Competition Policy Review Secretariat
The Treasury
Langton Crescent
PARKES ACT 2600

Submission to the Competition Policy Review

About the Australian Dental Association Victorian Branch

The Victorian Branch of the Australian Dental Association (ADAVB) is the peak body for the dental profession in Victoria, and represents over 80% of registered dentists, working in both public and private sectors. The ADAVB engages in policy work on all aspects of oral health and dental service delivery (Attachment A).

Our mission is to promote the art, science and ethics of dentistry, and the oral health of all Victorians. The ADAVB is highly respected, providing a variety of services and information to members as well as government representation, ensuring the maintenance of dentistry practice standards for the benefit and protection of the public and dental staff. The ADAVB is part of a Federation, and we are therefore affiliated with the Federal ADA Inc. The ADAVB supports the Federal ADA's submission to the Competition Policy Review. The ADAVB welcomes the opportunity to provide this additional submission, which is intended to compliment that of the Federal ADA.

1. Anti-competitive behaviour of Private Health Insurers (PHIs)

Preferred provider schemes

There are a range of activities by health funds that result in greater out-of-pocket expenses for consumers, reduced choice for the consumer and impacts on competition. The whole philosophy of private health insurance has been built upon the consumer having the choice of provider as distinct from a 'lack of choice' in the public health care system. PHIs have used discriminatory and punitive differences in rebate levels, to erode consumers' freedom of choice of provider.

Health Funds have introduced practices that lead to lower rebate levels when the member wishes to use the services of their dentist of choice, with whom they have an established relationship. Continuity of care is a key lynch-pin in patient centred primary health care. Continuity enables the practitioner and patient to develop a familiarity with and trust of each other, which leads to an improved quality of care.

As all members of a particular insurance plan pay identical premiums, the level of rebates for the same service should also be identical – however, this is not the case. Transparent competition has been eroded by these 'preferred' contracted provider arrangements and the inequality of rebate is causing increased out-of-pocket expenses for those consumers who wish to attend a dentist who is not a 'preferred provider'.

Private Health Insurer lack of transparency around rebates

There is a lack of clear communication from PHIs to consumers concerning rebates from claims, and when or if their health insurance will cover their treatment. Rather than being able to use an online lookup facility, PHI members are obliged to contact the insurer for an estimate of the benefit available on their treatment. This contact may then be used to redirect patients to preferred providers and to interfere with the pre-existing relationship the patient had formed with their dentist.

Recommendation 1: Discriminatory conduct by Private Health Insurers relating to the payment of rebates based on whether or not the health professional is a preferred provider be declared illegal, as it is against the interests of the patient and undermines open competition. As all members of a particular insurance plan pay identical premiums, the level of rebate for a given dental procedure should also be identical, regardless of which dentist provided the service.

2. Australian Health Practitioner Regulation Agency (AHPRA) - regulatory restrictions and codes of practice are only enforceable on registered practitioners. The bias of the AHPRA regulatory structure penalises practitioners but is permissive to corporations who own dental practices.

Companies owning dental practices – large corporation dental practices and networks

PHIs or corporations who own dental practices have a duty to shareholders to maximise profit. This can place pressure on dentists to become part of the 'corporate enterprise' and reach patient quotas, shorten consultation times or over-service. The consequences can be serious, patients may receive unnecessary procedures or more expensive procedures. Shortened consultations decrease patient satisfaction with their experience, and there is a risk of decreased quality of care.

Although PHI/body corporate practice owner policies may drive this situation, under the Health Practitioner Regulation National Law (the National Law), registered practitioners are held accountable. This creates a situation where a corporation can adopt policies to maximise profit, with associated risks of potentially breaching codes of practice, but it is the practitioner who suffers the consequences.

Although the PHI or body corporate may be responsible for the policies leading to this situation, it is the practitioners who face risk of investigation and could potentially lose their livelihood. There is no direct method for requiring that corporations create an environment that complies with practitioner codes of practice and there is no direct method under the National Law to hold accountable corporations that have breached these codes. The current provision in the National Law is that corporations that breach this law can be prosecuted in the relevant State or Territory Magistrates' Court, which may lead to a financial penalty. However, we are not aware of any cases where a corporate body has actually been prosecuted for violations of the National Law through this or any other mechanism.

The relationship between the practitioner and the patient is one where a large asymmetry of knowledge may occur. Patients expect to receive all of the information they need to make informed health care decisions. The practitioner is trusted to act in the best interests of their patient, but the influence of corporate practice owners can interfere with this relationship.

Key example – Advertising:

AHPRA has set strict regulations around the advertising of regulated health services[1]. Section 133 of The National Law prohibits advertising that:

- is false, misleading or deceptive or is likely to be so
- offers a gift, discount or other inducement to attract a user of the health service without stating the terms and conditions of the offer
- uses testimonials or purported testimonials
- creates an unreasonable expectation of beneficial
- treatment, and/or
- encourages the indiscriminate or unnecessary use of health services

These Guidelines are intended to protect the public interest. Practitioners are expected to comply with them and can be penalised if they do not. However, corporations that own dental practices, run preferred provider schemes or provide dental insurance to patients frequently flout these regulations. There is currently no direct method of recourse within the National Scheme to address this problem[2]. This example highlights both the inequities faced by small, owner-operated dental practices compared to large corporate practices owned by non-registered persons, and the potential risks to the public.

Recommendation 2: That unregistered practice owners be held accountable under the National Health Practitioner Regulation Law and the AHPRA/DBA Guidelines, to the same extent that a registered practitioner would be held responsible.

3. De-regulation leading to adverse outcomes for consumers: the university demand-driven funding model contributes to excess dentist graduates and workforce oversupply

De-regulation of Universities to allow for the removal of almost all caps on undergraduate places has generally been viewed by the Tertiary Education sector as a positive reform that allowed the system to become more competitive internationally.

[1] Australian Health Practitioner Regulation Agency. National Board Guidelines for Health Practitioners – Guidelines for Advertising Regulated Health Services (March, 2014)

[2] According to the AHPRA Guidelines: bodies corporate who breach the Advertising Guidelines may be prosecuted "under the advertising provisions of the National Law in the relevant state or territory magistrates court, which may lead to a financial penalty", however, we are not aware of any cases where a corporate body has actually been prosecuted for violations of AHPRA's Advertising Guidelines through this or any other mechanism

There are two forms of demand - firstly the community need such persons and their skills and secondly students applying for specific courses. Unfortunately, the latter has always outstripped the former in courses such as dentistry and medicine.

The de-regulated approach may be successful in situations where the demand for qualified graduates is less than or equal to the supply of new graduates. However, the 'demand-driven' funding system, has contributed to a rapid increase in the number of dentists entering the workforce, far more than can reasonably be expected to be able to find work. Supporting uncapped places in dental programmes when there is no pathway to gainful utilisation of the training through employment is a waste of resources and taxpayers' monies. It is also unfair to students, who can be viewed as the consumers in this situation, especially given the large proportion who are full fee paying and who may have incurred costs of well over $200,000 in course fees as well as living expenses while they undertake the course.

The number of qualified dentists graduating from Australian Universities will soon be double that of 2005. The workforce can absorb around 510 new dentists per year, but in 2013, 581 qualified dentists graduated from Australian Universities. A further 230 overseas-trained dentists entered the workforce through the Australian Dental Council pathway in 2013. Consequently, many new graduate dentists are now unemployed or under-employed.

As consumers of Tertiary Education, dentistry students have been greatly disadvantaged by the 'demand-driven' funding policy. They have paid many tens of thousands of dollars in tuition fees and been given great hopes of joining the dental profession and gaining professional experience, but in reality the dental economy in Australia cannot support them.

Adverse impacts of the demand driven model are:

1. *Skilled graduates with limited employment outcomes*

A dentist qualification may take from between five to seven years to achieve, depending upon the type of programme undertaken. Obtaining a dentist qualification provides the graduate with a well-defined skill set. These skills do not translate to any other sphere of employment opportunity. A graduate either seeks to practise dentistry or seeks to embark on a whole new career – most likely requiring another 3–4 year minimum course of study. There are no options that the ADA can identify that provide any alternate employment pathway to another career for the dentist graduate.

2. *Reduced ability to attract high calibre students to dentistry*

Currently dentist courses attract a high calibre candidate for enrolment. If, through the continued use of the demand model, a situation was created where dentist supply grossly exceeds demand then that high calibre candidate is likely to avoid pursuit of that degree due to poor employment prospects. This would result in a lower calibre candidate entering the course and graduating. In all spheres of professional practice, it is the leaders that dictate the level of performance of the profession. High calibre graduates will enhance the development of the profession.

If they are not part of the profession, research and development will suffer as will the high skill levels that currently exist.

The community will suffer as a result.

3. *Impact on fees for dental services*

The ADAVB recognises that in a balanced perfect economy, where demand for dental services exists with shortages in supply of dentists, the impact would be to increase the price of dental services. If supply of dentists exceeds demand for services then economic theory suggests prices will decrease in the market. Having excess supply will have a favourable outcome for consumers.

However, dentistry is not performed in such an economic market setting. Factors such as the role of private health insurers and government schemes, which help fund dental services, create an economic environment that causes the standard supply and demand theory to no longer work in this pure fashion. These contributors significantly influence the price of services regardless of supply of dentists or demand for services. The cost of the highly regulated and mainly imported materials and equipment required for dental treatment is also a factor in keeping dental fees high.

It is the ADA's opinion this impact on prices will be lost where supply exceeds demand by more than 15%. When supply exceeds demand by more than this amount, in the case of dental services and most capital intensive professional labour service delivery models, the tendency will be for prices to increase. This is because the provider has a level of overhead that will need to be covered. The supplier of the services will seek to meet the cost of the overhead and achieve resultant profit by either providing services that may exceed real need or alternatively (and more likely) increase prices for the services provided.

Dental practices average about 70% overheads so that for every dollar paid in fees, 70 cents is required to cover the costs of staff, infection control, material and equipment, waste management, equipment services, software licenses, and other practice expenses.

Allowing the demand driven model to produce an oversupply of dentist graduates that flood the market, creates a market not in equilibrium and one that will have an adverse impact on consumers through increased prices.

Recommendation 3: That dentistry student enrolment numbers be capped at a level that reflects projected workforce needs.

Contact:
Mr Garry Pearson,
Chief Executive Officer
Australian Dental Association Victorian Branch
Level 3, 10 Yarra Street, South Yarra VIC 3141
Ph. 03 8825 4600 Fax 03 8825 4644
Email: garry.pearson@adavb.org

ATTACHMENT A

INFORMATION SUMMARY 2013/14

ABOUT THE ADAVB INC.

The ADAVB is the professional association of Victorian dentists which aims to

- improve the dental health of all Victorians
- promote the art and science of dentistry
- promote the highest standards of professional dental care
- enhance the professional lives of members

MEMBERSHIP

- Over 3500 Members in private and public practice, along with students and international dental graduates

MEMBER SERVICES & FUNCTIONS

- Continuing Professional Development Program
- Dental health education (e.g. Dental Health Week and Facebook page 'Caring for your kids' teeth')
- Community Relations – dispute resolution
- Code of Ethics (Conduct)
- Recent and Overseas Graduates' support
- Practice staff Training seminars
- Practice+ (Consulting Services) and PracAdmin Network
- Member Benefits(eg Professional Insurances; preferred suppliers)
- IR advice and representation (via the ADA HR Advisory Service on 1300ADAINC)
- Defence and legal support
- eviDent Dental Practice Based Research Network (in partnership with the Oral Health CRC)
- Quality Assurance (including Member Assistance Program)
- Benevolent Fund
- Reading Room and resource collection
- Advocacy and representations to Government bodies
- Superannuation (Professional Provident Fund)
- Sports, social functions and community and charitable activities
- Publications – Newsletter, Journal, Manuals etc.
- Website, including many members' only resources e.g. employment register (find us at **www.adavb.net**)

DISPUTE RESOLUTION SERVICES

The Branch provides information to the public on dental matters, and offers a conciliation service to assist patients to resolve disputes with members. Information on treatments, facilities, dental issues and careers is available.

PRESIDENT
Dr Jo-Anne Cherry
BDSc

Jo-Anne is a general dentist in Melbourne.

CEO
Director, eviDent DPBRN
Mr Garry Pearson
MEdSt, HDT (SAC)
FAIM, MAICD

Garry joined the ADAVB in 1991 after senior executive roles in the Victorian Education Ministry

AUSTRALIAN DENTAL ASSOCIATION VICTORIAN BRANCH INC.
LEVEL 3, 10 YARRA ST. (P.O.BOX 9015) SOUTH YARRA 3141
TEL: (03) 8825 4600 FAX: (03) 8825 4644 ask@adavb.org
ABN 80 263 088 594 ARBN 152 948 680 Reg'd Assoc. No. A0022649E

HISTORY

The ADAVB was formed in 1928 through the amalgamation of the Odontological Society of Victoria (est. 1884) and the Australian College of Dentistry Alumni Society (est. 1915).

The ADAVB was formally incorporated in 1991.

In April 2008, the ADAVB office relocated to Level 3, 10 Yarra St. South Yarra (opposite the South Yarra Station).

LEGAL STATUS

The ADAVB is incorporated under the Associations Incorporation Act (Vic) and as such, it is a not for profit organisation.

AFFILIATIONS

The Branch is a member of the national organisation, the Australian Dental Association Inc., and thus provides automatic membership of the Federal association.

The Branch is also a member of:

- Australian Industry Group
- Australian Taxpayers Association, and
- Australian Institute of Management.

AFFILIATED SOCIETIES/ GROUPS

- Australian Society of Orthodontists
- Australian Society of Periodontology
- Australian Society of Endodontology
- Australian Prosthodontic Society
- Australian and New Zealand Society of Pediatric Dentistry
- Various other societies and Dental Study Groups

REPRESENTATION ON STATUTORY AND OTHER BODIES

- Cancer Council of Victoria
- Department of Health reference and working groups
- Department of Oral Health, La Trobe University
- Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne
- RMIT University

COMMUNICATIONS ADVISORS

Porter Novelli

BANK

Westpac, South Yarra Branch

AUDITORS

Advantage Advisors (previously known as Bentleys)

SOLICITORS

Health Legal

STAFF

The Branch employs 21 staff (17.6 EFT), including four senior dentists (each of whom works part time) to provide advice to the public and members