Submission: Comments on the National Competition Policy Reforms, Productivity Commission Discussion Draft, Canberra, October, 2004

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Background :

Born in Western Australia, graduated BDSc (UWA) 1977.
Registered Dental Practitioner
1978 – 1980 Employed Perth Dental Hospital mobile country dental clinics
1980 – 1986 Self employed practice in country Western Australia (Bridgetown, Donnybrook & Boyup Brook)
1986- current Partner in group practice with 3 partners and 5 Associates in 4 separate Perth metropolitan dental surgeries.

Former Federal and State Australian Dental Association councillor and a past ADA (WA) Inc President.

Status of Submission:

This is a personal submission as a concerned private practitioner and the contents are my thoughts and are not made on behalf of my partners or the ADA.

Introduction:

For ease of discussion and reference I have numbered the points and have endeavoured to follow the layout and order of the Productivity Commission Discussion Draft.

1. Looking to the future: what to draw from NCP –Box 3, page xxiv

“An effective public interest test is essential to secure beneficial reform and to enhance community acceptance of the reform process”

Is it cost?
Is it quality of service?
Is it availability of service?
Is it qualification of the provider?
Is it ensuring the safety of delivery of service?
Is it ensuring the patient fully understands the nature of the service provided?
Is it ensuring the patient is fully informed as to the name of the service provider?

In my opinion it is all of these.

The public interest test,Box 2.4 page 17, makes no specific reference to dental or medical determinants for Public Interest tests

I would ask the Productivity Commission (PC) to determine what are the key factors for a public interest test applicable to dentistry.

Furthermore, I would ask the Productivity Commission to question as to how the implementation of NCP guidelines through legislative review with respect to dentistry has been of public benefit.

2. Professions and occupations – page 74

The LRP has considered dentistry in the same manner that the deliveries of gas, water, electricity, telecommunications, transport and other occupations.

I quote a recent lecture by Dr Thomas W Boland on dentolegal matters "The very practice of dentistry thus sets up a quite different and more difficult relationship between the practitioner and the patient than in other areas of medical service. It is not the same qualitative relationship as a patient has with a medical practitioner, a nurse or a pharmacist. In fact, dentistry is unique among health care professions in that the practitioner acts as physician/diagnostician, anaesthetist and surgeon,(the dental handpiece is essentially a rotating scalpel removing diseased tissue) who then prescribes, dispenses and fits the appropriate prosthesis – all this in just one simple filling.

I would put it to the Productivity Commission (PC) that dentistry requires a unique consideration because dentists on regular and often multiple occasions perform irreversible and invasive procedures.

The LRP programme must take this into consideration when it considers "deregulation" and removal of "anti-competitive" restrictions on practice.

The example quoted on page 75 regarding medical practitioners to perform foot treatments is not a good example as I believe these treatments are well within the scope of competencies and training of medicos.

With respect to dentistry there is mounting pressure on the WA Govt to comply with the removal of anti-competitive restrictions on Prosthetists to perform the fitting of partial dentures direct to patients. There is also pressure on the Govt to allow Prosthetists to fit implant supported prosthesis, snore guards, occlusal splints, supply and application of bleaching agents as well as allowing them ownership of dental practices and employing dentists.

Whilst the purist can argue restrictions of this nature are anti-competitive, there is a compelling public interest and safety issue at stake. Prosthetists simply do not have the educational background or ability to undertake such studies. To enrol in undergraduate university approved dentistry courses, the highest TEE scores are required and a minimum of 5 years full time study at an approved University. Prosthetists are dental technicians who have left school, often in year 10, some go to year 12, undertaken an apprenticeship and done a 6 or 12 month part time course at TAFE. The asymmetry in knowledge is enormous.

Even more mystifying in Western Australia, Private Health Fund data clearly shows that Prosthetists are on average 10-15% more expensive than dental practitioners in providing Full dentures to patients. Why are the legislators looking at expanding the duties of Prosthetists?

I would ask the Productivity Commission to question where is the public benefit in Western Australia in allowing a less trained, less qualified and more

expensive person to be allowed under NCP guidelines to perform such extended procedures.

3. Some views on benefits of NCP reform to the professions - Box 4.8 page 76

It is quoted that “the Victorian Branch of the ADA has indicated that deregulation of ownership restrictions applying to dental practices in that State has resulted in the establishment of more than 100 non-dentist owned practices.”

I would ask the PC to question what the public benefit of such action. There are no demonstrable public benefits that I have been able to find. There has been no drop in fees to patients; no extra services to benefit patients; created problems with codes and regulations for the Dental Board; created problems with corporate professional indemnity. There may well be instructed increase of services to improve profitability to the “investor” owner or corporate owners.

See the attached newspaper clippings which only talk about profitability and how much money the directors of such companies are enjoying from their ownership.

There have been no instances of improved services, more accessibility to dentists, improved hours or less fees. In fact under corporate ownership, a common complaint from patients is that they never get to see the same provider in large corporate owned practices.

There are very few corporate owned practices offering increased hours of service.

Patients, especially the elderly, are grossly inconvenienced because they can no longer access the local dentist or doctor as the corporate owners have bought out all the neighbouring practices and relocate them into larger buildings to save management costs and increase profit to the corporation. A specific example of this is in Mirrabooka, WA where Foundation health bought the neighbouring medical practices of Mirrabooka, Nollamara and Honeywell Boulevard and moved them all into one large building.

I would ask the Productivity Commission to question the public benefit of non-dentist ownership

I would put it to the Productivity Commission the most competitive model for dental practice ownership would be one dentist- one practice. As soon as an individual or other entity can own, say 100 practices, competition is reduced not increased

4. Regional Impacts of NCP –page 90

In its current form NCP will destroy rural and remote dentistry in WA. There are no incentives for young practitioners to move into country areas and buy or establish practices when corporations are offering such lucrative employment contracts to young and established practitioners. Fear of not being able to move “back to the big smoke” and have your own practice in the CBD or metropolitan area is killing country practices.

The same principal is destroying city practices. The age old concept where the elderly principal introduces a younger practitioner into the practice who then buys out the older practitioner is being destroyed by corporate ownership. Corporations are

taking up the younger practitioners. Practices will sell for less and corporations will just buy up more practices for less cost. **There will be less competition**.

Preferred provider schemes promoted by health funds will destroy rural dental practices. As with nearly all rural business, running costs are higher and availability of services is restricted, causing higher overheads. Health funds are intent on driving down fees and whilst there may be short term gain to patients, the reduced profitability may drive the dentist out of the town. **Where is the public benefit?**

5. GDP per hour worked in OECD countries 2003. – Figure 71, page 151

"Absolute productivity levels still remain below those in many other developed countries "

As I stated in my verbal presentation to the PC in Perth on the 20th December 2004, and subject of a separate submission [Submission DR 184] we have a health fund in WA, namely Hospital Benefit Fund (HBF) that has 72% of the private health insurance market in WA. HBF have introduced what I believe is a preferred provider scheme. They call it a participating provider scheme but application to participate does not entitle the applicant to automatic acceptance by HBF, therefore it is a preferred provider (PP) scheme. The PP's patients will get a much higher rebate than the non - participating provider's patients. The rebates are based on the PP's individual HBF profile of fees and the PPs cannot increase their fees without the consent of the HBF. There are anti-competitive elements here as HBF are attempting to control the fees charged, especially with 72% of the market and with about 70-80% of most practices patients having private health insurance.

Is this unconscionable conduct by misuse of market share?

Third line forcing (as defined on ACCC web page) -Third line forcing is a specific form of exclusive dealing prohibited outright by the Trade Practices Act. It is not subject to the substantial lessening of competition test. It involves the supply of goods or services on condition that the purchaser buys goods or services from a particular third party, **or a refusal to supply because the purchaser will not agree to that condition.**

As the purchaser (the patient) refuses to see a PP and sees the provider of their choice, the supplier (the health fund) refuses to supply (higher rebate level).

Is this third line forcing?

HBF controlling the fees charged means that it will control the output of the PPs and hence hold fees down. How can GDP contribution from WA dentists increase?

If an underlying principal of NCP reform is to increase GDP, then is this anti-competitive behaviour?

Whilst the purists will argue patient benefit due to reduced out of pockets, annual limits remain the same and there can be no quality controls. There are no figures on re-treatments. The standard of care must drop as providers strive to earn their previous level of fees. This exactly parallels National Health Service Dentistry in the UK, which has had disastrous consequences for the standard of dental services to the public, to the point where that quality of service is readily apparent to all who examine the patients who have been treated on the NHS.

Furthermore, the HBF schedules specify which items of treatment are permitted by that particular PP's profile. Not all profiles for services permitted by HBFare identical. In my personal circumstances where I have 4 practice locations, 3 partners and 5 associates we have 15 different issued schedules from HBF. The fees and the services are all different. For procedures not on the profile, the PP must first get authorisation from HBF and negotiate the fee from HBF **before** proceeding. This is not workable out of normal business hours nor for emergencies. This smacks of USA managed care issues and conflicts with a significant drive of NCP reform regarding deregulation of working hours. HBF will not only dictate fees and services but also hours of surgery.

Where are the long term public benefits? Are there short term benefits other than reduced out of pocket fees for the short term?

The Preferred Provider schemes by sheer financial pressure and market share will **destroy the patient's choice of provider**. HBF intends to circulate and list on their web page the PP's.

Where is the public benefit of such?

It would appear to me that that under NCP guidelines health funds are given special dispensation to implement anti-competitive practices. Private businesses selling products would not be allowed to have preferred retailers with specially negotiated set maximum prices that gave them an unfair advantage over non-preferred retailers? Why so for health funds?

6. Finishing the job in some key impact areas - page 203

The Wilkinson report found that ownership of pharmacies was in the public interest. This was supported by a COAG working group. The exact reasons found within the Wilkinson report can be paralleled to dental practice ownership.

Dentists on a regular basis, almost each patient, prescribe some form of medication, supply it and often inject it eg local anaesthetic.

Dentists perform on a regular basis, and often in multiples, totally irreversible and invasive procedures.

Dental practices do not have locality restrictions.

Not surprisingly, the corporations are contesting the LRP and using NCP guidelines to flaunt patient safety for their own benefit ie increased profits and not the public benefit.

Non-dental owners of practices will dictate what materials, what brand, what procedures and daily targets for employees. There is no public benefit in this behaviour. The attached file of newspaper clippings clearly indicate where corporate sentiments lie.

The Productivity Commission should question why is NCP reform driving dentistry into this arena?

8. Providing Choice for Consumers –page 254

‘In general, people appreciate the opportunity to make choices about things that matter to them, whether they be every day items or from the supermarket, or services such as health and education.”

PP schemes promoted by health funds such as HBF, MBP and HIF erode the freedom of choice of provider of dental services by punitory financial means. If a patient sees their provider of choice who is not a PP, the level of rebate is significantly lower than if they attended a PP listed by the health fund. On some particular items of service the level of rebate is lower by as much as $200+ per item of service eg HBF PP rebates on item 615 compared to non-PP rebate.

As ACOSS commented in it’s submission to the PC recently –“The power to choose between different providers is very important for the consumers of human services, especially those …..[people] who are economically and politically marginalised.”

Because of the intimate, invasive and irreversible nature of most dental services, patients develop confidence in their dental provider. Interestingly, it is well known that most of the cheapest dental practitioners in WA are not very busy as the discerning patient holds significant value to the quality of service rather than costs. This has been confirmed in studies carried out by Prof. J. Spencer of the AIHWA.

PP schemes are not about quality of service but about **long term control of fees** to reduce outgoings and **increase profitability** to health funds.

I would ask the Productivity Commission to question why, under the guise of complying with NCP guidelines, that health funds have been allowed to establish preferred provider schemes and that by punitory measures directed at patients, the funds have been allowed to destroy the fundamental right of the patient’s choice of dental provider?

“Policy makers have to strike an appropriate balance” – I would postulate that the current balance is heavily biased to health funds and as I have commented earlier seem to be receiving favourable treatment by the ACCC.

The PC draft also states “Further, competitive neutrality between providers is a prerequisite for efficient choice. Where some providers enjoy a competitive advantage by virtue of government ownership or discriminatory subsidies, choice is likely to be biased”

I would put it to the PC that health fund owned dental clinics, as in NSW, have a competitive advantage over private dental practices in that there is not neutrality in choice because of the punitive monetary influence in dental rebates.

The same argument can be said for PP schemes.

In WA, we have a health fund, namely HIF who have appointed a sole dental practice corporate, namely DB Dental, as their preferred provider. This is evidenced in the 2005 WA Yellow pages where DB Dental advertises such fact.

I would ask the PC to investigate the fact that Preferred Provider Agreements are in their own right anti-competitive and erode the patient’s right to freedom of choice

9. Redefining Competition in US Health Care – Box 10.6 page 257

Australia has one of the highest standards of community dental care in the world. Australia has one of the lowest DMFX (decayed, missing, filled or extracted) indices in the world. This has occurred because of strict regulation over quality and registration qualifications by regulatory boards and strict legislative acts governing the acts of dentistry. Dentistry has promoted fluoridation of scheme water, developed preventive techniques, promoted good dental health, embarked on privately funded (ADA member's fees) public dental education projects (Dental Health Month). These are significant public benefits which corporate and non-dental owners will not show any interest unless there are increased dollar returns to the owners

Porter and Teisberg have stated " …that the "wrong" kinds of competition have made a "mess" of the American health care system, the "right" kinds of competition can "straighten it out"."

Porter and Teisberg advocate shifting the focus of competition to" who provides best value" and in their opinion this would be characterised by-

i) competition at the level of specific diseases and conditions
ii) distinctive strategies by payers and providers
iii) incentives to increase value rather than shift costs
iv) information on provider's experiences, outcomes and prices
v) consumer choice

In my opinion these are fundamentally key issues that the PC should be encouraging in the delivery of health services, especially dentistry in Australia

Preferred provider schemes and non-dental ownership do not enhance any of these key issues.

I would like to make some further comments on some specific areas of particular personal interest to me which are in my opinion not been emphasised or dealt with adequately under the current LRP attempting to conform with NCP guidelines.

1. Paediatric Dental Care

PPs , PP schemes and non-dental owners have placed little emphasis on paediatric dental care because it is costly, time consuming and difficult. Simply, the profit margins, in the hands of general practitioners not well versed in this type of specific dental care, are not here and will not be promoted.

2. Geriatric Care

For exactly the same reasons above but with a different age group

3. Physically and Mentally Impaired Patients

This really is a specialised area of treatment care and it takes a particularly dedicated and devoted practitioner to put considerable time into these treatments. Corporate owners are not interested in this type of care unless there is some promotional motive to advertise such care. Again, purely driven by profit.

4. Domicillary and Hospitalised care

Again as for the reasons for # 3 above.

5. Department of Veterans Affairs

Generally, most private practitioners participate in the DVA scheme as a Local Dental Officer due to a moral obligation to treat the returned soldiers and their widowed families. However, poor remuneration levels have seen significant numbers of LDO's withdraw from the scheme. Non- dental owners and corporations will not participate as profit margins are not there.

CONCLUSION:

Once profit margins become the underlying principal of dental management, the future of Australian dental care is doomed to a downward spiral.

The ACCC is hanging its hat on the dental profession's codes of ethics to maintain standards but the ACCC have been extremely aggressive on professional bodies to remove anti-competitive elements from their codes or ethics and constitutions which in effect have watered them down to the point where they are powerless weapons. Once the new generation of practitioners, who have not been brought up under the proud "old" codes, become the norm then standards will fall away as profits become the underlying principal of "competition".

Health funds will influence treatments and fees and practitioners will be forced to take "shortcuts", drop standards, use lesser quality equipment and materials and review their own profitability and productivity. This is nothing new. The NHS in the UK has been going since 1948 and it is a clear example where this will lead the standard of dental care. **Why does Australia who has arguably the highest standard of general dental care in the world want to implement measures under the guise of competition that has the potential to destroy this magnificent reputation? Where is the public benefit?**

Corporate ownership can only either drive fees up or lower standards in order to increase profitability. Given that the average practice overheads in Australia are around 65-75% of practice turnover, adding another tier of profits cannot have any public benefit.

NCP guidelines being implemented into dental care runs the enormous risk of multi-tiered levels of treatment quality. Those that can afford the provider of choice will get the "Harley Street" treatment, and those who cannot will get NHS (PP) treatment or worse if they have no private health insurance and are financially poorly off.

As was stated in our presentation to Mr Gary Banks, Chairman and Mr Philip Weickhardt, Commissioner there has not been enough emphasis on what is right under the current legislation governing dentistry in WA and in attempting to comply with NCP guidelines it seems the legislators can only find wrong.

An example I have used previously is one of Dr Good and Dr Bad. Dr Good was more expensive than Dr Bad, but Dr Good's standard of care was exceptional. He did not advertise, his practice built up by word of mouth, he was extremely busy but he gave his patients due care and attention and was most ethical.

Dr Bad on the other hand did cut price dentistry, was fast and cheap, and advertised extensively as he was not very busy.

Along came NCP and preferred providers schemes and suddenly Dr Bad was good in the ACCC's and health fund's eyes and Dr Good was bad. Corporation "X" purchased Dr Bad's practice for $1 million and Dr Bad trained as many bad dentists as he possibly could which was good for Dr Bad.

Poor old Dr Good then had to decide whether he wanted to be bad or stay good. He tried to sell his practice so he could retire but no-one wanted a good practice. So Dr Good became bad and signed up to be a PP

The dilemma I put to the Productivity Commission is Good bad or Bad good!!!!

Warwick Wilkinson, Chairman, NSW Professional Standard Council in a speech on the 5/12/96 stated " It is possible to have an environment in which what's good for the professions, is good for consumers. Professionals governed by their ethical principals, put the community ahead of self interest. However, they need to be able to conduct viable practices so as to remain in the profession and thereby serve the community."

I would ask that the Productivity Commission seek urgent reviews of LRP and instruct legislators to ensure more emphasis is placed on public interest and benefit rather than pure competition policy.

Terry Pitsikas