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NCP review of the Northern Territory Dental Act

Prepared for Territory Health Services

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Executive summary

THE REVIEW OF THE *DENTAL ACT* is one of 12 reviews being undertaken of the Northern Territory's health legislation under National Competition Policy (NCP) requirements. This report briefly describes NCP principles and procedures and provides some background information about the act and procedures adopted in its administration.

Subsequent chapters of the report follow the steps that must be taken in any NCP review, namely to:

- clarify the objectives of the legislation;
- identify the nature of every restriction on competition;
- analyse the likely effects of the restrictions on competition and on the economy generally;
- assess the balance between the costs and benefits of the restrictions; and
- consider alternative means of achieving the same results including nonlegislative approaches.

A final brief chapter presents the recommendations arising from the review.

Features of the legislation that have been identified as potentially restricting competition include:

- persons carrying out functions as dentists, dental specialists, dental therapists and dental hygienists must be registered, holding appropriate qualifications for the category of registration sought;
- criteria for what constitutes a 'fit and proper person' to be registered under any of these categories are not spelled out in the act;
- dentists and dental therapists must obtain permits to undertake X-ray procedures from the Northern Territory's Radiographers Registration Board (the restriction is in the *Radiographers Act*);
- the act sets out what dental hygienists and dental therapists are allowed to do and how they are to be employed; it restricts activities of dental therapists to working with children in the public sector; the activities of dental prosthetists

and dental technicians are not regulated; thus the act segregates the professional market into discrete activities between which there is no room to move;

- dental hygienists and dental therapists (as well as Aboriginal health workers, registered under the *Health Practitioners and Allied Professionals Registration Act*, undertaking oral procedures) must all work under the supervision of a registered dentist;
- a dentist is not permitted to form a company with a dental specialist and vice versa;
- there are restrictions on who can be directors and hold shares in dental companies;
- the Dental Board must be informed about the directors, members, shareholders and voting rights, and must approve the name and constitution, of any dental company; and
- persons can only use the title 'dental hygienist', 'dental therapist' or 'dentist' if they are registered in that category under the act.

It is stressed that a number of the features of the legislation are *potentially* anti-competitive. Whether they *actually* restrict competition, and what their effects might be, depend on how they are administered and other features of the competitive environment.

Chapter 6 undertakes an assessment of the balance between public benefits and costs of these restrictions on competition. Our conclusions are as follows.

- A revised act should state the objectives of the legislation. These objectives should be stated in terms of protecting the health of the Northern Territory public. The revised act should be called the *Oral Health Services Act* and the Dental Board renamed the Oral Health Services Board.
- It is in the public interest that dental specialists, dentists, dental therapists, dental hygienists and dental prosthetists should be registered and receive exclusive right to title. But for title protection to provide ongoing value to the public, registrants must maintain their competency to practice.
  - Professional criteria for registration should be determined by the Dental Board.
  - Registration should involve a practicing certificate renewable annually subject to the registrant being able to demonstrate to the board's satisfaction evidence of continuing competency to practise.
  - Fit and proper person criteria should continue to be required for registration, but these criteria should be explicitly defined in the act.

- To ensure greater vertical mobility within the group of oral health professionals, section 14 of the act, which contains schedules specifying limits on the allowable activities of certain categories of registrants, should be deleted. Instead, allowable activities should be expressed in terms of core competencies and what each professional is trained and capable of doing. It should be the responsibility of the board to discipline any registrant who undertakes activities beyond their core competency and capability.
- It is in the public interest that registrants should continue to receive practice protection (section 44). But the board should have the power to grant authorisation to persons outside the categories of registrants nominated above to provide dental services for which they have been trained (this may include remote area nurses, Aboriginal health workers and other suitably trained allied health professionals). This should improve the access of citizens in the Northern Territory to dental services.
  - Authorisation of Aboriginal health workers to undertake dental work should be confined to those workers who are appropriately trained to perform such work.
  - The right of the Minister to specify a part of the Northern Territory in which Aboriginal health workers authorised to provide dental services may not provide those services should be repealed.
- Dental therapists, dental hygienists, dental prosthetists, Aboriginal health workers and any other categories of professionals authorised on the basis of their training and competence to undertake dental work should remain under the supervision of dentists for as long as their educational preparation is not geared to practicing as an independent practitioner.
- It is in the public interest that:
  - the restriction preventing dental therapists from working in the private sector should be removed; and
  - the restriction on dental therapists treating adults should be removed subject to the board establishing on an individual basis that dental therapists have the necessary training to treat adults.
- The social costs of conduct regulations on dental companies are likely to exceed the social benefits. Hence, all restrictions on ownership of dental companies, the requirement that company directors, members, shareholders and voting rights be provided to the board and the requirement that the name and constitution of a dental company be approved by the board should be removed.
- Because they are procompetitive, current restrictions on advertising and promotion should be retained.

- Membership of the board should be broadened to include a stronger representation from persons other than oral health professionals and to reflect a broader coverage of oral health professionals to better serve and represent the public interest.
- The wording of a new act should use gender neutral language and give due attention to how categories of registrants should be referred to.
- In summary, the changes we are advocating are designed to allow for greater flexibility in the provision of dental services to the Northern Territory population. They will, however, require that the board play a much greater role than at present in assessing the training and competence of oral and allied health professionals to perform various tasks within the field of dentistry.

1 Introduction

THE CENTRE FOR INTERNATIONAL ECONOMICS (CIE), a private economic research consultancy, in conjunction with Desliens Business Consultants has been commissioned by Territory Health Services (THS) to undertake an independent review of the *Dental Act* in accordance with the principles for legislation review set out in the Competition Principles Agreement (CPA) entered into by all members (Commonwealth, states and territories) of the Council of Australian Governments in 1995. The review forms part of the Northern Territory government's obligation under the CPA to review and, where appropriate, reform all laws that restrict competition by the year 2000. Legislative reviews along National Competition Policy (NCP) lines are currently being undertaken of health and health related acts in other states. The Commonwealth is also conducting NCP reviews of its health legislation.

The *Dental Act* is one of 12 Northern Territory health acts to be reviewed (box 1.1).

In undertaking this review we held preliminary consultations with stakeholders involved in the provision of dental services in the Northern Territory, including officers of THS. A number of relevant documents were reviewed, including a 1998 review of the professional boards. An issues paper was prepared and made available on the THS website. The issues paper worked through the various steps of an NCP review and raised questions and issues to be addressed at each step of the review. The issues paper identified those parts of the act that potentially restrict competition.

Newspaper advertisements drew attention to the review and the issues paper and called for submissions for interested parties. Eight submissions were received (appendix B). Further consultations were held with interested parties to discuss aspects of their submissions. This report documents the findings and recommendations of the inquiry.

1.1 Acts to be reviewed

- ***Dental Act***
- *Optometrists Act*
- *Radiographers Act*
- *Community Welfare Act*
  - Community Welfare Regulations
  - Community Welfare (Childcare) Regulations
- *Health Practitioners and Allied Professionals Registration Act*
- *Nursing Act*
- *Mental Health and Related Services Act*
- *Public Health Act*
  - Public Health (Barber's Shops) Regulations
  - Public Health (Shops, Eating Houses, Boarding Houses, Hotels and Hostels) Regulations
- *Medical Act*
- *Private Hospitals and Nursing Homes Act*
- *Medical Services Act*
- *Hospital Management Boards Act*

2 *The 'industry' and its customers*

DENTAL SERVICES IN THE NORTHERN TERRITORY are provided by six categories of service providers — dental specialists, dentists, dental therapists, dental hygienists, Aboriginal health workers and dental prosthetists. The act provides for registration of dental specialists, dentists, dental therapists and dental hygienists. Aboriginal health workers are registered under the *Health Practitioners and Allied Professionals Registration Act* to practise Aboriginal health work, some of which involves dental work, though the current role of Aboriginal health workers within the oral health service delivery area is small. Dental prosthetists are not registered under the current act, though provision for their registration is made in a proposed draft act (see appendix C).

There are 20 dental specialists registered to practise in the Northern Territory, seven of which have Northern Territory addresses. There are 84 dentists registered in the Northern Territory, 68 of which have Northern Territory addresses. There are 17 dental therapists registered in the Northern Territory, all of which have Northern Territory addresses. There are three dental hygienists registered to practise in the Northern Territory, all of which have Northern Territory addresses. There are 437 Aboriginal health workers registered in the Northern Territory.

Consumers of dental services also fall into various categories, each with particular needs for dental care — preschool children, primary school children, high school children, adults, indigenous communities and residents of remote areas, residents of nursing homes and hostels, home-based persons, prisoners and persons of non-English speaking backgrounds. Some categories of service providers are focused on meeting the needs of particular customer groups. Dental therapists play a major part in meeting the dental needs of preschool and primary school children, and Aboriginal health workers are important providers of basic dental services to indigenous communities.

Oral health plays an important part in determining general health. This is particularly true of Aboriginal communities where poor oral health has been linked with diabetes and renal diseases. The Northern Territory Dental Therapist Association (NTDTA) considered that Aboriginal health service delivery could be improved by providing further training and support to the Aboriginal health

workers in the communities enabling them to continue ongoing oral health services.

The public sector, through THS, which employs all the dental therapists, about 17 dentists and most Aboriginal health workers, plays a major role in facilitating dental health care opportunities to children, health care cardholders and dependents, and people in remote areas and is a substantial purchaser of dental services on behalf of consumers. The THS dental services budget for 1998-99 was $5.8 million. THS funds dental services in three main areas — Children's Dental Service (CDS), urban adult services, and remote and rural dental services. In 1998-99 there were 30 127 occasions of service within the CDS, 22 766 within the urban adult services program and 6786 within the rural services.

Because of the professional isolation of the Northern Territory and its lack of a dental school, it is difficult to recruit dentists to service the needs of the community. The Northern Territory has one private practitioner to 5428 persons. For Australia as a whole, the ratio is one private practitioner to 2628 persons.

Access to dental services for some segments of the community is restricted because of insufficient service providers, geographic remoteness and an inability to purchase private dental services. Dental services in urban areas of the Northern Territory achieve a 94 per cent coverage of preschool and primary school children. But access in remote communities is much less. The THS submission noted that this is reflected in a significant difference in oral health status between indigenous and non-indigenous children as follows.

- In 1997 only 32.9 per cent of indigenous children had never experienced dental caries compared with 60.6 per cent of non-indigenous children and indigenous children had nearly three times the average number of untreated carious teeth.
- In 1996 indigenous 12 year old children had twice the incidence of untreated decay of non-indigenous children.

Children up to year 7 can access the children's dental service free of charge. Oral health of Northern Territory children on average mirrors that of children in Australia as a whole, though the oral health of indigenous children is considerably worse than other children (higher levels of untreated decay and higher total cases).

The submission from Dr Walker reported extensively on the oral health care needs of Aboriginal communities and cited several recent studies documenting a significantly higher incidence of decayed teeth and caries experience in the deciduous and permanent dentition of Aboriginal children compared with non-Aboriginal, Australian born children. The submission argued that, given the severity of oral health needs of Aboriginal communities, it is important that

legislation not prohibit equipping Aboriginal communities with the prerequisites to achieve and maintain good dental health.

It is estimated that only 15 to 25 per cent of high school students and less than 50 per cent of adults access a dentist. Reasons for this low participation include insufficient appreciation of the importance of oral health to general health and limited availability of dental services at affordable prices to some segments of the community. High school students can be seen at public sector adult dental clinics (but not by dental therapists) and are not means tested, but most do not take advantage of this service.

3 NCP principles

UNDER THE CPA, nearly 2000 pieces of Commonwealth, state and territory legislation are being reviewed over a six year period. The guiding principle behind these reviews and the reforms that follow them is that legislation (encompassing activities of authorities set up under that legislation and any regulations, rules, etc. authorised under it) should not restrict competition unless it can be demonstrated that the:

- benefits of the restriction to the community as a whole outweigh the costs; and
- objectives of the legislation can only be achieved by restricting competition.

It is significant to note that *both* of these criteria are required to be met if a restriction is to be retained. This means that even if a restriction passes a net public benefit test, it should not be retained if there are other less restrictive ways of achieving that outcome. Also, if a restriction is to be retained it is necessary to demonstrate that to keep it will result in a public net benefit. It is not sufficient to demonstrate that its removal would result in no or little net benefit.

It is important when assessing the benefits and costs of a restriction that distinctions are made between private benefits and costs, industry benefits and costs and communitywide benefits and costs.

The CPA does not define how any piece of legislation should be reviewed. However, it does state that, without limiting the issues that can be addressed, it should:

- clarify the objectives of the legislation;
- identify the nature of every restriction on competition;
- analyse the likely effects of the restrictions on competition and on the economy generally;
- assess and balance the benefits and costs of the restrictions; and
- consider alternative means of achieving the same results including nonlegislative approaches.

The CPA lists a range of public interest issues that are to be taken into account where relevant in assessing the benefits and costs of any restrictions. These include:

- ecological sustainability;
- social welfare and equity;
- occupational health and safety;
- industrial relations and access and equity;
- economic and regional development including employment and investment growth;
- interests of consumers;
- competitiveness of Australian businesses; and
- efficient resource allocation.

Thus, NCP recognises that unrestricted competitive markets may not result in best community outcomes. However, the NCP and the legislative review process is underpinned by the view that free interactions between consumers and producers result in broadly based benefits throughout the community.

This does not mean that fewer rules and restrictions would necessarily be better. Competition itself cannot operate outside a framework of trust which is underpinned by general commercial, industrial, health and safety, and environmental laws. Some features of these laws themselves restrict actions that are deemed to undermine the operations of an efficient competitive economy.

4 The legislation and its objectives

THE CURRENT *DENTAL ACT* was introduced in 1986. The legislation replaced a prior *Dental Registration Act*. The act makes provision for the registration of specified categories of providers of dental care in the Northern Territory — dental hygienists, dental specialists, dental therapists and dentists — and controls the practice of dentistry by these providers. It also establishes the Dental Board and provides for the investigation into the professional conduct of registered providers of dental care.

Objectives

There are no stated objectives in the act. Nor were objectives to be achieved by the act stated in the second reading speech upon its introduction to the Assembly. It is not, therefore, possible to compare the performance of the act against stated objectives or to evaluate the contemporary relevance of the objectives.

The implicit objective of the act appears to be to protect the oral health of the Northern Territory public by ensuring that only those persons suitably qualified to undertake dental health care are allowed to undertake it. This interpretation was supported by the submission from the Dental Board. The submission from Drs Simmons and Plummer and the Northern Territory Branch of the Australian Dental Association (ADANT) considered that the objectives of the legislation should be clearly stated in the act.

The objective that the legislation seeks to achieve should be explicitly included in a revised act. The THS submission proposed the following objectives for a revised act to be renamed the Oral Health Services Act.

- To protect the health of the Northern Territory public by ensuring that only persons suitably qualified to undertake oral health care are allowed to practise, for example:
  - provide for registration of oral health care providers and investigations into the professional conduct and fitness to practise of registered oral health care providers;
  - regulate the provision of oral health care services; and

  - define the powers and functions of the board and how it operates.
- To allow consumer choice by promoting information to allow consumers to make informed choices.

Objectives advanced in other submissions included:

- to regulate the practice of dentistry to ensure the highest level of competence of practitioners and thereby provide for appropriate standards of oral health care for the community;
- to promote the community's access to dental care and minimise the community's exposure to health risks in dental care;
- to protect the public through restriction of those who can provide appropriate oral health care while allowing access to appropriate health care; and
- to protect the oral health care of the Northern Territory public by ensuring that only those persons suitably qualified and competent to perform the duties in each field of oral health care undertake them.

The submission by David Walker emphasised the importance of increased access to oral health care for Aboriginal communities and the need to consider the costs, in terms of reduced access, of restrictions on providers of oral health care.

What the act does

The act authorises the establishment of a Dental Board and specifies its powers and functions. The board has the power to:

- authorise registration of dental specialists, dentists, dental therapists and dental hygienists;
- vary their conditions of registration including suspending or cancelling registration;
- issue directions in relation to the professional conduct of registered persons and dental companies; and
- take legal action against persons for offences under the act.

The act defines the powers and functions of the board and how it operates. It allows for the approval by the board of professional qualifications and other requirements to authorise registration. It contains schedules specifying the limitations on certain registered persons — dental therapists, dental hygienists and Aboriginal health workers (who are registered under the *Health Practitioners and Allied Professionals Registration Act*) — who must practise under the direct or indirect supervision of a dentist according to guidelines set by a dentist. The act also

enables the Minister to specify a part of the Northern Territory where Aboriginal health workers are not allowed to provide dental services. The intention of this provision is to ensure that Aboriginal health workers carry out dental work only within their own rural communities.

The act sets out a process for considering complaints about the professional conduct of a registered person and for investigating the complaints and suspending or cancelling registration. Complaints are infrequent. They are invariably of a minor nature and have not got to the stage of requiring action by the board. The act also specifies the establishment of a Dentists Disciplinary Tribunal to handle appeals against board decisions on registration or acts against professional complaints. Thus far, no appeals have been made to the tribunal.

The act specifies various offences and penalties for breaching them. Penalties relate to:

- falsely holding out or advertising to be a registered dental hygienist, dental specialist, dental therapist or dentist; and
- practising dentistry in the Northern Territory unless entitled to do so by way of registration under the act, being a medical practitioner or being an approved Aboriginal health worker.

The act also contains regulations specifying the membership, directors and naming of dental companies.

Links with other jurisdictions

Each state in Australia has its own dental act and procedures for registering dental service providers and regulating the scope of their activities. Mutual recognition operates throughout Australia and New Zealand. The purpose of the Mutual Recognition Act is to ensure that a person registered in one or more jurisdictions would be accepted as qualified in all other jurisdictions. Dental professionals who have obtained registration in another state or New Zealand can obtain registration in the Northern Territory by providing details and identification.

Boards in other states from time to time have viewed the Northern Territory as being the back door to entry into the dental professional for those with overseas qualifications. The Northern Territory board always seeks advice from other boards where an overseas qualification is at issue. The Northern Territory board is currently working with boards in other jurisdictions for all assessments of overseas applicants to be undertaken through the Australian Dental Council. This would alleviate problems arising from one jurisdiction making judgements about overseas qualifications that were not shared by others.

It has been proposed that the Australian Dental Council be responsible for assessing and accrediting dental schools and courses in Australia and for conducting examinations for persons with dental qualifications gained elsewhere. This has been supported in principle by the Australian Health Minister's Advisory Council.

The ADANT submission argued for a national standard for oral health auxilliaries to facilitate movement between the states and improve public understanding of each role.

There are significant differences across jurisdictions in what registered dental health professionals are allowed to do. This is particularly so with dental therapists. For example, in the Northern Territory and all other states except Western Australia dental therapists are not allowed to work in private practice. In Western Australia dental therapists have worked in the private sector for 20 years. Northern Territory dental therapists are only authorised to treat preschool and primary school children. In Queensland dental therapists can treat patients to year 10 (with no age limit). In New South Wales 18 year olds with a health care card can be treated by dental therapists.

The Dental Board submission noted that there was little rationale for the wide variation in the provisions of the various acts in terms of restrictions on the practice of auxilliary dental workers. The submission considered that the development of a consistent approach would promote national uniformity, facilitate ease of mobility and assist the public in their understanding of the worker's role. Competence and public safety should be the only principles for development of scope of practice.

The NTDTA submission considered that standardisation of work practises and the monitoring of ongoing professional training should be the responsibility of the Australian Dental Council.

The THS submission argued that there should be an allowance for variation in some circumstances in order to provide access to services in remote areas and for indigenous people. Increased use of allied health professionals was advanced as a means of achieving this, which was also suggested in a 1998 Senate report into public dental services.

All jurisdictions are at various stages in conducting NCP reviews of their dental legislation. The NCP review process provides for a coordinated approach across jurisdictions to legislative reviews. While this is being followed in some areas (all states and territories are adopting a coordinated approach with the Commonwealth to reviews of their pharmaceutical legislation), it is not being followed in the case of reviews of dental legislation, which are being carried out separately. It is unlikely, therefore, that the NCP review process will result in a uniform approach

across jurisdictions to the services that various categories of dental professionals are allowed to perform.

The submission from Dr Simmons considered that dental boards, through the Australian Dental Council, in pursuit of a more uniform approach might try to reach agreement on a revised and expanded role for dental therapists. The council could be responsible, as they are with dentists, for setting and ensuring standards are achieved through new courses for new students and retraining for qualified therapists. But the biggest challenge for the industry will be to agree on the range of services, age range of clients, private and public practice rights and degree of control required of dentists.

Victoria is the jurisdiction most advanced in the case of dental legislation. The review of Victoria's dental legislation was completed in October 1988 and new legislation passed in May 1999 with promulgation expected in April 2000.

In the revised Victorian act, dental therapists and dental hygienists, previously under licence as a subgroup in the act, require registration and title protection is provided them. Practice protection is provided for all registered dental care providers. Restrictions on the employment of dental therapists in the private sector have been removed. Representation on the Dental Practice Board has been widened to include a dental auxilliary to represent dental therapists and dental hygienists. The board is to have 11 members, including five dentists, two dental prosthetists, two non-dental community members, one dental auxilliary and one lawyer. Restrictions on practice ownership have been removed. Anyone can own a practice, but it is an offence to direct others to practise unprofessionally. Professional indemnity insurance is a requirement of registration, though this could be provided by an employer or company, not necessarily the practising professional. Evidence of recent practise is a requirement for registration. Renewal of registration can be denied for people who have been out of the professional workforce for over five years.

The new Victorian act has provision for codes of practice to describe appropriate standards of practise of dental care providers. These are to be devised by the board and are intended to have the capacity to be flexible enough to respond to changing needs. It is expected that these standards of practise will describe the activities of dental therapists and hygienists and their professional relationship with dentists. This in turn is likely to involve offsite referral to dentists, with dentists in an advisory role.

The age range for patients that dental therapists are allowed to treat was not defined in the new Victorian legislation, but is expected to be included in the codes of practice. (The review recommended that dental therapists could treat all children up

to and including 17 year olds and that this age limit should be removed when there was evidence that it was safe to do so.)

South Australia has completed its review, but review panel recommendations are still under consideration. The review panel has recommended removal or relaxation of a number of restrictions. These include:

- that dental therapists should be permitted to practise dentistry with no restrictions on employment (but under the control of a dentist);
- that the restriction preventing dental therapists from working on adults should be removed once competence to do so is able to be demonstrated;
- removal of all ownership restrictions;
- no code of conduct to contain advertising restrictions; and
- Dental Board membership to include representation from dentists, a dental prosthetist and/or dental technician, a dental therapist, a dental hygienist, a legal practitioner and consumer representatives.

5 Nature of restrictions on competition and their effects

ALL LEGISLATION REGULATES BEHAVIOUR in some way, but not all regulation necessarily restricts competition. The National Competition Council (NCC), the Commonwealth body set up to advise on progress in meeting NCP obligations, has suggested seven ways in which regulation might restrict competition (NCC, *Legislation Review Compendium*, April 1997, p. 4). According to the NCC, legislation could restrict competition if it:

- governs the entry and exit of firms or individuals into or out of markets;
- controls prices or production levels;
- restricts the quality, level or location of goods and services available;
- restricts advertising and promotional activities;
- restricts price or type of input used in the production process;
- is likely to confer significant costs on business; or
- provides advantages to some firms over others by, for example, sheltering some activities from pressures of competition.

The review is required to identify the *nature* of restrictions in the act which limit competition. The actual impact of each restriction on competition or potential restriction on competition needs to be assessed prior to any evaluation of the balance between benefits and costs to the community.

As noted earlier, efficient competition cannot take place in a totally unrestricted way but requires a body of laws which set the rules in terms of property rights, the types of commercial and industrial relationships permitted, and obligations within commercial relationships for health and safety and for the environment. Indeed, part IV of the *Trade Practices Act 1974* (which is an integral part of NCP) prohibits a range of actions which, while they might otherwise be used by individual market players to promote their competitiveness, are considered anticompetitive in an economywide context.

A competitive industry is generally considered to be one in which:

- there are no restraints on firms or consumers entering or leaving the industry;
- there are no constraints on the free flow of information between suppliers and consumers; and
- prices paid and received for the industry's outputs and inputs are determined by the independent actions of many suppliers to and consumers in the markets for those services.

Restrictions on entry and exit

Part III of the act provides powers to the board to approve qualifications for registration as dental hygienists, dental specialists, dental therapists and dentists. Applicants must:

- hold appropriate qualifications for the category of registration sought
- be (in the opinion of the board) a fit and proper person to be registered
- pay a registration fee.

Each of these requirements, in principle, restricts entry to the profession and hence weakens competition. The cost of initial registration for dental specialists and dentists is $180. Annual renewal of their practising certificate costs $100. For dental therapists and dental hygienists the initial registration fee is $30, with annual renewal costing $10. These fees are tax deductible.

These fees are too low for them to act as a restriction on entry to the profession. For this reason, there is no need to consider later the costs and benefits of registration fees as an impediment to competition.

The benefits of professional registration are premised on judgements that market forces may not work efficiently in the provision of dental services and that it is better for consumers of dental services to exclude incompetent (or unfit) practitioners at the outset rather than deal with the consequences of their actions later. If professional standards for carrying out certain professional services are set too high relative to the standards needed to meet consumer requirements for the service they wish to purchase, then the standard setting process will exclude suitable service providers and restrict competition to the detriment of consumers.

Just what is a fit and proper person is not defined in the act. The submission on behalf of the Dental Board defined fitness to practise in terms of:

- adequate physical and mental health;

- absence of relevant convictions for indictable offences, statutory offences relating to the professional's practise and findings of guilt in either civil or disciplinary proceedings in any jurisdiction; and
- absence of relevant criminal or disciplinary investigations in a foreign (outside of Northern Territory) jurisdiction.

The THS submission also argued that the act should define the dimensions of fitness and competence to practise in the same terms. The submission from Dr Simmons considered that the act should define the dimensions, perhaps in omnibus legislation, but the board would still need discretion, whereas the submission from Dr Plummer considered the issue should be at the discretion of the board.

Once registered, there is no requirement for dentists and allied oral health professionals to undertake further education and training for them to maintain their registration. The board's guidelines do, however, require that registered dentists keep up to date and there are powers in the act to deregister an incompetent dentist. Technological and scientific advances are bringing about continuous changes in the range of services and how they are delivered to consumers. The Australian Dental Association runs a continuing education program. Participants accumulate points for courses undertaken.

The Dental and Oral Health Therapist Association of Queensland (DOHTAQ) submission noted that professional development is essential to all oral health professionals and that professional development and training should be a requirement of annual registration and be included in the development of a code of practice for each oral health professional. The submission from Dr Plummer considered that formal education and training on an ongoing basis should be part of the requirement for an annual practising certificate.

Dentists and dental therapists must also obtain permits to undertake x-rays from the Northern Territory Radiographers Registration Board. This is despite radiography being an integral part of dental training and practise. Permits issued are specific to particular procedures and locations. The process of obtaining permits could be construed as being anticompetitive.

The NTDTA submission argued that this practice represents protectionism of the radiography profession and should be discontinued. It noted that appropriate training is provided for oral health professionals in this area to make external permits from another board superfluous. The submission from Dr Simmons also recommended a discontinuation of permits. The submission by Dr Plummer argued that dentists should be exempt as they were trained in dental radiography, but not all therapists had such training.

The Dental Board submission also noted that dental radiography is a component of the education and usual practise of dentists, dental therapists and dental hygienists and that it is arguably anticompetitive to require these persons to have a permit in addition to their professional licence to practise, especially as the radiographic equipment being used is already subject to inspection and testing under the permit system pursuant to the *Radiation (Safety Control) Act 1978*.

Dental prosthetists and dental technicians are the two categories of dental service providers not covered in the act. Dental technicians are not engaged in providing dental services directly to the public.

The Dental Board submission argued that, given the rationale for all occupational regulation is the protection of the public interest, dental prosthetists should be regulated as they are involved in the direct provision of professional services to the community which have the potential to harm the physical or mental wellbeing of an individual. But dental technicians do not provide direct services to the public and these activities are monitored by a regulated professional prior to reaching the consumer — which is adequate for ensuring public safety.

The DOHTAQ submission considered that, on the basis of the potential to harm the public, all six categories of oral health professionals should be registered.

The NTDTA submission and THS submission argued that both these groups be registered because both could have opportunities for dealing directly with the public. The THS submission argued that, while dental technicians work to a dentist, it is still desirable that they be registered because they operate in private practice and registration would provide the opportunity for core competencies and ongoing professional education. The Dental Board submission argued that, as dental technicians do not provide direct services to the public and their activities are monitored by a regulated professional before reaching the consumer, registration is unnecessary as current arrangements are adequate for ensuring public safety.

The submission from Dr Plummer argued that both dental technicians and dental prosthetists should be regulated as both have the potential to supply potentially irreversible treatment. The submission from Dr Simmons also argued for registration of both groups, but expressed a concern if either group were to try to demand restrictions that prevented other dental staff from performing such services such as pouring dental models, making mouth guards and special trays.

The act gives the power to the Minister, at the request of the board, to authorise a person to practise dentistry in the Northern Territory without being subject to other provisions of the act.

Restrictions on the quality, level or location of goods and services available

For two categories of registrants — dental therapists and dental hygienists — the act sets out what they are allowed to do and how they are to be employed. The ACCC has suggested that regulations of professional markets that separate the market into discrete professional activities may inhibit competition.

Dental therapists are trained for two years and their course is oriented toward working with children. They are employed by THS, primarily in the CDS. As noted earlier, they are not allowed to work in the private sector in the Northern Territory. Nor are they allowed to treat high school children and adults.

Dental hygienists train for two years. They work in private practice at the prescription of a dentist to provide both preventative treatment and treatment of periodontal problems. None are currently employed by THS.

In its October 1999 submission to a government review of oral health services in the Northern Territory, the Northern Territory branch of the Australian Dental Association argued against removing these restrictions on dental therapists. The association argued that the training of school dental therapists is focused on the recognition and management of caries in the primary and early permanent dentition of young children and that dental therapists have limited understanding of oral disease initiation and progression, and clinical expertise in recognition and management of oral diseases in the adult population. The submission also noted that school dental therapists rarely see the long term results of their management strategies (the act prevents them from doing so) and do not appreciate the oral changes that can occur with time. The association considered that to allow dental therapists to treat adults would greatly increase the risk of failure to diagnose periodontal disease (which is rare in children) in its earliest stage when treatment is relatively simple for persons with the relevant training.

In its submission to this review, the ADANT argued that persons trained as school dental therapists would need dental hygienist training to undertake additional duties involving the care of periodontal disease (under specialist supervision).

In a submission to the same review, the NTDTA considered that the restrictions on dental therapists impose a monopoly employer (the public sector) on the profession, limit market entry (which is driven by public sector demand) and reduce their employment flexibility, career development prospects and financial rewards. The submission argued that dental therapists could and should be used to provide dental services in general dental practices, paediatric and orthodontic dental practices. The submission asserted that it was clearly anticompetitive and unnecessary to limit the client groups of dental therapists. These restrictions were seen as reducing access to dental health care and raising costs to consumers. The

submission considered that a more appropriate model would allow dental therapists to treat patients whose treatment needs match the skills of a dental therapist.

The legislation also requires that allied health professionals must all work under the supervision of a registered dentist. Where they work in remote areas, there must be periodic visits from a registered dentist.

The Dental Board submission noted that, as with any other licensed practitioner, the scope of practice for dental therapists should be limited to that for which they are educationally prepared, competent to perform, willing to be accountable and which do not pose a serious risk to the physical or mental wellbeing of the community. On this basis, it considered that restricting dental therapists to the public sector is anticompetitive and not in the public interest. The submission also argued that the educational preparation of dental therapists is not directed to producing an independent practitioner and that the requirement for supervision is therefore in the public interest.

The ADANT submission argued that to treat adults would require school dental therapists undergoing additional training to embrace much of the curriculum of the undergraduate degree course in dentistry (which is five years full time training).

The Dental Board submission considered that it was in the public interest to maintain a schedule of the dental services that dental auxilliaries provide as these assist in reducing the information asymmetry between provider and consumer. The submission considered that, if appropriate training was provided to therapists to ensure their competence to provide services to a wider group of clients, then, and only then, would it be acceptable to remove the current restrictions on their scope of practice.

The NTDTA submission argued that all categories of oral health professionals should be registered to ensure public confidence and safety, and that continuing registration require ongoing professional development on an annual basis. The level of activity for dental therapists should be broadened to include a wider range of clients given that professional expertise includes the ability to recognise limitations and to refer on appropriately. Broadening would provide a more cost effective service, freeing up dentists for more complex work. The submission noted that dental therapists should be able to work in a setting of their choice and that prohibiting dentists in private practice from employing dental therapists and prohibiting dental therapists from treating adults reduces efficiencies and adds to patient costs.

The THS submission argued the case for a core practice model. Consumers are protected by ensuring that only registered professionals that are adequately trained are able to undertake a core practice — which should be based on levels of training, education, skills and competencies. A list of core practises needs to be

determined for allied oral health professionals. The submission argued that, in a time of continual change with new processes and procedures being developed, it is inappropriate to specify activities in the act itself.

The THS submission argued that the restrictions that dental therapists must only work in the public sector, only on patients to primary school level and only under the supervision of a dentist denied choice to consumers, increased service costs, reduced efficiencies and reduced access to dental services, resulting in longer waiting lists. The submission considered that there was no reason why standards of service should drop if these restrictions were removed. The issue was about training and practise. Allowable services should be defined in terms of training and competence.

The DOHTAQ submission stated that there is no logical argument why dental therapists cannot work in the private sector and that the current restriction stifles innovation in models of service delivery — the team approach to dentistry. It considered that a more appropriate model would see dental therapists treat patients whose treatment needs match the skills and training of a dental therapist. Consumers would benefit from greater choice of service provider and increased access to more affordable health care.

The submission from Dr Plummer argued that schedules of allowable activities for dental therapists and dental hygienists should remain because they are not trained to provide all basic services. Restrictions preventing dental therapists from working in the private sector and on adults were seen as appropriate because of the lower level of training of therapists. Therapists were considered as needing further training to perform adequately in a deregulated market. The submission argued that therapists are trained to different levels of service delivery.

The submission from Dr Simmons argued that, while it is appropriate that the activities of dental therapists and dental hygienists should be constrained in schedules, the lists are too narrow clinically. The constraints on dental therapists from working in the private sector and treating adults were seen as being too restrictive. Dr Simmons argued that standards of dental care might drop in areas where there has been no prior training or experience and costs to consumers may or may not drop. He considered that additional training would need to be provided dental therapists if the restrictions on them were to be removed, but not all would be willing to undergo retraining.

The submission from the DOHTAQ argued that the listing of allowable activities in legislation has resulted in an inflexible system that is unable to respond easily to changes in technology and education. The submission argued that the core practice model offers the most substantial benefits and protection to the community as well as clear guidelines for dental professions. It recognised that some core practices

will be shared between the professions and will be conditional on training. It considered that the Dental Board, in consultation with each category of oral health professional and education institutions, should be responsible for the development of a code of practice for each profession covering best practise, ethics, conduct, clinical protocols, peer reviews, continuing education, quality assurance measures, discipline, accreditation of service delivery and training.

The allowable activities listed for dental therapists appear to involve inconsistencies measured against their capability and training and against those of Aboriginal health workers. For example, dental therapists are allowed to undertake forceps extraction of deciduous teeth under local anaesthesia, but are prevented from extracting permanent teeth. Yet Aboriginal health workers (registered under the *Health Practitioners and Allied Professionals Act*), who have much less training, are able to extract under local anaesthesia periodontally compromised teeth. Practises of Aboriginal health workers have never come up as an issue before the board.

The Dental Board submission noted that the current Aboriginal health worker course (which previously included a dentistry module) does not include any dentistry training and that the authorisation for Aboriginal workers to undertake limited dental services under the supervision of a dentist will ultimately cease to have effect. The submission recommended that the act provide a legislative provision that would allow the board to grant authorisation to any person who it believes has adequate training to undertake dental procedures which, if undertaken by an appropriately trained person, may pose serous potential for harm. Such persons may include remote area nurses and medical practitioners as well as Aboriginal health workers.

The ADANT submission considered that, as no current dental training for Aboriginal health workers exists, no specific provision be included in the act for their activities. Instead, the Dental Board should be authorised to allow Aboriginal health workers with appropriate training and proficiency to undertake limited emergency oral health procedures.

The submission from Dr Walker considered that, given the high rates of oral disease and the barriers to access of oral health care faced by Aboriginal communities, and the low risk and significant benefits of primary oral health care provided by Aboriginal health workers within their communities, legislation should not be drafted to restrict Aboriginal health workers from caring for the oral health of their communities.

The submission from Dr Simmons noted that there are major unmet needs for oral health services and promotion in urban and remote Aboriginal communities and emergency needs might be addressed by training other health service providers

(medical practitioners, nurses, Aboriginal health workers) in both public oral health and emergency dental care.

The restriction on where an Aboriginal health worker is allowed to perform health (including dental) services has the potential to restrict competition. The Dental Board submission argued that this restriction did not appear to have any public interest basis. The ADANT submission also considered that there was no valid reason for restricting Aboriginal health workers to their own community.

Restrictions on price and type of input used in the production process

Section 51 of the act contains a number of conduct regulations about dental companies.

- Section 51(1) prohibits a dentist forming a company with a dental specialist and vice versa.
- Section 51(2) places restrictions on who can be directors of dental companies and the shares of the company they are allowed to hold. The restrictions ensure that directors are predominantly dentists (in the case of dental companies) and dental specialists (in the case of dental specialist companies). For example, in a dental company of two directors, at least one must be a dentist who holds at least two thirds of the company's voting rights. Where there are more than two directors, at least two thirds shall be dentists who hold at least two thirds of voting rights. Similar restrictions apply for dental specialist companies.
- The name and constitution of a dental company must be approved by the Dental Board.
- Details on company directors, members, shareholders and voting rights must be provided to the board.

Restrictions on who can own health practitioner businesses are a common feature of legislation controlling dental, pharmaceutical, optometric and medical activities in the states and territories. The argument for these restrictions appears to be to protect the public from unethical practises if non-health practitioners were in an ownership role. The restrictions on dentists and dental specialists operating in the same company, although anticompetitive, are believed to have been put there for procompetitive reasons — to prevent a specialist from employing a non-specialist dentist and the public thinking the dentist to be a specialist. It is likely, however, that the risk of this happening is minimal as it would undermine the specialist's competitiveness.

In the second reading speech when the Dental Bill was introduced, the Minister for Health at the time stated that the provisions for control of dental companies by the Dental Board were included at the request of the Australian Dental Association.

The NTDTA submission argued that persons other than dentists should be allowed to form dental companies provided that only qualified registered persons are able to carry out professional services on clients. The Dental Board submission argued that the current restrictions on ownership deny the professions and the public the benefits that accrue from alternative business structures such as access to wider sources for investment, reduced costs through greater competition and increased efficiencies through innovation, and simply shield health professionals from exposure to competition.

The ADANT submission considered that restrictions ensuring that directors are predominantly dentists in the case of dental companies offer a degree of consumer protection and that it would be difficult for dental boards to provide protection to the public where a registered dentist does not own the practice.

The submission from Dr Simmons considered that there is opportunity for exploitation and diminishing of professionals' self-regulation but, because of difficulties, there was little likelihood of non-dentists in the Northern Territory setting up 'no frills' dental companies.

The submission from Dr Plummer supported removing the restrictions on company and firm membership.

Restrictions on advertising and promotional activities

Section 42 of the act requires that persons shall not advertise or hold themselves out to be dental hygienists, dental therapists, dentists or dental specialists unless they are in fact qualified members of these professions. They are also not allowed to advertise or represent themselves as registered unless they are registered.

These are restrictions of a trade description nature. Prima facie, they may be viewed as being anticompetitive. But they can also be viewed as being procompetitive.

The Dental Board submission argued that the section 42 provisions can be demonstrated to be procompetitive in that they prohibit inappropriately qualified persons from engaging in misleading and deceptive conduct through portraying that they are qualified to engage in activities for which they have not been deemed competent.

The ADANT submission maintained that the regulations should remain so as to limit false or misleading advertising. The submission from Dr Plummer considered that this restriction helped safeguard client health.

6 Balance between costs and benefits of each restriction

THE FOURTH REQUIREMENT of the NCP review process is to assess the balance between the costs and benefits of any potential restrictions on competition. That is, there is a requirement to consider whether restrictions on competition are in the public interest. The guiding principle of NCP requires the onus of proof in this regard to be with those who argue for the maintenance of any restrictions.

The case for restrictions on competition being in the public interest (that is, their social benefits exceed their social costs) is usually made on grounds of 'market failure' in an unrestricted market. Unrestricted markets might fail to deliver best community outcomes if:

- benefits flow to sectors of the community which do not contribute to costs or costs are imposed on those who do not receive benefits (externalities);
- information available to one group is not available to others with whom they do business (information asymmetry);
- economies of scale are so large that only one provider would survive in the market (natural monopoly); or
- goods and services are provided in ways from which no potential user can be excluded (public goods).

The existence of externalities and the presence of information asymmetry are key considerations behind some of the restrictions that are routinely included in health acts. A basic premise of an efficient competitive market is that people are capable of making informed choices. A major argument for restrictive provisions in many health related acts is that users of health care services do not have sufficient information to be able to make informed choices. Not only can this lead to unsatisfactory 'market driven' outcomes for individuals, but there is a contingent liability on the community in cases where treatment is not of an appropriate standard.

Registration and 'trade description' requirements for dental practitioners can be seen as providing valuable information to consumers on the capabilities of the service provider. And schedules specifying the services a practitioner can deliver

can be viewed as providing assurance to consumers that the dental treatment they purchase will be carried out professionally, minimising the risk to their oral health and general health, which in turn is of benefit to consumers and society as a whole.

Benefits

The benefits of any restrictions on competition in the Northern Territory dental industry need to be assessed with respect to the stated or implied objectives of the legislation. With no stated objectives, the implied objectives — to protect the oral health of the Northern Territory public by ensuring that only those persons suitably qualified to undertake dental health are allowed to undertake it — becomes the benchmark against which the legislation should be assessed. In addition, the overriding objective of NCP itself, which is to encourage efficiency by means of a more competitive economy, must be considered, as should the public interest issues nominated in the NCP agreements — namely, the environment, employment regional effects, consumer interests as well as the competitiveness of business.

Statutory registration of dental health practitioners and schedules of allowable practises aim to identify those who possess the qualifications necessary for the safe and competent practise of a specific type of dental treatment. The benefits of professional registration are premised on judgements that market forces may not work efficiently in the provision of the various categories of dental health services and that it is better for consumers of these services to exclude incompetent (or unfit) practitioners at the outset rather than deal with the consequences of their actions later. These consequences may spill over from the individual to the community at large. The links between oral health and general health are strong. It is widely accepted that the community as a whole benefits from improvements in the health of its citizens.

It is not unreasonable for the community to require assurance that services are being provided effectively and that there is continuing improvement in their delivery. Governments too, as funders of many health care services, need assurance that individuals and organisations which provide services on their behalf are both effective and efficient. Professional and service organisation standards are therefore of core importance in health care legislation.

A concern about standards in an NCP legislative review is therefore not to question the need for them as such, but rather to ensure that any standards established or underwritten by legislation do not needlessly restrict competition. They could restrict competition if they introduce inflexibilities that stifle innovation in service provision or exclude service providers who could effectively service specified needs at low cost.

A concern of NCP reviews is also that standards not be used to exclude entry of service providers who can achieve outcomes of a required standard for limited tasks, but may not have the qualifications to achieve a wider spectrum of outcomes that are not required in particular circumstances. In this regard, it may be desirable to frame legislation in ways that allow horizontal mobility between professions and vertical mobility within professions.

Costs

Costs of the restrictions to the dental industry and to the community can be of several types:

- administrative, enforcement and compliance costs
- efficiency losses
- imposts on consumers.

Unlike the situation in most other Australian jurisdictions, professional regulation in the Northern Territory is not self-funding. Annual registration fees charged do not cover the cost of the board's administrative and enforcement activities. It is estimated that the Northern Territory government, through THS, currently contributes about $350 000 per year to the operation of all professional boards. The community as a whole, through the budgetary process, picks up this bill. Registration fees, although borne in the first instance by professionals, are likely to be, at least in part, passed on to consumers in fees charged. This is also likely to be the case with compliance costs.

The benefits of registration are shared between the registrant and the community. On this basis, an argument can be made for professional registration fees to be increased to achieve a higher degree of cost recovery than at present. The sparse population and small numbers of registered professionals in the Northern Territory would make it more difficult to achieve self-funding professional regulation than in the more populous states. The issue of appropriate registration fees and the level of cost recovery to be targeted is best considered in the context of how the various, at present, separate registration boards are likely to be administered in the future.

Balance between benefits and costs

The following assessment considers in turn the balance between benefits and costs of each of the potential restrictions on competition identified in the previous chapter.

Registration, right to title and right to practise

The act specifies qualification requirements in relation to each category of registration and the requirement to be a fit and proper person to be registered in the category. Use of title is restricted to registered persons. The act also specifies limits, through schedules of specified services, to the services provided by dental therapists and Aboriginal health workers and requires their supervision by a dentist. The act provides practice protection to registrants by forbidding non-registrants from practising (medical practitioners excepted). It therefore provides both title protection and practice protection.

Consider, first, restricted use of title. Right of title provides a number of public benefits.

- It provides information to potential users of services, increases confidence about service providers and reduces risks that an inappropriate service will be provided.
- It gives a sense of professional identity and professional recognition.
- Health care costs borne by government, contingent on service users in-appropriately choosing unqualified health care providers, are reduced.
- To the extent that risks of professional liability are reduced, costs of professional indemnity cover might also be reduced.
- Continuation of right of title restrictions would reduce the likelihood of the Northern Territory becoming a dumping ground for inappropriately qualified personnel service providers.
- Costs associated with restricted use of title are confined to the costs associated with registration (registrants' fees and compliance costs, and the administrative costs of the board in processing applications, checking qualifications and other relevant personal characteristics, the maintenance of registers, investigations regarding complaints and annual reporting). There are no anticompetitive costs since restricted title by itself does not exclude those not registered from providing services.

On balance, registration that restricts use of title to those who hold recognised professional qualifications and satisfy other fitness to practise requirements are comparable to 'trade description' or 'trademark' registration that applies in other areas of commerce. This lowers costs and risks to service users, employers of service providers and indemnifiers of professionals registered to use that title. In these regards, it can be considered procompetitive rather than anticompetitive. Therefore, provided the costs to operate the registration system are modest and are borne by their beneficiaries, there is a net public benefit from restricting use of title to those professionally qualified. This said, restrictions on title should be limited to the title commonly used by the profession and not be extended to cover variant

titles which might be seen to lock out those trained in overlapping professions (or in no recognised profession at all).

However, for title protection to delivery continuing public benefit, the registrant must maintain his or her skills and competency to practise. It is important therefore that right to title only be assigned to persons who are able to demonstrate their continuing competency to practise their profession.

Consider next the fit and proper person requirements for registration. The likely public benefits are:

- the community is protected from professionals of known or demonstrated incapacity or bad reputation; and
- the profession is protected from costs imposed on it from unprofessional activities;

The likely costs arise through a potential for the fit and proper person requirement to be used anticompetitively and also inequitably if it is not clarified in the legislation.

On balance, provided there are safeguards against the fit and proper person requirement being used anticompetitively or inequitably, and there is no evidence that it has been used in this way, benefits are likely to exceed their costs. This said, confidence about a net public benefit from continuing with fit and proper person requirements is likely to remain questionable for as long as the requirement remains undefined. The proposal in the submissions from the Dental Board and THS for a fitness to practise requirement includes:

- adequate physical and mental health;
- absence of relevant convictions for indictable offences, statutory offences relating to the professional's practise, and findings of guilt in either civil or disciplinary proceedings in any jurisdiction; and
- absence of relevant current criminal or disciplinary investigations in a jurisdiction outside of the Northern Territory.

This definition appears to be sufficiently clear to preclude any anticompetitive or otherwise inequitable treatment criteria being used under a fitness to practise requirement and hence would enhance confidence in the net public benefit.

Consider next right to practise restrictions. The Dental Board submission noted that the public protection rationale for occupational regulation is premised on the belief that regulated professionals deliver safer and higher quality health care than those likely to be provided by an inappropriately educated person and thereby minimise the personal, economic and social consequences of inappropriate and unsafe health care practise. The activities of dentists and dental specialists are not defined

specifically in the current act beyond those implied from a generic definition of what dentistry means, though there are schedules specifying allowable treatments of dental therapists, dental hygienists and Aboriginal health workers.

The benefits of restrictions on practise are that they reduce the risks to the patients and to the community at large from incompetent treatments and they reduce the contingent costs to government in the event of government services having to pick up responsibilities for outcomes from incompetent treatments.

Offsetting these beliefs are a number of costs, as follows.

- There is a social cost (wasted training) if the schedule of restrictions prevents persons from practising what he or she is trained to practise. A clear example of this is the restriction requiring dentists and dental therapists, who may be well trained in x-ray procedures, having to get permits to undertake them from the Radiographers Registration Board.
- Restricted rights to practise reduce competition and increase prices:
  - horizontally between professions, where other registered or unregistered professions are excluded from providing certain procedures;
  - horizontally within professions, such as the restriction preventing dental therapists from working in the private sector; and
  - vertically within professions, where there are barriers against what certain categories of professionals can do, such as the restrictions on dental therapists treating adults.

Both logic and evidence suggest the following propositions.

- The costs of excluding oral health professionals from doing what they are professionally trained to do are likely to exceed the benefits of the restriction.
- The costs of restrictions on rights to practise are likely to exceed the benefits where risk of serious damage, which causes permanent disability to individuals or requires remedial action at cost to government, is small.
- The benefits of restrictions on rights to practise are likely to exceed the costs where risk of serious damage, which causes permanent disability to individuals or requires remedial action at cost to government, is large.

On this basis and on the arguments put to the review in consultations and submissions, we consider that it is in the public interest for the following to apply.

- Each category of oral health professional (dental specialist, dentist, dental therapist, dental hygienist, dental prosthetist) is entitled to practise any procedure for which they are appropriately qualified which encompasses formal training plus subsequent experience and skills acquisition.

- The Dental Board, structured with membership from each category of oral health professional, and all of whose members, irrespective of their professional background, are charged to represent the public interest, is the appropriate body to decide who is trained to do what.
- General restrictions on rights to practise should apply where there is a high probability of serious damage, which can cause permanent disability to individuals or require remedial action at cost to government.
- Restrictions should apply on rights to provide services and procedures specified in regulation in areas where there is a low probability of serious damage, but a significant likelihood of serious outcomes emerging from those services and procedures unless undertaken by a person with a recognised qualification to undertake them.
- Where general restrictions on rights to practise apply, allied oral health professionals should be permitted to provide services in addition to those restricted to their principal qualification, providing they demonstrate evidence of professional training and competence to undertake them. Schedules specifying what certain categories of registrants are allowed to do should be removed from the act. Registrants should be expected to recognise the limitations of their competencies and when to refer on to more skilled professionals. Registrants should be subject to the discipline of the board should they move beyond their core competency areas without having the necessary skills and training to do so.

Based on this assessment of where the public interest lies and the evidence provided in submissions and consultations, we conclude the following to be in the public interest.

- Registration should be required for dental specialists, dentists, dental therapists, dental hygienists and dental prosthetists on the basis of appropriate academic qualifications and training as determined by the board. The fit and proper person requirement for registration should continue, but the criteria for fit and proper person should be explicitly defined in the act.
- Registration should provide practice protection for each category of registrant. But practice protection is to be specified in terms of core competencies and what each professional is trained and capable of doing. The board should have responsibility for disciplining any registrant who undertakes activities beyond their core competency and capability. The underlying principle to be followed by the board is that of allowing any registrant to practise whatever they are trained and competent to practise.
- The restriction preventing dental therapists from working in the private sector should be removed.

- The restriction on dental therapists treating adults should be removed subject to the board assessing on an individual basis that dental therapists have the necessary training to treat adults. This requirement is necessary because of the considerable variation in training represented by dental therapy courses in earlier years. Depending on the course they have done, the board may determine that additional training is needed. Part time courses to provide the necessary training for school dental therapists to upgrade their skills are currently available.
- The board should have the power to grant authorisation to persons outside the categories of registrants to provide dental services for which they have been trained to provide (this may include Aboriginal health workers, remote area nurses and other suitably trained allied health professionals). In considering this issue, the board will need to balance the requirements of remote communities for oral health care with the right of such communities to be protected from incompetent service providers. Authorisation of Aboriginal health workers to undertake dental work should be confined to those workers who are appropriately trained to perform such work.
- Dental therapists, dental hygienists, dental prosthetists, Aboriginal health workers and any other categories of professionals authorised on the basis of their training and competence to undertake dental work should remain under the supervision of dentists for as long as their educational preparation is not geared to producing an independent practitioner.
- Authorisation of Aboriginal health workers to undertake dental work should be confined to those workers who are appropriately trained to perform such work.
- The right of the Minister to specify a part of the Northern Territory in which Aboriginal health workers authorised to provide dental services may not provide those services should be repealed.

Conduct regulations on dental companies

Benefits

The benefits advanced to support the restrictions on dental company ownership and naming are that they may prevent non-practitioner owners from lowering professional standards of service delivery. The argument is that a non-practitioner owner may unduly influence a health practitioner to compromise professional standards in the pursuit of profits.

No evidence was presented to support this proposition. The submission from the Dental Board considered that the evidence shows that such restrictions in

professional regulation acts provide no protection against unethical practices. Unethical and fraudulent behaviour occurs in health practitioner owned businesses.

Costs

The costs of these restrictions are that they may limit the company's access to capital and business expertise. They may also prevent the company adopting the most efficient structure to deliver health services.

Balance

On balance, the social costs of these restrictions are likely to exceed the social benefits. On this basis, all restrictions on ownership of dental companies, the requirement that details on company directors, members, shareholders and voting rights must be provided to the board and the requirement that the name and constitution of a dental company be approved by the board should be removed.

Restrictions on advertising and promotional activities

These restrictions prevent persons advertising or holding out to be (registered) members of the profession unless they are qualified (and registered) members.

Benefits

Restrictions on advertising may prevent creation of a consumer demand which is not justified. They may also prevent what might be misleading advertising.

Costs

Restrictions on advertising may restrict the provision of useful information to consumers on the availability of services. This may prevent consumers from making more informed choices on what services to purchase. They may also constrain new entrants to the profession from competing for business.

Balance

The restrictions do not prevent advertising. Rather, they only prevent unqualified and unregistered persons from advertising. Hence, they do not incur any of the above costs. The restrictions are procompetitive, as argued in the Dental Board and several other submissions. They provide social benefits without involving social costs. Current restrictions on advertising and promotion should therefore be retained.

Other matters

Composition of Dental Board

In submissions and consultations, a number of comments were made concerning the composition of the Dental Board. Arguments were advanced to support a stronger consumer representation (two members rather than one) and for greater representation of oral health professionals other than dentists. All members of the board, irrespective of their professional qualifications and background, are there to serve and represent the public interest and to ensure that the objectives of the act are met. It is also important that the interests of the various categories of registrants be better reflected in the structure of the board, particularly as the direction of the reforms we are advocating as being in the public interest involve the replacement of regulations on practice with assessments by the board on the training and competence of allied health professionals to perform various tasks within the field of dentistry.

Wording of a new act

Terminology issues such as how oral health professionals should be labelled, the use of gender neutral language and whether the act should be referred to as 'oral health services' rather than 'dental' are important to some members of the profession and were raised in several submissions. Due consideration should be given to terminology issues in a revised act.

A new draft Dental Act

A new draft Dental Act has been prepared by THS. The new act addresses some of the anticompetitive concerns of the current act (see appendix C).

7 Alternative ways of achieving objectives

NCP REVIEWS ARE REQUIRED to consider whether there are alternative means for achieving the same results as those which restrict competition, including nonlegislative approaches. The key question is whether the implicit objective of the act — to protect the public from malpractice — can be achieved efficiently and effectively, but in less regulatory ways than at present.

The issues paper invited interested parties to comment on this proposition and to suggest less regulatory ways of delivering safe and high quality oral health care to Northern Territory consumers.

There are a range of alternative, perhaps less costly, mechanisms that might be considered to achieve the oral health and consumer protection objectives of the act. These include:

- providing enhanced information to consumers, including official warnings, advertising campaigns and publication of pamphlets about specific professional and occupational services;
- listing or certification schemes which require practitioners to inform a central authority about educational qualifications and previous experience in the industry as a substitute for the specification of allowable practices; and
- so-called negative registration where service providers are not screened before starting practise, but only prohibited from practising if shortcomings in their operations are identified.

These alternatives have traditionally been rejected in the case of most professionals providing health services. None of the submissions received responded to these alternatives. Nor were any of them advanced in discussions as being likely candidates for practical, less costly alternatives to the registration procedures recommended in the previous chapter.

8 *Recommendations*

THE FINAL TASK FOR THIS REVIEW is to make clear recommendations that flow from the foregoing analysis. A requirement of the terms of reference is that, if change is not recommended and restrictions on competition are to be retained, a strong net benefit for retention must be demonstrated.

An overall net benefit can be concluded for the current registration system, though certain changes are required to the act to remove some components which we have assessed as not being in the public interest.

We make the following recommendations.

- A revised act should state the objectives of the legislation. These objectives should be stated in terms of protecting the health of the Northern Territory public. The revised act should be called the *Oral Health Services Act* and the Dental Board should be renamed the Oral Health Services Board.
- Dental specialists, dentists, dental therapists, dental hygienists and dental prosthetists should be registered and receive exclusive right to title.
  - Professional criteria for registration should be determined by the board.
  - Registration should involve a practising certificate renewable annually subject to the requirement of being able to demonstrate to the board's satisfaction evidence of continuing competency to practise.
  - Fit and proper person criteria should continue to be required for registration, but these criteria should be explicitly defined in the act.
- Section 14 of the act, which contains schedules specifying limits on the allowable activities of certain categories of registrants, should be deleted. Instead, allowable activities should be expressed in terms of core competencies and what each professional is trained and capable of doing. It should be the responsibility of the board to discipline any registrant who undertakes activities beyond their core competency and capability.
- Registrants should continue to receive practice protection (section 44). But the board should have the power to grant authorisation to persons outside the categories of registrants nominated above (including medical practitioners) to provide dental services for which they have been trained (this may include

remote area nurses, Aboriginal health workers and other suitably trained allied health professionals).

  - Authorisation of Aboriginal health workers to undertake dental work should be confined to those workers who are appropriately trained to perform such work.
  - The right of the Minister to specify a part of the Northern Territory in which Aboriginal health workers authorised to provide dental services may not provide those services should be repealed.

- Dental therapists, dental hygienists, dental prosthetists, Aboriginal health workers and any other categories of professionals authorised on the basis of their training and competence to undertake dental work should remain under the supervision of dentists for as long as their educational preparation is not geared to practising as an independent practitioner.
- The restriction preventing dental therapists from working in the private sector should be removed.
- The restriction on dental therapists treating adults should be removed subject to the board establishing, on an individual basis, that dental therapists have the necessary training to treat adults.
- All restrictions on ownership of dental companies, the requirement that company directors, members, shareholders and voting rights be provided to the board and the requirement that the name and constitution of a dental company be approved by the board should be removed.
- Current restrictions on advertising and promotion should be retained.
- Membership of the board should be broadened to include greater participation from persons other than oral health professionals and to reflect a broader coverage of oral health professionals to better serve and represent the public interest.
- The wording of a new act should use gender neutral language and give due attention to how categories of registrants should be referred to.

Appendixes

A Terms of reference

THE REVIEW OF THE LEGISLATION shall be conducted in accordance with the principles for legislation review set out in the Competition Principles Agreement. The underlying principle for the review is that legislation should not restrict competition unless it can be demonstrated that:

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition.

Without limiting the scope of the review, the review is to:

- clarify the objectives of the legislation, clearly identifying the intent of the legislation in terms of the problems it is intended to address, its relevance to the economy and contemporary issues and whether or not the legislation remains an appropriate vehicle to achieve those objectives;
- identify the nature of the restrictions to competition for all relevant provisions of the specified legislation. This analysis should draw on the seven ways identified by the National Competition Council in which legislation could restrict competition, which include:
  - governs the entry or exit of firms or individuals into or out of markets,
  - controls prices or production levels,
  - restricts the quality, level or location of goods or services available,
  - restricts advertising and promotional activities,
  - restricts price or type of input used in the production process,
  - is likely to confer significant costs on business, or
  - provides some advantages to some firms over others by, for example, shielding some activities from the pressure of competition;
- analyse the likely effect of any restriction on competition and on the economy generally;
- assess and balance the costs and benefits of the restrictions for each anticompetitive provision identified;

- consider alternative means for achieving the same result and make recommendations including nonlegislative approaches; and
- clearly make recommendations. These should flow clearly from the analysis conducted in the review. If change is not recommended and restrictions to competition are to be retained, a strong net benefit for retention must be demonstrated.

When considering the matters referred to above, the review should, where relevant, consider:

- government legislation and policies relating to ecologically sustainable development;
- social welfare and equity considerations, including community service obligations;
- government legislation and policies relating to matters such as occupational health and safety, industrial relations and equity;
- interests of consumers generally or of a class of consumers;
- government legislation and policies relating to ecologically sustainable development;
- economic and regional development including employment and investment growth;
- the competitiveness of Australian business; and
- the efficient allocation of resources.

The review shall consider and take account of relevant legislation in other Australian jurisdictions and any recent reforms or reform proposals including those relating to competition policy in other jurisdictions.

The review shall consult with and take submissions from those organisations currently involved with the provision of health services, other interested territory and Commonwealth government organisations, other state and territory regulatory and competition review authorities, affected members of the medical profession and their organisations and members of the public.

B Submissions received

SUBMISSIONS WERE RECEIVED from the following interested parties.

- Northern Territory Dental Therapists Association (Debbie Franklin).
- Geoff Clark, Director, Northern Territory Professional Boards (submission prepared on behalf of the Dental Board of the Northern Territory).
- Territory Health Services (Heather Boulden).
- Dr Bruce Simmons, Dentist.
- Dr John Plummer, Dentist.
- Dr David Walker, Dentist.
- The Dental and Oral Health Therapist Association of Queensland (DOHTAQ).
- The Australian Dental Association, Northern Territory Branch (ADANT).

C A new draft Dental Act

THS, IN CONJUNCTION WITH MEMBERS of the dental profession, has developed a draft new Dental Act. The new draft act is an internal document and has as yet no official status. While this development has preceded the NCP review of the existing Dental Act, the new draft act addresses some of the anticompetitive concerns in the current act. While some existing restrictions have been removed, some still remain and some new restrictions have been introduced. Key changes from an NCP vantage point are as follows.

- The Dental Board's membership has been broadened to provide representation for dental auxilliaries. One person is to be appointed from a list of three jointly nominated by the Dental Hygienists' Association, the Dental Therapists' Association and the Dental Prosthetists' Association of the Northern Territory. Scope also exists for a board member with consumer or legal interests to be appointed as the board will now contain one non-dental practitioner who has not at any time been registered to practice dentistry.
- Dental prosthetists are included in the act as dental practitioners requiring registration and specified qualifications to achieve it.
- The dental services that can be provided by dental prosthetists, dental therapists, dental hygienists and Aboriginal health workers are specified in schedules in the act. All must work under the direct or indirect supervision of dentists. Dental therapists are restricted to applying thc services specified in their schedule to all school children (no age restriction) compared with the current act where restriction is specified as preschool and primary school children. Dental therapists are still restricted to working only in the public sector (must be 'employed by the Territory').
- Dental hygienists must be 'employed by the Territory or a dentist'. In the current act there is no restriction on how a dental hygienist may be employed. Aboriginal health workers must be employed by a community health clinic to provide the services specified in their schedule.
- Provision is made in the new draft act for an Impaired Practitioners Committee to be established by the board to carry out an investigation in respect of the fitness of a particular dental practitioner to continue to practice. But the focus

of the committee is on physical and mental fitness to practice rather than maintenance of competency.

- Regulations on who can form dental companies have been weakened substantially. Dental practitioners may form companies either on their own or with other dental practitioners. This removes the current restriction on dentists and dental specialists being part of the same company. An individual dental practitioner may form a dental company with one other person who is not a dental practitioner.
- The board is still required to approve the name of a dental company and the company's memorandum or articles of association cannot be altered unless approved by the board. Details of company directors, members, shareholders and voting rights still have to be provided to the board.
- All other restrictions identified in the current act remain.