their shareholders than to their patients. Some, but not all, States have included a requirement in their legislation that non-dental owners of dental practices be registered or listed with the Dental Board. This increases their accountability but does not remedy the situation entirely.

2. AUSTRALIA'S DENTAL SHORTAGE.

The Review has sought comment on the impact of NCP and related reforms undertaken to date by Governments in relation to "rural and regional Australia."

The level of competition in dentistry is uneven across the country. One of the most significant issues affecting the provision of dental services in Australia is the lack of access to dental services for a significant number of the population. There is a chronic shortage of dentists, especially in remote and rural areas and in the provision of Public dental services[6] (see Schedule 4). Any amount of increase in competition among the majority of dentists in the dental profession is not going to address this problem. The current concentration of dentists and dental practices means that the effect of any competition reform will only be evident in some urbanised areas of major cities where the concentration is such that this in itself provides more than adequate levels of competition.

Health professionals are an integral part of economic and regional development. However, there are barriers which stop eligible professionals relocating to rural and remote areas. There is currently no competition for the provision of dental services in some rural and remote areas because there are no dentists providing these services. State and Federal Governments should concentrate on encouraging dentists to relocate to these areas of need, as this would result in increased competition as well as better services.

If the Federal Government truly wishes to increase competition in the dental healthcare sector and, at the same time, improve delivery of dental care universally across the country, it should initiate steps to increase the number of dental students and dental graduates to service those areas of the country where delivery of dental services suffers through lack of a workforce. The ADA has in submissions to the Education Minister suggested that to achieve this objective the government could:

[5] See Schedule 3 – ADA-Policy Statement-Principles of Ethical Practice

[6] Spencer AJ, Teusner DN, Carter KD & Brennan DS 2003. The dental labour force in Australia: the position and policy directions. AIHW cat. No. POH 2.

- Extend additional funding to each of the various dental faculties and schools to facilitate the education of 20 to 24 additional dental students per annum in each school.

- Introduce special programs for dental students, similar to those proposed for nursing and education students. Due to deterioration in numbers of teaching and nursing students, there has been recognition by the government of a need for special treatment to be provided to students participating in teaching and nursing studies. In view of the chronic shortage of dentists and dental students that exist, the ADA suggests that similar provision be extended to dental facilities. Similar economic incentives and funding to those provided to teaching and nursing students and faculties should also be made available for dental students and faculties.

- Review fee scales for both HECS and full fee paying students undertaking dentistry studies to ensure they attract sufficient candidates. Under the HECS Scheme it is anticipated the likely fee for students will be $8,355 per annum by 2005. A HECS dental student would expect a total fee liability on graduation to be approximately $45,000. Expectations are that for full-fee paying students, the cost of undertaking a degree to achieve qualification as a registered dental practitioner will be in the vicinity of $130,000 to $150,000. When compared with an anticipated full-fee paying student for Law paying $80,000 and for an education student $46,000, such cost could represent a significant disincentive for prospective dental students to undertake a dentistry course. This needs to be addressed.

- In relation to the last two recommendations, the ADA suggests the introduction of a fee repayment and interest moratorium for dental graduates until an income of a minimum of $75,000 p.a. is earned by a graduate.

- Make it mandatory for Universities to at least continue to educate dental students in the numbers that are currently being educated. Already we have seen that the economic imperative imposed by the Government to make Universities economically accountable for their own operation has lead to the University of Sydney closing its future nursing training program.[7]

- Economic incentives should be made available to undergraduates and graduates who would be prepared to practice in particular areas of special dental need.

The focus of productivity and competition reforms ought to address these issues. The creation of additional dentists through our educational institutions would have the dual beneficial effects of:

i. Increasing the effective delivery of dental care to all areas of the community,
ii. Increasing the level of competition in the delivery of dental health care across Australia due to the increase in participants in the delivery of dental service.

[7] Sydney Morning Herald- 9th May 2004.

3. REGISTRATION.

In Australia, dentists must be registered in order to practice the full range of dentistry. In some ways this may be perceived to be a restriction on competition, in that dental practice is restricted to those who are registered. However, this requirement is obviously in the public interest and the ADA supports its maintenance.

a). Reasons for registration requirements.

Dental Boards in each State and Territory require Dentists to have reached a certain level of education in order to qualify for registration and they require dentists to also adhere to high standards of professional conduct. Dentists are in a position of trust in the community. Patients place their trust in their dentists and in return expect that dentists will be appropriately trained and will act in a professional manner. Registration requirements provide an effective control and monitor on the qualifications and conduct of dentists.

The ADA therefore advocates the maintenance of the existing high educational and practice standards required by the existing registration process.

b). An option for registration reform.

One reform which could be contemplated in the area of dental registration involves the process and structure of registration. Currently, dentists must be registered by the Dental Board of the State or Territory in which they wish to practice. Under the *Mutual Recognition Act* 1992 dentists who are registered in one State or Territory are, subject to the registration process for each State, able to practice in other States and Territories around Australia. However, in order to do so they must register with that State's Dental Board. Each State and Territory has different legislation governing registration of dentists.

The ADA believes that as the actual practice of dentistry is universal across the Nation, once registration is obtained in one State, that registration ought to be able to utilized in whatever State/Territory the dentist may then wish to later practice. Formal notice of an intention to practice in a "new" State would be required to be given to a Board in the "new" State and, once provided, there would be no other process to be followed. Renewal of registration would occur in the State/Territory where the practitioner is practicing as at the date of renewal. Jurisdiction of a Dental Board over the actions of a dentist would later depend, not on where the dentist was currently registered but be determined by where the activity of the dentist in question was performed. The current system only serves to increase costs for individual practitioners who may wish to move States to practice or who may be capable of practicing in 2 States/Territories e.g. practitioners in State border towns.

To assist in the tracking of the dentist workforce within the country, the ADA would propose that in the case of any practitioner moving from one Board's jurisdiction to another, there be an obligation on that practitioner to notify not only the Board of the "new" State or Territory but also the Australian Dental Council.

The ADA does not envisage any deterioration in standards of practice by the adoption of this recommendation. It sees significant administrative costs being saved by virtue of the avoidance of unnecessary duplication; which savings may well be able to be directed to dental care.

Modelling of this scheme along the lines of that sought to be achieved in the National Legal Profession Bill would, in dentistry, result in:

- the regulation of the practitioner remaining the responsibility of State and Territory Governments and Boards.
- dentists being able to practise anywhere in Australia with the one practising certificate. (On this matter, lawyers in the Model referred to, are required to seek their practising certificate from the "home jurisdiction" as defined in the Model Bill. The practising certificate is fully transportable and recognisable throughout each jurisdiction and responsibility for regulation of the lawyer is that of the home jurisdiction issuing the practising certificate.)
- a practising certificate being required to undertake work in areas that are reserved to dentists.
- Regulatory bodies will be able to share information and cooperate in investigations, including matters relating to complaints and discipline.[8]

4. MODERN DENTAL PRACTICES

Modern dental practices are run effectively and efficiently. There is little margin to be manipulated by cost saving initiatives and integration. The two major costs in dental service provision are the capital and staff costs[9]. Competition reform will have no effect on these costs. As stated previously, any cost savings that may be achieved may not result in fee reduction but only in increased profits being earned. As such, no 'public benefit" would ensue.

5. FEE SETTING

The ADA notes that it is contrary to NCP principles for professionals to engage in price fixing.

The majority of Australian dentistry is practiced by single practitioners[10]. Recently, the Australian Competition and Consumer Commission (ACCC) authorised certain general medical practitioners to engage in price fixing within specified business structures[11]. In doing so they indicated that the circumstances in which the ACCC will allow price fixing under the *Trade Practices Act* 1974 (TPA) for groups of medical professionals. The circumstances were very limited. Having analysed the delivery of health services in considering that case and allowing price setting in certain circumstances, the ADA believes that with that experience the Government may now be able to create clear guidelines for all health providers, including dentists, to follow to allow such practices which could result in some significant capital and labour cost saving. The ADA recognises that, to allow this to occur, there may need to be some provisos imposed that in part result in some of the savings achieved be passed on in benefits to consumers, to achieve some "public benefit".

6. ADVERTISING.

It is perceived that advertising of dental services increases competition. The ADA supports the ability of members to advertise to the extent that advertising assists in the delivery of dental

[8] NSW Law Society Journal-June 2004-' National Practice: National Legal Profession Model Bill'
[9] Barnard PD and White J, "Dental practice survey -2001" ADA News Bulletin, May 2003, 6.
[10] Barnard PD and White J, "Dental practice survey -2001" ADA News Bulletin, May 2003, 6.
[11] Yee-Kong S and Neylan M, "Are you price fixing?" ADA News Bulletin, May 2004, 7.

services. However, the ADA does not support advertising which heavily promotes the use of one dental service provider over another, as it sees no benefits to the consumer achieved by this means.

Advertising rules are currently governed by State Act and regulation. Creation of national uniformity would be of benefit.

7. STATE GOVERNMENTS MUST ACCOUNT FOR COMPETITION PAYMENTS.

We understand that if the State and Territory Governments around Australia implement the provisions of the National Competition Policy they will be financially rewarded, in that payments from the Federal Government will be received.

The ADA submits that any such funds that State and Territory Governments receive as a result of the perceived increase in competition in the dental profession should be quarantined for use exclusively to improve dental health.

The ADA is concerned by the poor state of dental health in Australia. Funds are particularly required in the public dental health sector, to address the poor oral health of the elderly and of Aboriginal and Torres Strait Islanders. “Public benefit” interests would clearly be obtained.

8. PROFESSIONAL INDEMNITY.

Currently, there are only a limited number of insurers in the market offering professional indemnity insurance to dentists. This is because the professional indemnity market for dentists is considered by many insurance companies to be unattractive. Lack of participants in the market may reduce the competitiveness of the market and allow insurers to dictate premiums to the market.

The ADA endorses the Federal Governments steps in attempting to restrict the circumstances in which successful claims for compensation can be brought and also endorses action taken and proposed action to be taken to restrict damages in such cases, so that compensation payable in such cases is in line with that available in many statutory schemes in Australia. It sees this as increasing the attractiveness of the risks in the dental market to be assumed by insurers and thus likely to increase the participants in the market.

9. NATIONAL WORKERS COMPENSATION.

The ADA would also like to take this opportunity to comment on the Productivity Commission’s recent Inquiry into National Workers Compensation. We note that the Commission is reported to have recommended that a national scheme of workers compensation will be available for some businesses. We expect that if this occurs, workers compensation premiums should reduce for all professionals and again endorses the action taken to explore this more fully.

10. CONTINUING EDUCATION.

The ADA believes that Dentists have an ethical obligation to engage in continuing professional education (CPE) throughout their practising careers so that the public will continue to receive quality patient care.

The ADA does not support the mandating of arbitrary levels of CPE through the Dental Registration Acts. The ADA says that there is no significant evidence indicating that better health or safety outcomes arise from mandatory CPE rather than through voluntary programs of continuing education.[12]

The ADA would support further research into the relationship between CPE and improved quality of patient care. In particular it would support research into identifying the areas of greatest oral health care risk (cost/volume/adverse clinical implications) and the areas of priority for continuing education to minimise risk in those areas. Such investigation will be in the public interest as it will ultimately result in the delivery of more effective oral care in that treatment outcomes will be enhanced, resulting in the reduction of expenditure in overcoming adverse outcomes.

The ADA would further support investigation into how the participation of dentists and other dental personnel in continuing education could achieve some economic savings for the participants through reduced Professional Indemnity premiums, registration fees and perhaps payment of higher benefits through government funded dental schemes and health funds. For example, some medical GPs are removed from HIC registration, if continuing education programs are not participated in by the GPs.[13] Such measures would achieve the dual objectives of increasing the level of skill of the practitioner and at the same time economically reward the practitioner. The cost benefits obtained could well be passed on to the consumer thus making the compliant practitioner more competitive vis-a-vis the non participating practitioner.

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[12] ADA-Policy Statement-"Continuing Professional Education.
"The Direction of Continuing Education in Australia"-Associate Professor Mike Morgan and Mr. David Harrison-August 2003.

[13] Removal from the Recognised General Practitioner list with the Health Insurance Commission occurs which means that the benefits received by those non participating GPs is below that obtained by GPs who receive the appropriate continuing education levels.

CONCLUSION:

1. The ADA has concerns about the way in which the National Competition Policy applies to dental health in Australia. We are concerned that:

    - patient safety may be compromised if ownership of dental practices is not restricted to members of the dental profession.

    - third party ownership of dental practices is not in the public interest. During their training and their continuing education dentists focus on their responsibility to ensure that their patient receives the best possible medical treatment. This will not be the focus of owners of dental practices who are not dentists. The health of dental patients must be the highest priority in the provision of dental services.

    - the effect of the corporate ownership of dental practices on the quality, accessibility and standard of service provided by dentists in Australia. Business goals are not always compatible with service goals in the healthcare setting. It is not in the public's interest for business goals to be allowed to dominate in dental practices.

2. All Australians should be able to access dental services in their area. Evidence suggests that this is not the case in some regional and remote areas of Australia. This issue requires the urgent attention of governments around Australia.

3. It is in the interests of the community that dentists-only restrictions are placed on the ability to practice dentistry and the restriction is that dentists must meet educational and professional conduct standards in order to become and remain registered. This protects the health of the public. It is also in the interests of the community that the practice of the full range of dentistry is limited to dentists. Other dental health providers should be limited in the services they can provide, in light of their skills and experience.

4. Registration requirements should be eased, as the current system of registration in cases where practitioners move from one State to another increases administrative costs. Should this proposal be adopted the ADA would be very interested in being involved in the development of such a system.

5. Dental services cannot be compared with the supply of other goods and services which are provided within a market where rational economic models can be applied. Dental services are unique in that the consumer often lacks the knowledge to assess either the quality of the dental service or the expertise of the dentist providing the service. The delivery of dental services involves a level of dependency on the part of the consumer which can only be sustained with the maintenance of the existing high levels of trust that exist, free of any taint of 'commercial' influence.

6. Further research be conducted into the benefits of continuing education with a focus on how those benefits might be passed on to the consumer by making the compliant practitioner more competitive vis-a-vis the non participating practitioner.

SCHEDULE 1.

AUSTRALIAN DENTAL ASSOCIATION INC.
POLICY STATEMENT

CORPORATE OWNERSHIP

1 Introduction

1.1 The Australian Dental Association [ADA] believes that the oral health needs of the community are best met by a clinically efficient and ethically conducted dentist-owned practice. This model provides community-based care with adequate opportunity for continuity of care and patient records [single patient record]. It is possible to facilitate quality and efficiency gains within the existing framework of dentist-owned practices, and without the need for equity investment by non-dentists or corporate owners.

1.2 The existing dental workplace landscape includes non-dentist owned facilities for provision of dental services, including health fund clinics and mutual organisations, which, in the main, are not-for-profit entities.

1.3 Recent changes to some Australian State and Territory Dental Acts provide opportunities for the ownership of dental practices by non-dentists and/or corporate entities.

1.4 The ownership of dental practices by entities other than dentists raises significant issues.

2 Community and Professional Interest Issues

2.1 It has been claimed that corporatisation will deliver improved economies of scale, improved patient focus and increased competition. The existing practice profile in Australia already addresses these areas.

The introduction of an additional management layer and the need to give a return on shareholder or owner equity -

- could compromise the individual dentist's ability to practise patient-centred dentistry, including the formulation of treatment plans and referral of patients,

- could compromise the ethical standards of an individual dentist and patient treatment outcomes by requiring an agreed turnover, thus affecting the quality and time needed to be spent with patients,

- ! could see the achievement of a return on shareholders' funds or owners' equity being placed above the interests and needs of the patient, and

- ! could result in the development of vertical and horizontal integration structures and the resultant tendency to inappropriately refer patients and thus increase the cost base to patients.

2.2 Rural and remote areas with lower population densities could be disadvantaged by the loss of dentists deciding to work for corporations in larger population centres. This is of particular concern where patients, because of age, access or equity reasons, would find difficulty utilising dental services.

3 Primary Legal and Accounting Advice Required Prior to Selling a Dental Practice to a Corporate Entity

The ADA strongly recommends that any dentist considering the sale of a dental practice to a corporate entity should seek independent legal and accounting advice. Experience has highlighted a number of risks when selling a practice to a corporate entity, especially where the sale is for shares in that entity, or when the dentist contracts to continue to provide dental services for a new owner.

Policy Statement 4.3
Adopted by Federal Council, November 21/22, 2002.

SCHEDULE 2:

COMPARATIVE TABLE OF FEES

Mean Fee as per ADA 2003 (2002 fees) Survey and Current DVA schedule Fees.

Service	Mean $ 2003	DVA FEE	% Difference
DIAGNOSTIC SERVICES			
011 Comprehensive oral examination	43	34.95	19
012 Periodic oral examination	36	29.20	19
022 intraoral periapical or bitewing radiograph	32	28.33	17
– 1st exposure	69	69.40	(.05)
037 Panoramic radiograph – per exposure			
PREVENTIVE SERVICES			
111 Removal of plaque and/or stain	43	36.05	16
114 Removal of calculus – 1st visit	73	48.95	33
121/111 Topical application fluoride (1x treat	45	21.70	52
incl plaque rem)	120	90.75	24
151 Provision of mouthguard - indirect	37	31.65	14
161 Fissure sealing - per tooth			
PERIODONTICS			
222 Root planing and subgingival curettage - per 8 teeth or less	108	85.70	21
ORAL SURGERY			
311 Removal of tooth or part(s) thereof	100	78.80	21
ENDODONTICS			
415 Complete chemo-mechanical preparation	177	151.40	15
of root canal,- 1x	80	62.90	21
416 " chemo-mechan preparation of root	166	151.40	9
canal,- each additional	80	62.90	21
417 Root canal obturation - one canal			
418 Root canal obturation, - each additional canal			
RESTORATIVE SERVICES			
511 Metallic restoration - 1 surface	83	65.60	21
512 Metallic restoration - 2 surfaces	101	81.60	19
513 Metallic restoration - 3 surfaces	122	99	19
514 Metallic restoration - 4 surfaces	141	116.40	17
515 Metallic restoration - 5 surfaces	162	133.95	17
531 Adhesive restoration – 1 surface –	99	80.05	19
posterior tooth	125	104.10	17
532 Adhesive restoration – 2 surfaces –	152	127.20	16
posterior tooth	171	149.55	13

533 Adhesive restoration – 3 surfaces – posterior tooth 534 Adhesive restoration – 4 surfaces – posterior tooth 535 Adhesive restoration – 5 surfaces – posterior tooth 575 Pin retention – per pin 577 Cusp capping – per cusp 582 Bonded facing – direct	194 23 26 197	171.70 19 19 154.95	12 17 27 21
CROWN AND BRIDGE			
615 Full crown – veneered – indirect`	1036	981.90	10
618 Full crown – metallic - indirect	957	745.50	22
651 Recementing crown or veneer	82	55.45	32
PROSTHODONTICS			
711 Complete maxillary denture	770	618.20	20
719 Complete maxillary and mandibular dentures	1369 642	1098.65 559.05	20 13
721/733/731 Partial maxillary resin, 6 teeth, 2 free end saddles, 2 retainers	32 990	27.65 369.35	14
731 Each retainer (for resin partial)	270	231.20	14
727/728 Partial denture, cast metal framework – 1 or 2 teeth	99 118	92.25 126.25	7 (7)
743 Relining – complete denture – processed	37	28.90	22
763 Repairing broken base of complete denture 768 Adding tooth to partial denture to replace lost tooth / tooth 776 Impression – dental appliance – repair/modification			
GENERAL SERVICES			
911 Palliative care	55	30.65	44

* Sample is central 90% of responses (excludes zeros) from general practitioners. [was central 80% less zeros in 2002]

SCHEDULE 3

AUSTRALIAN DENTAL ASSOCIATION INC.

POLICY STATEMENT

PRINCIPLES OF ETHICAL DENTAL PRACTICE

1 Introduction

The ADA Inc. has established these Principles of Ethical Dental Practice as a guide to the obligations and conduct of Members of the Association. In addition, each State Branch of ADA Inc. has established its Code of Ethics, the observance of which is a mandatory condition of membership. These Codes of Ethics are complementary to State and Territory statutory requirements.

2 Obligations Towards Patients

2.1 The primary responsibility of dentists is the health, welfare and safety of their patients.

2.2 Dentists should perform treatment only within areas of their competence.

If appropriate, referral for advice or treatment to other professional colleagues should be arranged.

2.3 Dentists must accept full responsibility for all treatment undertaken by themselves and, as permitted by law, by allied dental personnel acting under their supervision, direction and control.

2.4 No service or treatment shall be delegated to a person who is not qualified or is not permitted by the Laws of the Commonwealth, State or Territory to undertake that service or treatment.

2.5 Professional confidentiality must be maintained except where the Laws of the Commonwealth, State or Territory determine otherwise. It is the obligation of dentists to ensure that allied dental personnel observe this confidentiality.

2.6 Dentists should ensure that they provide patients with clear information about their dental condition and proposed treatment options so that patients can make an informed decision about their treatment.

3 Attitudes Towards Colleagues

3.1 Dentists should build their professional reputation on merit.

3.2 Dentists should be willing to assist their colleagues professionally.

3.3 Dentists should make the results of personal research freely available and should be prepared to share any scientific, clinical or technical knowledge.

4 The Practice of the Profession

4.1 Dentists should act at all times in a manner that will uphold and enhance the integrity and dignity of the profession.

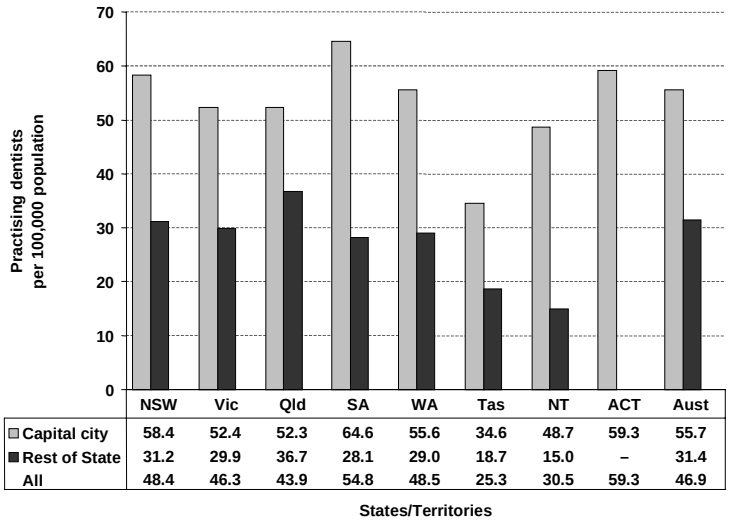
4.2 Dentists should express opinions, make statements or give evidence in an objective and truthful manner.

4.3 Dentists should maintain professional competence throughout their careers by active advancement of their knowledge of scientific, clinical and technical developments.

Policy Statement 5.4
Adopted by ADA Federal Council, November 21/22, 2002.
Adopted by Federal Council as the Code of Ethics of ADA Inc., April 10/11, 2003.

SCHEDULE 4.

Practising dentists per 100,000 population by region, 2000



	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Aust
Capital city	58.4	52.4	52.3	64.6	55.6	34.6	48.7	59.3	55.7
Rest of State	31.2	29.9	36.7	28.1	29.0	18.7	15.0	–	31.4
All	48.4	46.3	43.9	54.8	48.5	25.3	30.5	59.3	46.9

Source: AIHW DSRU: Teusner & Spencer 2003