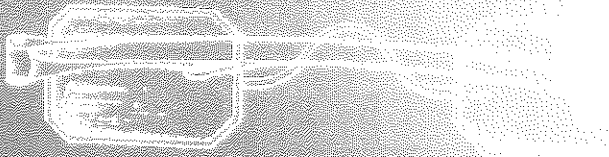
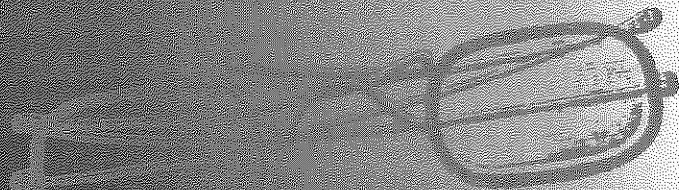


Review of the Business Ownership & Associated Restrictions

UNDER THE OPTOMETRISTS ACT 1974



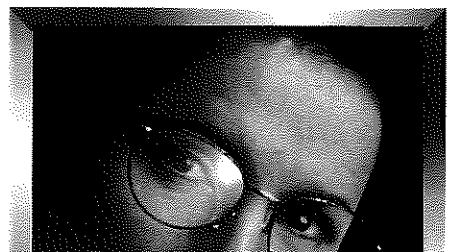
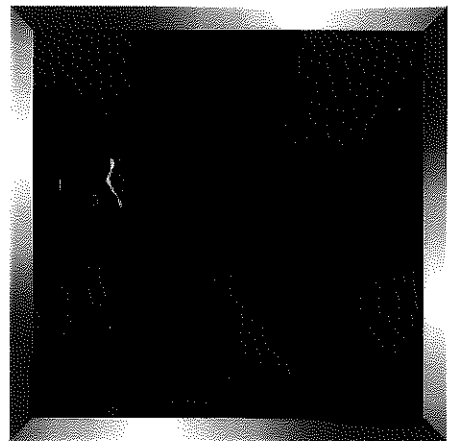
PUBLIC BENEFIT TEST



September 1999

SKM ECONOMICS

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Executive Summary

This is a report of a Public Benefit Test of the Business Ownership Restrictions of the Optometrists Act 1974

This report presents the results of a Public Benefit Test review of the business ownership and associated restrictions of the Queensland *Optometrists Act 1974*, as required to meet the Government's obligations under National Competition Policy (NCP).

The Competition Principles Agreement, states that legislation should not restrict competition unless it can be demonstrated that:

- 5(1)(a) the benefits of the restriction to the community as a whole outweigh the costs; and
- 5(1)(b) the objectives of the legislation can only be achieved by restricting competition.

The *Optometrists Act 1974* imposes various business restrictions relating to optometry practices. The most significant restriction is that optometry practices may only be owned by optometrists or bodies comprised exclusively of optometrists.

The scope of the review also included the *Optometrists Act 1974* restrictions on the fitting of optical appliances although in practice these restrictions are not enforced. Stakeholder feedback on this issue strongly suggested there would be no impact on the level of protection or quality of service provided to the public if the restriction on the selling and fitting of optical appliances were removed. Moreover, it is expected that the removal of the existing restrictions will provide some positive impacts on the industry, notably through the simplification of the existing legislation and removal of anti-competitive barriers. Given that there would be some benefits from the removal of the optical appliance restrictions and no negative impacts on the Queensland public were identified, it is possible to recommend that the restrictions on selling and fitting be repealed. This Public Benefit Test then focused on the ownership provisions of the *Optometrists Act 1974*.

The key objectives of the proposed health practitioner registration legislation are to protect the public and ensure that health care is delivered in a safe, competent and up-to-date manner. It is against these objectives that the business ownership and associated restrictions have been assessed.

Restrictions on clinical practice are an issue for a number of registered health professions and are being dealt with in the Core Restricted Practices Review. This is a separate review that is being undertaken on all restrictions on clinical practices.

The Public Benefit Test involves a full assessment of the costs imposed on, and the benefits to, all affected groups. This report outlines both the qualitative and quantitative information regarding who will be affected and how they will be affected under various Options with respect to ownership.

Five regulatory Options have been considered in the Public Benefit Test:

- Option 1: **No restrictions** on ownership of optometry practices or businesses;
- Option 2: **No restrictions with Statutory Offence** - no restrictions but with a statutory offence clause for undue influence¹;
- Option 3: **Base Case** - existing situation continues, including current legal circumvention;
- Option 4: **Controlling interest** in the ownership of optometry businesses is held by registered optometrists; and
- Option 5: **100% ownership and control** of optometry practices by optometrists.

The methodology followed in undertaking this Public Benefit Test is derived from the Public Benefit Test Guidelines prepared by Queensland Treasury. The lack of suitable data and the polarised views on certain issues has led to a focus on a qualitative assessment, using a combination of descriptive analysis and significance rankings, rather than a purely numerical analysis. The following analytical stages have been applied:

- construction of an Impact Matrix;
- comparison of Options using the Impact Matrix; and
- indicative quantification of a small number of impacts.

The impact matrix is summarised in section 5.8. Three broad groupings of impacts have been adopted, namely:

- impacts on consumers;
- impacts on existing and potential service providers; and
- impacts on administrators/regulators.

For the purposes of this evaluation, the stakeholders have been divided as follows:

- consumers (as both consumers of products and services and the wider community);
- optometrists;
- optical dispensers, and potential new entrant non optometrist owners; and
- administrators/regulators - the Queensland Government, the Optometrists Board of Queensland and the Health Right Commission (HRC).

¹ Undue influence refers to pressure an owner could place on an optometrist to operate in an unprofessional manner.

Key results of the Public Benefit Test are summarised

Key Results

The key results of the Public Benefit Test assessment of ownership restrictions contained in the Queensland *Optometrists Act 1974* are now summarised.

Impacts on Consumers

- Stakeholders consulted in the review agree that the level of eye care currently being delivered in Queensland is at the required standard. Very few complaints (fewer than 10 per year) are made about optometrists to the HRC.
- There is some evidence that there is a marginal difference between the way in which optometrists undertake their consultations in a corporate environment, compared to an owner-operator practice, but there is no evidence that this has an impact on eye health care.
- Under the 'no ownership restrictions' Options (1 and 2), no adverse effects on the quality of health care is expected relative to the Base Case. No adverse impacts have been reported in jurisdictions where ownership restrictions have been lifted.
- Secular changes in rural and regional areas are likely to dwarf the impacts of changes in ownership restrictions on the quality of optometry services provided to these communities across all the Options.
- No major change in the price of optometry services is expected under any of the options although marginally higher prices are expected under options 4 and 5. Medicare establishes benchmark prices for optometry consultations, and there is already a competitive market for optical appliances. In the long term, however, a marginal reduction in the underlying costs associated with running an optometry practice is expected under Options 1 and 2. This reduction in underlying costs may help reduce any increase in consultation costs in the future and may also flow on to reduce the cost of optical appliances.
- Under Options 1 and 2 it is expected that a slight increase in access to economies of scale in the industry, may also work to reduce the price to consumers of optometrical goods and services under these Options.
- Options 4 and 5 could lead to a restriction of consumer choice. This would result from reduced corporate participation in the market, lessening access to non-price choice benefits currently enjoyed by consumers, such as access to national networks and the ability to exchange optical appliances at different geographic locations.

Impacts on Service Providers

- Despite the existing ownership restrictions, commercial incentives currently apply to all service providers. This is due to the reliance on the retail side of business for a significant proportion of total income generated by a typical optometry practice.
- Small businesses dominate the industry at present and this is expected to remain if ownership restrictions are removed.
- The existing ownership restrictions are, in fact, circumvented by corporate arrangements whereby optometrists act as the nominees of non-optometrist owners. Thus the current situation could be described as a "defacto" or constrained form of ownership deregulation.
- Under Options 1 and 2 there are more significant impacts on service providers than on consumers. These include the trade-off between higher profits through scale economies and avoided operational costs achieved by corporate groups, as compared to sole operators.
- No net change in terms of total employment in the industry is expected under any of the Options as total demand for optometry services will be unchanged.
- Options 4 and 5 are expected to result in some dislocation of the 20% - 25% of the optometry workforce who are presently employed under arrangements that would no longer be legal. This dislocation is likely to be disruptive and stressful to some members of the profession.
- Options 4 and 5 are expected to result in a slight decrease in the flexibility of work conditions in the industry in the longer term. For example, there could be a decrease in the number of part time positions available.

Impact on Administrators / Regulators

- Ownership restrictions represent a small share of the administrative burden of the legislation.
- Removal of ownership restrictions may see some reduction in administration, but little overall change is expected if administrative and monitoring processes rely more on supporting legislation (eg the statutory offence clause under Option 2).
- Under the more restrictive Options (4 and 5), there may be an increase in the cost of administering the ownership restrictions and some potential for compensatory issues associated with restricting or eliminating existing companies, which can operate in other jurisdictions. These costs would appear to exceed the potential benefits of these Options that are marginal at best.

Public Benefit Test Summary and Conclusions

The Public Benefit Test guidelines require that the results for the Options be judged against the following criteria:

- the objectives of the legislation – that is, protection of public health and provision of safe, competent and up-to-date health care;
- the overall net benefit of each Option (Clause 5(1)(a) of the Competition Principles Agreement); and
- the objectives of the legislation can only be achieved by restricting competition (Clause 5(1)(b) of the Competition Principles Agreement).

Table E.1 summarises the overall net benefit of each Option. The conclusions thereafter provide a summary of the results of this Public Benefit Test in the context of these criteria.

Table E.1: Net benefit – Summary by Option

Option	Net Benefit	Ranking*
1: No Restriction	Some avoided costs Some competition benefits Slight increase in the flexibility of employment options in the industry Same quality of eyecare as base Positive net benefit (lower than Option 2)	2
2- Statutory Offence	Some avoided costs (less avoided costs than Option 1) Some competition benefits Slight increase in the flexibility of employment options in the industry Potential marginal improvement in quality of health care Positive net benefit (higher than Option 1)	1 (Highest)
3 - Existing (Base)	Base – for comparison purposes	3
4 – Controlling Interest	Higher costs than Base Some dislocation of existing workforce Long term decrease in the flexibility of employment options in the industry Potential marginal improvement in quality of health care No net benefit	4
5 – 100% Ownership/Control	Higher costs than Base Some dislocation of existing workforce Long term decrease in the flexibility of employment options in the industry Potential marginal improvement in quality of health care No net benefit	4

*Rankings reflect each Option's ability to meet the review criteria, Option 2 best meets these criteria.

Option 2 – No ownership restrictions, with a statutory offence clause is the preferred Option under the Public Benefit Test.

In explanation the following conclusions are made:

- Under Option 1 (no ownership restrictions) a minor potential health risk is identified that undue pressure could be applied by an owner on the clinical practice of an optometrist. This minor risk also exists under the Base Case. This risk can be effectively mitigated, by implementation of supporting statutory offence legislation (Option 2) or a tightening of the ownership restrictions (Options 4 and 5).
- Option 2 (statutory offence model) prohibits optometry owners from exerting undue commercial pressure on employee optometrists, and is expected to provide the same quality of health care as would be expected under either Options 4 or 5, and a marginal improvement over the Base Case and Option 1.
- Options 1 and 2 are expected to lead to marginal cost savings and some competition benefits compared to the Base Case. The cost savings under Option 2 will be slightly lower than Option 1, due to the additional costs of administering the statutory offence legislation.
- The slightly lower costs of Option 1, compared to Option 2 are not expected to be large enough to offset the potential additional health risk of Option 1. Option 2 will therefore be expected to result in higher net benefit than Option 1 (and the Base Case).
- The tightening of ownership restrictions (Options 4 and 5) are expected to have higher administration and compliance costs than the Base Case and some negative impacts on employment conditions in the industry.
- Removal of ownership restrictions, under Options 1 or 2, is expected to create marginal net benefits compared to the existing situation, with Option 2 expected to provide marginally higher benefits than Option 1. In accordance with Clause 5 (1)(b) of the Competition Principles Agreement, the objectives of the legislation can be achieved under Option 2, without a restriction on ownership being in place.
- Overall, Option 2 (No Ownership Restrictions with a statutory offence clause) is the preferred Option because under this Option:
 - the optometry industry is expected to be able to provide at least the same quality of health care that would be provided under any of the alternative Options and potentially a higher quality of health care than would be provided under the Base Case or Option 1;
 - the net benefits are expected to be higher than the net benefits of the alternative Options; and
 - the objectives of the legislation can be achieved without restricting competition.

1. Introduction and Background

The most significant business restriction imposed on the optometry industry is the restriction that optometry practices can only be owned by optometrists

1.1 Introduction

This report presents the results of a Public Benefit Test review of the business ownership and associated restrictions of the Queensland *Optometrists Act 1974*, as required to meet the Government's obligations under National Competition Policy (NCP). The guiding principle of NCP, as set out in Clause 5(1) of the Competition Principles Agreement (CPA), states 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.

The *Optometrists Act 1974* imposes various business restrictions relating to optometry practices (see section 1.4). The most significant restriction is that optometry practices may only be owned by optometrists or bodies comprised exclusively of optometrists. As these restrictions are deemed to be anti-competitive, a Public Benefit Test assessment is required to be undertaken using the methodology outlined in the Public Benefit Test guidelines published by the Queensland Treasury.

The Public Benefit Test involves a full assessment of the costs imposed on, and the benefits to, all affected groups. This report outlines both the qualitative and quantitative information that is available regarding who will be affected and how they will be affected under various Options with respect to ownership.

1.2 Scope of the Public Benefit Test

The scope focuses on the need for statutory restrictions on the ownership of optometry practices in Queensland

The purpose of the review process is for recommendations to be made to Government on the need for statutory restrictions on the ownership of optometry practices in Queensland. The Terms of Reference for this Public Benefit Test include specific examination of those matters specified in Clause 5(9) of the CPA:

- clarification of the objectives of the legislation;
- identification of the nature of restrictions on competition;
- analysis of the likely effect of the restriction on competition and on the economy generally;
- assessment and balancing of the costs and benefits of the restrictions; and
- consideration of alternative means for achieving the objectives, including non-legislative approaches.

The key objectives are to protect the public and ensure that health care is provided in a safe, competent and up-to-date manner

1.3 Objectives of the Legislation

The *Optometrists Act 1974* does not specify its objectives. However, the Second Reading Speech for the introduction of the legislation indicates that the regulation of optometrists was to protect the public against unqualified persons practising optometry.

The objectives of the legislation regulating optometrists and other health practitioners have recently been examined in the context of the review of the Health Practitioner Registration Acts. The 1996 Draft Policy Paper proposed that the objectives of new health care practitioner legislation are to **protect the public and ensure that health care is provided in a safe, competent and up-to-date manner**. It is understood that these objectives have subsequently been endorsed by the Queensland Government and therefore, it is in accordance with these objectives that any restrictions on the ownership and operation of optometry businesses have been assessed.

The review has also been conducted within the context of the Queensland Government's wider objectives, which include:

- more jobs for Queenslanders;
- building regions;
- skilling Queensland;
- safer / supportive communities;
- better quality of life;
- valuing the environment; and
- strong Government leadership.

1.4 Ownership and Associated Business Restrictions in the Act

This review evaluates the impact of the following sections of the *Optometrists Act 1974* on all stakeholders:

- Section 29(1) which prohibits an individual who is not an optometrist from supplying any optical appliance.
- Section 32 which prohibits a body or association of persons from engaging in the practice of optometry unless:
 - the body or association is comprised exclusively of optometrists; or
 - the fitting and supply of any optical appliance is undertaken by an optometrist employed by (or acting as agent for) the body or association, on a prescription of a medical practitioner or optometrist who is not employed by (or acting as agent for) the body or association.
- Section 33(1) which prohibits any person who is not an optometrist from owning an optometry practice or business.
- Section 33(4) which prevents a body or association from owning an optometrist practice or business unless the membership of that body or association is comprised exclusively of optometrists.

This review examines three sections of the Optometrists Act 1974

1.5 Clinical Practice Restrictions

Restrictions on clinical practice are an issue for a number of registered health professions and are being dealt with in the Core Restricted Practices Review. This is a separate review that is being undertaken on all restrictions on clinical practices. As outlined in section 1.4, this Public Benefit Test is restricted to business ownership and associated restrictions. However, there may be a link between ownership of optometry practices and clinical practice issues².

While the outcome of the Core Restricted Practices Review has not yet been determined, the assumption made for the purposes of this review is that the preferred position regarding the core practice of optometry, is as given in the Health Practitioner Registration Acts Review Draft Policy Paper. That is, core practices for optometry (restricted to registered optometrists) are 'prescribing optical appliances for the correction or relief of visual defects and the fitting of contact lenses'³.

1.6 The Selling and Fitting of Optical Appliances

The scope of this NCP review also extends to the restrictions on the fitting and supply of optical appliances. In a national context, the legislative regimes covering this activity differs amongst the other States and Territories. The relevant provisions in Queensland's legislation (Sections 29(1) and 32(3)(b)(ii)) effectively restrict competition by prohibiting non-optometrists from undertaking the activity of fitting and supplying optical appliances. These restrictions therefore need to be considered against Clause 5(1) of the CPA.

Clause 5(1)(a) states that 'legislation...should not restrict competition unless it can be demonstrated that the benefits of the restriction to community as a whole outweigh the costs'.

The restrictions do not appear to generate any benefits for stakeholders. The Optometrists Association noted that their removal might result in a slight reduction in job opportunities for optometrists because they will no longer be required to supervise optical dispensing, however, there is no evidence to support this argument.

² For example, it is proposed that new Health Practitioner Registration Acts will include an offence provision for the owner of a practice to use 'undue influence' on clinical practice.

³ Queensland Health, September 1996, *Review of Medical and Health Practitioner Registration Acts, Draft Policy Paper*, p57.

It has been suggested, however, that removing these restrictions would provide some positive impacts, notably through the:

- removal of potentially anti-competitive barriers;
- the simplification of the administration of the legislation; and
- releasing of optical dispensers from the current requirement for dispensing to be supervised by optometrists (this requirement is not, in practice, widely complied with or enforced)

Clause 5(1)(b) states that 'legislation... should not restrict competition unless it can be demonstrated that "the objectives of the legislation can only be achieved by restricting competition'. As stated in section 1.3 of this report the objectives of the legislation are to protect the public and ensure that health care is provided in a safe, competent and up-to-date manner.

Although the restrictions are neither adhered to nor enforced, an acceptable standard of eye health care is nevertheless provided in Queensland. Stakeholder feedback concerning the ineffectiveness of the restrictions strongly suggests that the current operating environment is effectively the same as would exist if the restrictions were removed. For example, the Optometrists Association submission states that unqualified and unsupervised persons are already dispensing and 'the Optical Dispensers Registration Committee receives very few complaints regarding the practice of optical dispensing and can cite no evidence of physical harm resultant from the practice of optical dispensing performed by optical dispensers with or without the benefit of formal training'⁴.

The submission also notes that 'there is no danger to public in incorrectly dispensed spectacles' and 'existing consumer laws provide the public with adequate protection against poor optical dispensing and special regulation of optical dispensing is unnecessary to protect the public'⁵.

The restrictions are therefore having no effective impact in achieving the objectives and are considered to be unnecessary.

Therefore, considering that the restrictions are neither adhered to nor enforced, and eye health care is not diminished, the objectives of the legislation can be achieved without restricting competition. Furthermore, the restrictions do not currently generate any benefits for stakeholders and there may be a small net benefit in removing the restrictions. It is concluded, therefore, that the provisions restricting the fitting and supply of optical appliances be repealed.

On this basis, it is not necessary to address these particular restrictions in the remainder of this report.

⁴ Source: Optometrists Association of Australia - Submission to the review

⁵ Source: Optometrists Association of Australia - Submission to the review

Five detailed submissions were received

1.7 Submissions

As part of the Public Benefit Test process, Queensland Health invited submissions to the review process. Detailed submissions were received from:

- OPSM;
- Optometrists Board of Queensland;
- Optometrists Association of Australia (Queensland Division);
- Now Group; and
- an independent practitioner.

The issues raised in these submissions have been included in the discussion and analysis of the impacts of the restrictions and the potential removal of restrictions.

1.8 Value Management Workshop

A Value Management Workshop was held in Brisbane on 19 April 1999. The attendees are listed in **Appendix A**.

The workshop focussed on issues raised in submissions to the review. As a result of polarised views amongst the participants, it was not possible to progress towards determination of criteria weights and impact scores for a numerical assessment of the impacts. The Public Benefit Test therefore focuses on a descriptive qualitative assessment of the impacts.

The range of issues discussed and opinions expressed have been distilled into the analysis undertaken in this report. A summary of the workshop has already been presented in the Value Management Workshop Report.

2. Methodology

2.1 Introduction

The review of the Business Ownership and Associated Restrictions of the *Optometrists Act 1974* has involved two complementary processes. First, the collection of data relevant to the review process and discussions with key stakeholders and second, the analysis of this data within the Public Benefit Test Framework.

2.2 Data Compilation Process

The first stage of the project included:

- the identification of stakeholders;
- consultation with stakeholders;
- identification of key data sources; and
- a review of available literature.

2.2.1 Stakeholder Identification

Seven major stakeholder groups were identified using information provided in the Public Benefit Test Plan and discussions with industry representatives:

- optometrists;
- optical dispensers;
- consumers of optometry appliances and services in Queensland;
- Optometrists Board of Queensland;
- Health Insurance Commission;
- potential suppliers of optometry appliances and services; and
- Queensland Government as represented by Queensland Treasury, Queensland Health and the Health Rights Commission.

2.2.2 Consultation with Stakeholders

Consultation with stakeholders included a 'Value Management Workshop', as well as individual discussions with:

- the Optometrists Association of Australia, Queensland Division;
- the Optometrists Board;
- representatives from OPSM;
- the Now Group
- the Health Rights Commission;
- the Health Insurance Commission; and
- representatives from Queensland Health.

An independent academic from the Queensland University of Technology's Optometry School was also employed to provide advice on any major health issues associated with the review.

2.2.3 Review of available literature

The ownership provisions of professional health care practices have come under a significant level of scrutiny in recent years, both in Australia and overseas. Four major sources of literature were used as the basis for this analysis, namely:

- submissions from key stakeholders;
- review processes undertaken in other States, notably Victoria, NSW, WA and Tasmania;
- discussion papers from work undertaken by the Federal Trade Commission in the United States; and
- the Zifcak Report, 'A Detailed Inquiry into Issues Affecting the Optometrical Profession' conducted for the Victorian government in 1988. This report is the most detailed analysis of the optometry industry in Australia available (although it is based primarily on anecdotal evidence). The findings of this report have been referred to in Section 5.4.

2.2.4 Other Datasources

A number of additional data sources were also identified including:

- the Australian Bureau of Statistics Business Register Consultancy;
- the register of complaints regarding optometry practice in Queensland and other interstate jurisdictions;
- the databases of both the Optometrists Association of Australia (Queensland Division); and the Optometrists Board of Queensland.

2.3 Analytical Framework

The approach follows Treasury Guidelines, using a qualitative assessment methodology

The analytical framework used in undertaking this Public Benefit Test is derived from the Public Benefit Test Guidelines prepared by Queensland Treasury⁶. These guidelines outline a six step process:

- Step 1: Identification and description of a realistic 'without change' or 'Base' state;
- Step 2: Identification of a realistic 'with change' or 'alternative' state;
- Step 3: Identification of all major impacts;
- Step 4: Valuation of impacts;
- Step 5: Assessment and quantification of non-valued impacts; and
- Step 6: Timing, aggregation and presentation of results.

The methodology has been tailored to the needs of this review through the approach used in the assessment of impacts.

⁶ Queensland Treasury, Public Benefit Test Guidelines, National Competition Policy Unit, Issued April 1997.

A Public Benefit Test, like any cost benefit evaluation, should consider all relevant impacts. Where possible, impacts should be quantified in monetary terms. The quantified impacts need then to be assessed together with the unquantified impacts to determine which Option provides greatest net benefit to the community. Quantification of impacts in Public Benefit Tests, however, often needs to be based on assumptions which, whilst determined from available literature and input from key stakeholders, are often subject to a high degree of subjectivity. The lack of available data is often a significant constraint on valuation of impacts.

However, it is important that the Options are compared against each other on an equal footing, ensuring that all impacts are considered. In other words, the quantified impacts should not be given a higher priority than the unquantified impacts if that is not the correct weighting that society would attach to them.

Against this background, a methodology has been adopted which analyses impacts in a way which does not give unrepresentative weight to the quantified impacts. Furthermore, the lack of quantitative data enabled only indicative estimates to be attempted for a small number of impacts.

The following analytical stages have been applied:

□ **Construction of an Impact Matrix.**

This identifies the impacts by impact groups. The differences in the impacts are described for each Option and across the different stakeholder groups (see Table 5.12)

□ **Comparison of Options using Impact Matrix**

This can be undertaken at different degrees of sophistication depending on the available information. The different methods include:

- descriptive analysis;
- significance rankings; and
- numerical analysis, which requires impact group weights and scores for individual impacts for each stakeholder group to be determined.

As already mentioned, the lack of suitable data and the polarised views on certain issues led to the use of a combination of the descriptive analysis and significance rankings rather than a purely numerical analysis.

In describing the potential impacts on the quality of health care in Queensland, a two-stage approach has been adopted. In Stage 1, the evidence is presented on how a removal of the ownership restrictions could affect the way in which optometry services are carried out. In Stage 2, the impact of any changes in service delivery on public health is examined.

□ **Quantification of impacts where possible**

Given the polarised nature of some of the issues in this review, it was not possible to undertake a comprehensive numerical analysis for each of the impacts. In developing the impact matrix analysis, which covers all impacts, attempts have been made, where possible, to value some impacts. This has been undertaken by using data collected for the industry analysis, available literature and assumptions deemed 'reasonable' in consultation with key stakeholders.

3. Industry Analysis

Optometrists in Queensland are engaged in both the provision of professional optometric services and the sale of optical appliances

3.1 Overview of the Optometry Industry

The optometry industry in Queensland includes both the provision of professional optometry services and the sale of optical appliances.

Registered optometrists provide optometry services. Optometrists assess and prescribe the need for prescription lenses to assist vision. They also provide preventative and continuing ocular health services. Also active in the market are:

- optical dispensers, who make and provide lenses for glasses and contact lenses but do not have a clinical role in ocular care; and
- ophthalmologists, who are medical practitioners whose field of expertise is the treatment of diseases of the eye, using therapeutic drugs or surgery.

3.1.1 Scope of Clinical Practice

Queensland optometrists' basic range of clinical skills and procedures include:

- refraction;
- binocular vision tests;
- ophthalmoscopy;
- slit lamp biomicroscopy;
- tonometry; and
- supply and management of spectacles and contact lens to patients⁷.

Optometrists employ ophthalmic drugs to facilitate diagnostic procedures, using anaesthetics in performing tonometry, mydriatics where required for internal examinations and cycloplegics. Optometrists in Queensland are not currently permitted to use other drugs to treat patients.

3.1.2 Funding of Optometry Services

The Commonwealth Government included optometry in the Medicare program in 1975. Optometry is the only profession, other than medicine, to have its consultation services covered by Medicare benefits.

Almost all optometrists in Queensland have agreed to participate as providers of optometric care within the Medicare system. Participation in this scheme requires adherence to standards of practice and a schedule of consultation fees that are set out each year in, '*Medicare Benefits for Consultation by Optometrists*'⁸.

Optometry is the only health profession other than medicine that is within the Medicare system

⁷ Source: Optometrists Association of Australia (these terms are defined in Appendix C).

⁸ Health Insurance Commission - *Medicare Benefits for Consultation by Optometrists*

The Medicare fee structure is such that it sets a minimum and maximum fee that a patient may pay. The majority of optometrists in Queensland and across Australia 'bulk bill' their professional fees; that is, they do not receive any payment from the patient.

The Optometrists Board of Queensland determines professional standards in the industry and maintains a register of practitioners

3.1.3 Control of Optometry Practice

The control of optometry practice is currently undertaken through the Optometrists Board of Queensland. The functions of the Board include: maintaining professional standards; maintaining the register of practitioners and assisting in the control of the practice of the optometry profession in Queensland. The Board may initiate proceedings against a practitioner for professional misconduct.

The Health Insurance Commission (HIC) regularly monitors the payments to optometrists to guard against potential misuses of the system. For example, optometrists are flagged for further investigation against over servicing if they are in the group that receives the top 5% of payments from Medicare in a financial year. While this data is useful for the management of the Medicare system it has only limited value in the analysis of the quality of health provided by optometrists. For example, over servicing could be caused by fraudulent claims rather than rushed appointments.

3.1.4 Number of Participants

There were 636 optometrists registered with the Optometrists Board of Queensland in 1998. Of these, 419 each billed at least \$1,000 in fees in each quarter of 1998 and were considered active by the Health Insurance Commission.

3.1.5 Number of Consumers and Value of Industry

The Health Insurance Commission has provided details of the number of consultations carried out in Queensland by optometrists in 1997/98 and the Medicare fees that were paid to optometrists. This data is summarised in Table 3.1 along with data from the ABS Household Expenditure Survey. This survey includes an estimate of expenditure on optical appliances as well as the fees for optometrists' professional services.

Table 3.1: Industry Participation and Expenditure, Queensland 1997/98

	Queensland Optometry
Patients	660,000
Services (Consultations)	730,000
Medicare fees	\$28.2 Million
Total spending on optician fees (including spectacles)	\$68.7 Million
Percentage of earnings from professional fees	41%
Number of employees	1,636

Source: Health Insurance Commission, ABS Household Expenditure Survey, 1997/98, ABS Business Register, September 1998.

Note: number of employees includes all employees of optometry businesses as defined by the ABS Business Register; expenditure on opticians' fees includes expenditure on both optometry services and appliances.

Optometrists differ from most other health professionals in that they derive a significant proportion of their income from the goods (optical appliances) that are required to fulfil the prescriptions that they write. The Optometrists Association estimates that approximately 70% of optometrists have a retail side to their business which is involved with the sale of spectacles, lenses etc.⁹

3.1.6 Entry Requirements

The major barrier to entry into the optometry industry in Queensland is the requirement that persons can only practise optometry if they have completed the relevant tertiary education and are on the Board's register of optometrists.

In Australia, optometrists are educated to degree level at one of the three institutes conducting optometry courses: the University of New South Wales, the University of Melbourne and the Queensland University of Technology. Each course is of four years' duration and leads to a bachelor degree in optometry.

A typical new optometrist's practice can be established with a capital investment of approximately \$90,000¹⁰. This would include the fitting and stocking of a dispensing area as well as the capital cost of the optometrist's equipment including items such as:

- a slit lamp biomicroscope;
- an applanation tonometre;
- retinoscope; and
- vision charts.

The major requirement for entry is that all practitioners must have completed a bachelor degree in optometry

⁹ Optometrist Association of Australia, personal communication, April 1999

¹⁰ Estimated by the Optometrists Association of Australia (Queensland Division).

3.1.7 Ownership Structure of Optometry Practices in Queensland

Table 3.2 provides the ownership structure of optometry and optical dispensing businesses as extracted from the ABS Business Register.

Publicly-owned companies such as OPSM which have an interest in optometry practice, fall into the 'Other Registered Organisation' category. These companies account for 84 of the 503, (or 17%), of optometry businesses in Queensland. They account for 25% of employment in the industry.

Table 3.2: Structure of Queensland Optometry and Optical Appliance Businesses, September 1998

	Management Units	Business Locations	Employees	Employees/ business
Proprietary Limited ¹¹	136	194	622	3.2
Other Registered Organisation	3*	84	415	4.9
Sole Proprietor	70	88	201	2.3
Family Partnership	8	8	29	3.6
Other Partnership	16	24	74	3.1
Trust	78	105	295	2.8
Total	311	503	1,636	3.3

* Two of the companies in this category are registered interstate but operate in Queensland.
Source: ABS, Business Register, September 1998.

Note: number of employees includes all employees of optometry businesses as defined by the ABS Business Register; Management Units are individual businesses that may operate in more than one location.

¹¹ See Appendix D for definition of business classifications.

Overall, this data suggests that the industry is characterised by a large number of participants. However, many of these businesses do not compete directly with one another because consumers generally do not have the incentive to travel significant distances to an alternative supplier. For example, an optometrist in Townsville competes only indirectly (if at all) with an optometrist in Cairns or Mackay. Moreover, because the majority of optometrists bulk bill using Medicare, there is little or no price competition on the provision of optometry consulting services, as opposed to competition for the supply of optical appliances.

3.1.8 Other Vision Care Professions

Ophthalmologists and optical dispensers (spectacle makers) are the other major groups that provide vision care services or products to the Queensland community.

Ophthalmologists are medical practitioners who have completed a specialist course in the treatment of eye diseases. They also have the authority to write prescriptions for optical appliances. There were 102 practising ophthalmologists in Queensland in 1998¹². While these practitioners compete with optometrists to some extent, their primary role is in the treatment of eye disease through either drugs or surgery. Ophthalmologists' fees are significantly higher than those for optometrists and a referral from a medical practitioner or an optometrist is required before visiting an ophthalmologist.

Optical dispensers may only make up spectacles to a prescription written by an optometrist or medical practitioner. In Queensland, there is no legislative control over optical dispensers or the training which dispensers must have. No record of the number of people employed in this occupation is currently available.

3.1.9 Trends in the Provision of Optometry Services in Queensland

The practice of optometry in Queensland and Australia has changed over the past thirty years with the development of new health care procedures and diagnostic techniques. Over time, optometrists have come to regard their major role as being that of primary health care providers. This is in contrast to earlier this century, when they promoted themselves primarily as sellers and suppliers of spectacles¹³.

Optometrists now write over 70% of optical prescriptions compared to around 30% of prescriptions thirty years ago¹⁴. The increasing importance of optometrists in the writing of optical prescriptions, combined with the optometrist's traditional retail role has led to a greater integration between the provision of optometric services and the sale of optical appliances.

Optometrists now regard their role as primary eye health care providers

¹² Health Insurance Commission.

¹³ Source: Optometrists Association of Australia.

¹⁴ Source: Optometrists Association of Australia - Submission to the review

Optical dispensers in Queensland have allied themselves with optometrists to provide one stop shopping to consumers

Historically, a person with an optical prescription would be likely to have received a prescription from a medical practitioner and then sought a dispensing store, in much the same way as a prescription is taken to a chemist. As optometrists began to write more of the optical prescriptions, they also began to dominate the sale of optical appliances. In response to this trend, specialist optical appliance stores such as OPSM, began to develop alliances with optometrists to enable them to provide a similar level of 'one stop' shopping service to consumers.

In Queensland there are now over 80 businesses that are owned by optical dispensing companies. The majority of these stores have an alliance with an optometrist who operates a practice that is physically part of, or adjacent to, the dispensing store. Optometrists working in this environment do not dispense optical appliances and therefore tend to spend most of their time consulting with patients than do optometrists who also manage the retail side of a business.

This trend in optometric practice, away from the retail work associated with the dispensing of optical appliances, is evident across Australia. The trend has been accompanied by an increase in the scope of the health care provision aspects of an optometrist's work. For example, optometrists in Victoria have recently been given the authority to use and *prescribe* a limited range of therapeutic drugs for use in the treatment of eye-related conditions.

3.2 Regulatory Approach in Other Jurisdictions

Each of the States and Territories of Australia operates the same broad regulatory approach to the optometry industry

Each of the States and Territories of Australia operates the same broad regulatory approach to the practice of optometry. Optometrists are registered with an optometrists board which is empowered by legislation to control the practice of optometry. A similar regulatory approach is used in the United States where each of the States has its own optometry registration board.

However, ownership restrictions vary across the States, as described below and summarised in Table 3.3.

3.2.1 Tasmanian Ownership Restrictions and Reviews

The legislation concerning the ownership of optometry practices was redrafted in 1994, before NCP. This legislation upheld the existing ownership restrictions, which, in practice, allow optical dispensing stores to operate in association with optometrists through nominee structures. A NCP review of these restrictions is currently being undertaken.

South Australia, the ACT, Western Australia and Victoria presently have no ownership restrictions on optometry practices

3.2.2 South Australian Ownership Restrictions and Reviews

The restrictions concerning the ownership of optometry practices in South Australia were removed in 1992. It is currently possible for non optometrists to employ optometrists in South Australia. South Australia is considering including some form of statutory offence provision against undue influence¹⁵ over an optometrist in their legislation.

3.2.3 Victorian Ownership Restrictions and Reviews

A review of the ownership provisions in the relevant Act, undertaken in Victoria, resulted in a lifting of the ownership restrictions in 1996. Victoria is also considering imposing statutory offence provisions against undue influence over an optometrist.

3.2.4 New South Wales Ownership Restrictions and Reviews

NSW currently has similar ownership restrictions to those that exist in Queensland. A review of these restrictions under NCP guidelines is currently being undertaken.

3.2.5 ACT Ownership Restrictions and Reviews

The ACT *Optometrists Act 1956* does not include ownership restrictions.

3.2.6 WA Ownership Restrictions and Reviews

The Western Australian *Optometrists Act 1940* does not incorporate controls on the ownership of optometry practices.

A 1998 discussion paper¹⁶ found that there is no evidence to the effect that this arrangement in Western Australia has:

- led to excessive commercialisation and lower quality service;
- resulted in over-servicing or other unethical practices;
- rendered the disciplinary process difficult to administer; or
- led to any other undesirable result.

Furthermore, the discussion paper recommends that:

- health practitioners be permitted to work in partnership, or in corporations or in other associations with other persons, including other types of health practitioners; and
- a practice may be owned by registrants or non-registrants or a combination of such parties.

Western Australia has had limited ownership restrictions for the past fifty years

¹⁵ Undue influence refers to pressure an owner could place on an optometrist to operate in an unprofessional manner.

¹⁶ Discussion Paper, *Review of Western Australian, Health Practitioner Legislation* Health Department of Western Australia, October 1998

3.2.7 Summary

Table 3.3 summarises the ownership restrictions in the other Australian states. There has been a move away from ownership restrictions in the optometry industry in the past ten years and the restrictions remain in only two states, New South Wales and Tasmania.

Table 3.3: Ownership Restrictions in Other Australian States

	No Restrictions	Restriction under Review
Tasmania		✓
South Australia	✓	
Victoria	✓	
New South Wales		✓
Western Australia	✓	
Australian Capital Territory	✓	

3.2.8 United States

The Federal Trade Commission in the United States is charged by statute with preventing unfair methods of competition, and unfair or deceptive practices which affect commerce. Under this mandate, the Commission has undertaken three major studies of the impact of restrictions imposed on business practices of optometrists.

The first study, conducted in 1975, investigated the impact of advertising restrictions. It led to the 1978 trade regulation rule, Advertising of Ophthalmic Goods and Services¹⁷ which allowed non-deceptive advertising of optometry services. The study also identified that advertising restrictions were not the only restraints that appeared to limit competition. Other commercial restraints included the prohibition of optometrists from forming business relationships with non optometrists (for the purpose of offering eye care to the public) and from locating in mercantile locations (e.g. shopping malls).

To examine the effects of these other restraints, two studies were undertaken. The first, published in 1980¹⁸, compared the price and quality of optometric goods and services in markets with differing degrees of regulation. The second, published in 1982¹⁹, compared the price and quality of contact lens fitting services, for commercial optometrists and other provider groups.

¹⁷ 16 CFR Part 456 (Eyeglasses Rule).

¹⁸ Bureau of Economics, Federal Trade Commission, *Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry* (1980).

¹⁹ Bureaus of Consumer Protection and Economics, Federal Trade Commission, *A Comparative Analysis of Cosmetic Lens Fitting by Ophthalmologists, Optometrists and Opticians* (1983).

Reporting on these studies to the New Mexico Board of Optometry, it was stated that Federal Trade Commission 'studies provided evidence that restrictions on optometrists' commercial²⁰ practices raise prices but do not improve the quality of care'²¹. In particular, it was noted that the study data showed that prices were 18% higher in the markets that barred commercial chain firms.

During the 1980s, the Federal Trade Commission conducted an extensive rule making process to address state imposed restraints on the business practices of optometrists. In the statement to the New Mexico Board of Optometry, it was noted:

'The rule making record establishes that the presence of commercial optometric firms lowers the cost of eye care to patients of both commercial and non commercial optometrists. The evidence also indicates that these restrictions do not provide offsetting quality related benefits'²².

As a consequence, the Commission adopted a rule to prohibit state-imposed restrictions on:

- affiliating with non optometrists;
- locating in a commercial setting;
- opening branch offices; and
- using non-deceptive trade names.

This rule is not in effect because the US Court of Appeal found that the Commission does not have the statutory powers to make rules declaring state statutes unfair. The results of the Federal Trade Commission's research are, however, presented to decision-makers when changes to the regulation of optometry in the various States of America are debated.

²⁰ Commercial practitioners in the US Federal Trade Commission study are loosely defined as those with links to optical dispensing companies

²¹ Statement of Gary Kennedy, Attorney, Dallas Regional Office, Federal Trade Commission before the New Mexico Board of Optometry, Santa Fe, New Mexico, August 23, 1997.

²² Ibid

3.3 Industry Profile - Australian States and Territories

3.3.1 Operational Profile

Table 3.4 summarises the operational profile of optometrists, while Chart 3.1 illustrates the average population per optometrist in the States and Territories of Australia.

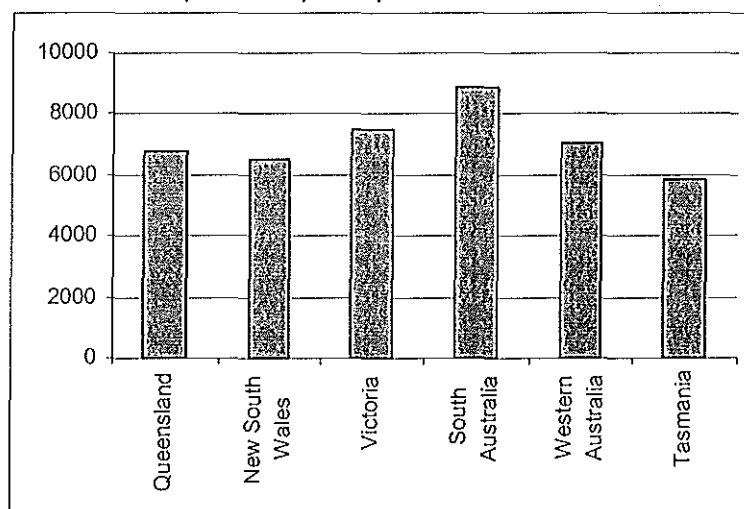
Table 3.4: Operational Profile, 1997/98

State	Active optometrists	Population per -optometrist	Average services per optometrist	Average \$ billed to Medicare per optometrist
Queensland	419	8,117	1,748	\$67,238
ACT	30	10,327	2,085	\$81,481
New South Wales	809	7,755	1,603	\$62,141
Victoria	541	8,512	1,661	\$64,474
South Australia	151	9,800	1,966	\$75,881
Western Australia	206	8,728	1,648	\$64,971
Tasmania	57	8,307	1,789	\$68,324
Total / Average	2,213	8,288	1,685	\$65,298

Source: Health Insurance Commission

Note: Optometrists are considered active when they have billed at least \$1,000 in fees in each quarter of a year.

Chart 3.1: Population per Optometrist Business Location, 1997/98



Source: Health Insurance Commission and Australian Bureau of Statistics, Business Register Counts, September 1998

A key feature of this data is the variation in the number of optometrists per person / business in each State. Those States with the highest percentage of population in the capital city (SA and ACT) have the highest population per optometrist. This variation within each State appears to be the major factor explaining differences between the average number of services per optometrist and the average income received from Medicare per optometrist.

3.3.2 Business Ownership

Despite the differences in ownership restrictions that presently exist across the States, the optometry practices in each of the States exhibit the same six basic forms of ownership structure. There are, however, some differences across the States in the proportions of businesses that are classified within each category, as highlighted in Table 3.5.

Table 3.5: Optometry & Optical Dispensing Businesses by ownership type, September 1998

	SA	WA	Vic	Qld	NSW	Tas	Aust
	%	%	%	%	%	%	%
Sole Proprietor	10	9	16	17	33	28	22
Family Partnership	4	5	2	2	4	4	3
Other Partnership	4	5	4	5	7	12	6
Trust	17	32	22	21	11	16	18
Proprietary Limited	38	31	47	39	35	28	38
Other Registered Organisation	27	19	10	17	9	11	13

Source: ABS, Business Register Counts, September 1998

Tasmania and NSW have the highest proportion of the traditional businesses (sole traders and family partnerships) while South Australia and Western Australia, the two States with the longest history of no restrictions on ownership, have the lowest proportion of these business types. This suggests that Western Australia and South Australia have a stronger corporate involvement in the provision of optometry services than the other States.

Although NSW and Queensland have similar ownership restrictions, Queensland appears to have moved further away from the traditional ownership model than NSW. The ownership profile of optometry businesses in Queensland is closest to that of South Australia and Western Australia, the States that have no ownership restriction.

Ownership restrictions do not appear to be the dominant factor influencing the ownership structure of the industry.

4. Specification of the Base Case and Options to be Assessed

In this Public Benefit Test of the business ownership and associated restrictions under the Act, five Options have been considered as alternative ways of achieving the objectives of the proposed health practitioner registration legislation. These Options have been derived from a range of sources:

- the three Options from the Public Benefit Test Plan (attached to the Terms of Reference);
- an Option, to include a statutory offence provision against 'undue influence' (in accordance with proposed health practitioner registration legislation); and
- an Option which was proposed by the Optometrists Board of Queensland that ensures 100% ownership and control of optometry practices by optometrists.

In summary, the five Options can be described as:

Five Options have been considered in the Public Benefit Test

- Option 1: No restrictions on ownership of optometry practices or businesses;
- Option 2: No restrictions with Statutory Offence - no restrictions but with a statutory offence clause for undue influence²³;
- Option 3: Base Case - existing situation continues, including current legal circumvention;
- Option 4: Controlling interest in the ownership of optometry practices is held by registered optometrists ; and
- Option 5: 100% ownership and control of optometry practices by optometrists.

The Base Case and alternatives are now described in detail.

4.1 Base Case Specification

The existing situation involves circumvention of legislation through use of nominee arrangements

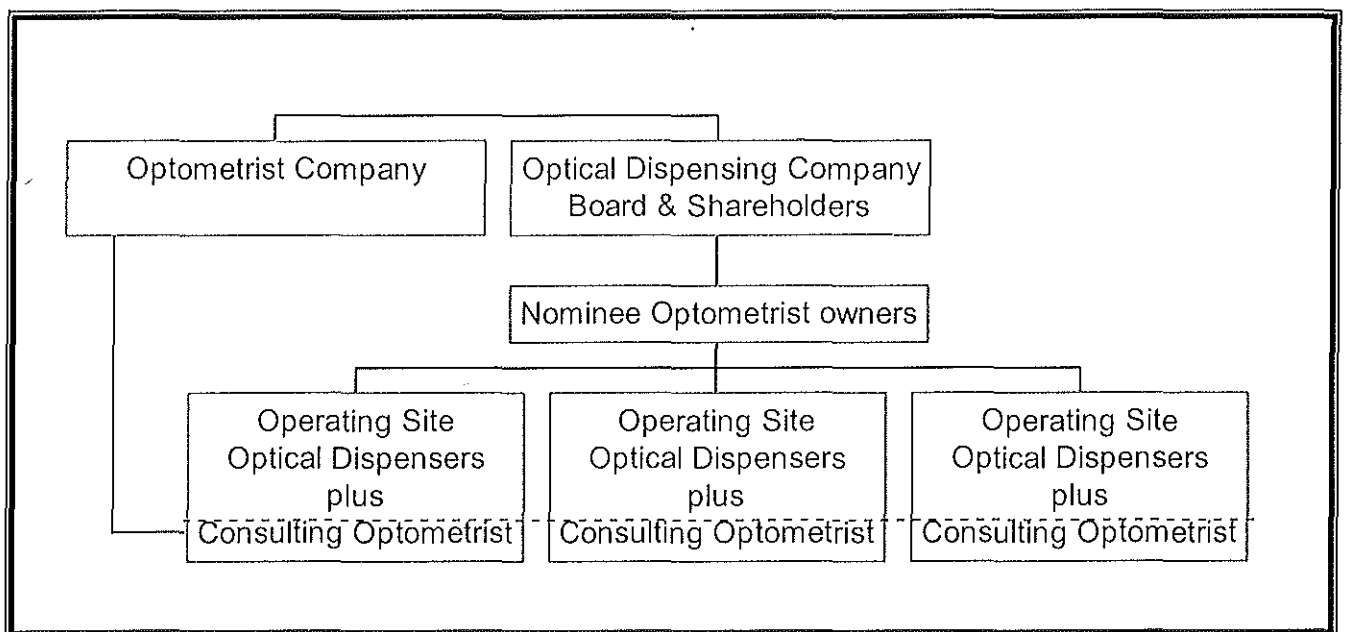
The Base Case (Option 3) represents the status quo. Although the current legislation seeks to restrict the ownership of optometry businesses to optometrists, the legislation is being circumvented. This circumvention involves the use of a 'nominee' ownership structure, whereby registered optometrists are nominee directors on behalf of non optometrists. Under the current restrictions non optometrists are able to, in effect, operate and control optometry businesses under nominee arrangements, whilst the ownership of the practice meets legislative requirements.

Therefore, in practice, the current situation can be described as either defacto deregulated or operating with only a semi constrained ownership restriction.

²³ Undue influence refers to pressure an owner could place on an optometrist to operate in an unprofessional manner.

This nominee business structure, as undertaken by corporations which combine optical dispensing and optometry practice in Queensland, is summarised in Figure 4.1.

Figure 4.1: Nominee structure under current ownership restriction



The reason that a dual structure has been established (ie. an optometrist company and a nominee-owned dispensing company) is now historical - namely, to allow advertising of dispensing services when more stringent restrictions against such advertising were in place.

A nominee business structure effectively circumvents the existing restrictions on ownership

We understand from current operators that since advertising restrictions have been relaxed, the dual structure is no longer required. What is required is the ownership of the company by nominees who must be registered optometrists.

The number of nominee optometrists required is not subject to any minimum level. It is understood that companies are operating in the Queensland market with two nominee optometrists. The nominees are not required to have any day-to-day management roles in the business.

In practical terms, the key features of this arrangement are that the consulting practice within an optical dispensing location is operated:

- by an optometrist employee of the nominee-owned dispensing company, or
- under a licence agreement between a self-employed optometrist and the nominee-owned dispensing company.

A customer who visits these practices is given a prescription by the consulting optometrist and is then free to take the prescription to any supplier of optical appliances. However, this supplier would usually be the optical dispensing store associated with the optometrist.

The Base Case for this Public Benefit Test is the continuation of the existing legislation, including the legal circumvention arrangements. Whilst some participants at the Value Management Workshop described the current situation as a 'de-facto deregulated ownership' system, it has been concluded that it may be more accurate to describe it as a 'semi-constrained' restriction.

To clarify, under the existing implementation of the restrictions, it is not legally possible for a company to operate a business which involves optometry consultation, unless:

- optometrists own 100% of the company; or
- a nominee structure (of registered optometrists) is put in place.

Agreement from a registered optometrist to participate in a nominee company is required

In other words, the current restrictions require that optometrists are at least part of the company. Given that there is a finite number of optometrists in Queensland (currently around 636), there is effectively a supply constraint on the potential for a company to enter the market. At present, a company must acquire professionally qualified optometrists to be part of the company. These optometrists are themselves bound to adhere to the clinical practice restrictions under the Act and would, *a priori*, be inclined to ensure that such standards are maintained in the companies for which they are nominees. This partial constraint on ownership would be effective if the nominee optometrist acted to ensure the adherence to professional standards within their company. Some stakeholders suggest that this factor has had a positive influence on the industry to date, however, no evidence is available to suggest that nominee owners have an influence over corporate optometry practices.

The continuation of the existing position in regard to ownership restrictions could imply that other companies, not necessarily involved in the eye care sector, could participate in the market in the future under the Base Case scenario. It should be restated, however, that in this eventuality, registered optometrists would need to agree to become nominees of such a company.

4.2 Options

Option 1: No restrictions on ownership

Under this Option there would be no restrictions on who can own a company that employs optometrists. There are presently no restrictions on the ownership of optometry practices in Victoria, South Australia, ACT and Western Australia.

Option 2: No Restrictions with Statutory Offence Clause

This Option has no regulated restrictions on ownership (same as Option 1), but includes a statutory offence clause that could lead to a person or company being prohibited from operating in the optometry industry²⁴. It is understood that this would be covered by the Optometrists Act, which is currently being drafted, and would include a clause which specifies a statutory offence for:

- an owner to engage in conduct or policies that result in, or are likely to result in, undue adverse influence on the professional independence or clinical decision making activities of optometrists employed by the owner.

This Option directly addresses the key issue raised by the Optometrists Association and Optometrists Board in the ownership restriction debate; that owners could apply pressure on optometrist employees to improve 'commercial' performance to the detriment of practice standards and the Board would have no power to prevent them from continuing this practice.

Under this model, any person may commence court proceedings against an owner in respect of undue influence. In practice, optometrists who have been subject to undue influence could notify the Board, which could commence court proceedings against the owner.

The Health Rights Commission (HRC) would become involved only if a consumer complained about an optometrist's service and the HRC's enquires into the matter indicated that the cause of the complaint was related to undue influence on an optometrist by an owner. In this case, the HRC could refer the matter to the Board to commence court action against an owner for 'undue influence'.

A court could impose significant penalties and/or rule that a company (and its owners, individually), found in breach of the statutory offence clause, be prohibited from participation in the optometry industry.

Option 3: Base Case: (see section 4.1 above)

²⁴ This 'statutory offence approach has been adopted for a number of other registered health practitioners in Queensland.

Option 4: Controlling interest

Rather than requiring 100% ownership by registered optometrists, proposals have been considered previously in other jurisdictions that registered optometrists have a controlling interest in the ownership of the business. For example, in Victoria, the Zifcak²⁵ report recommended that optometrists owned at least two thirds of each optometry practice (this recommendation was not adopted by the Victorian Government).

For this Public Benefit Test, the controlling interest Option is specified as:

'a statutory requirement that at least one registered optometrist must have a controlling interest (ie 51%) in the ownership of the practice'.

This involves a tightening of the current ownership restrictions, since it would not allow nominee company structures to exist as is now the case.

Option 5: 100% Ownership and Control

This Option involves a tightening of ownership restrictions, compared to the existing situation (Option 3) and also compared to Option 4 (minimum of 51% controlling interest). Under this Option an optometry practice has to be 100% owned and fully controlled by registered optometrists, thus preventing optical dispensers (or any other company) from using nominee company structures to combine optical dispensing and optometry activities under single ownership.

This Option was developed on the basis of discussions at the Value Management Workshop and was referred to as 'beneficial ownership' by the Optometrists Board. Under this Option, the owners of optometry practices must be registered optometrists and the only financial beneficiaries of the optometry practice operations.

Under this operating scenario, it would be possible for an optometrist to work in association with an optical dispensing company. An optometrist would be able to locate adjacent to the optical dispensing store and provide customers to the optical dispenser. The optometrist would, however, remain self employed (a separate company).

²⁵ Zifcak S, *Inquiry Into Issues Affecting the Optometrical Profession - Final Report to the Minister for Health*, Victoria, 1988

5. Impact Identification and Matrix Analysis

Impacts are characterised under five impact groups

5.1 Impact Groups

For this Public Benefit Test, the impacts of the implementation of the different regulatory Options have been categorised under 'impact groups' which reflect the main criteria on which the assessment will be made. These impact groups are:

- protection of the public and provision of safe, competent and up to date health care;
- cost of service and competition impacts;
- regional and rural service provision;
- small business; and
- employment.

5.2 Stakeholder Groups

For the purposes of this evaluation, the stakeholders have been divided as follows:

- consumers (as both consumers of products and services and the wider community);
- optometrists;
- optical dispensers, and potential new entrant non optometrist owners; and
- administrators/regulators - the Queensland Government, the Optometrists Board and the HRC.

These groups may not be homogeneous and within these groups the impacts may vary. For example, there are likely to be sections of the community that are better off and other sections that are worse off as result of the different regulatory Options. Where this is the case, differential impacts will be analysed.

5.3 Impact Description and Analysis

All the impacts taken into account in this Public Benefit Test are shown, in summary form, in Table 5.12 in the form of an Impact Matrix, which shows each impact in relation to the impact group (criteria) compared across each Option.

In sections 5.4 to 5.7, the impacts are described and analysed in qualitative terms. For the compliance costs, the available limited data allows some indicative quantification in monetary terms. These are, however, tentative estimates and the focus of the assessment should remain at the qualitative level.

5.4 Protection of the Public and Provision of Safe, Competent and Up To Date Health Care

A primary objective of the legislation is to protect the public.

As stated in the Public Benefit Test plan, the objective of proposed health practitioner registration legislation is to protect the public and ensure that health care is delivered to the Queensland public in a safe, competent and up-to-date manner.

It would appear that optometry is not a high risk area of health care, compared, for example, to medical practice. A 1994 report concerning Compensation and Professional Indemnity in Health Care noted that, although reliable claims data is difficult to access, there appears to be a lower rate of litigation in relation to negligent and other adverse patient outcomes for *non-medical* health care practitioners (ie, in comparison to medical practitioners)²⁶. Moreover, as noted at section 5.4.2 below, few complaints are recorded against optometrists by health complaints agencies in Australia.

However, the Optometrists Association has argued in its submission to the review that current standards of eye care could diminish in Queensland if ownership restrictions are removed. Their submission stated that:

'Lay ownership of optometric practices is likely to lower the quality of care because directors of companies have divided responsibilities to patients and shareholders and are remote from the patients although they make policies for conduct of the practice'²⁷.

Specifically, they suggest that this commercial pressure will cause:

- consultations to be shorter than would be optimal for patients' eye health; and
- prescriptions to be issued more regularly than is necessary.

Another submission to the review commented that optometrist owners are just as likely as non optometrists owners to exert commercial influence on employees.

Optical dispensing corporations argue that the ownership structure of optometry practices has no impact on the quality of eye health care. These corporations further argue that commercial ownership can in fact bring significant benefits to eye care, since corporate owners have greater access to investment funds for the purchase of new and expensive eye care technology.

²⁶ Commonwealth Department of Human Services & Health, *Review of Professional Indemnity Arrangements for Health Care Professionals: Compensation and Professional Indemnity in Health Care*, Interim Report, February 1994, AGPS, p.247.

²⁷ Optometrists Association of Australia, Queensland Division, April 1999, Submission to the Review of Business Ownership Under the Optometrists Act 1974, p2.

In examining these issues, a two-stage approach has been adopted. Stage 1 presents the evidence about how a removal of the ownership restrictions could affect the way in which optometry services are carried out. Stage 2 examines the impact of any changes in service delivery on public health.

5.4.1 Effect of the Ownership of Optometry Practices on the Length of Patient Sessions

The Optometrists Board and the Optometrists Association have stated that it is more likely that a non optometrist owner of an optometry practice will attempt to force or encourage optometrists whom they employ to undertake more appointments in a day than would otherwise be the case. To achieve this, it is suggested that optometrists will need to shorten the length of time that they spend with each client.

There is some evidence to suggest that patient sessions are likely to be shorter in commercially run practices

To support this statement, the Board and the Association drew evidence from the Victorian Zifcak Report and United States Federal Trade Commission studies into the optometry industry. The Zifcak Report states that 'there is evidence that in some commercially orientated practices, the time taken for consultations has been less than might normally be expected and that therefore the examination has not been as thorough as it should have been'²⁸. The United States Federal Trade Commission study²⁹ concludes that commercial practitioners³⁰ appeared to spend significantly less time with their patients than non commercial practitioners.

The present operating environment in Queensland includes a significant number of practitioners who are effectively working in corporate practices³¹. Experience in these practices is that appointments are usually booked at thirty minute intervals, which is generally considered adequate for an optometry examination. This is similar to the time that is usually set aside for a patient session in non-corporate practices. However, corporate practices tend to be located in high turnover retail locations and would be expected to have a higher proportion of 'walk-in' appointments than more traditional style optometry practices. These 'walk in' appointments are primarily made up of people who want to buy a new pair of glasses, rather than have their eyes checked. The time spent with the patient in these situations is likely to be shorter than that spent with a patient who has booked a specific period of time for their appointment. Therefore it would be expected that the average length of an appointment at a corporate practice in Queensland would be shorter than in a more traditional optometry practice.

²⁸ Zifcak S, *Inquiry into Issues Affecting the Optometrical Profession - Final Report to Minister for Health*, Victoria, 1988, p59.

²⁹ Bureau of Economics, op cit

³⁰ Commercial practitioners in the US FTC study are loosely defined as those with links to optical dispensing companies.

³¹ Corporate practices are optometry practices that are owned by business corporations comprising persons who may not be optometrists. For example, an optometry practice owned by an optical dispensing corporation is considered to be a corporate practice.

This commercial operational profile is not limited to corporately owned practices. There are a number of optometrists owned practices that are operating in similar locations and with similar operational profiles. This operational profile is, however typical of corporately owned practices but represents only a small proportion of practices owned by optometrists.

Overall, the operating profile of corporate practices in Queensland combined with the conclusions of the US Federal Trade Commission report and the evidence presented in the Zifcak Report, suggests that patient sessions are likely to be shorter on average in corporate practices than in more traditional practices, such as those run by sole practitioners. The health implications of this are discussed in Section 5.4.2 below.

5.4.2 Health Implications of Shorter Sessions

It is claimed by the Optometrists Association that a reduction in the length of time taken to assess a patient's condition will result in the misdiagnosis of some health problems and the missed diagnosis of some conditions.

In discussions with the Optometrists Board and the Optometrists Association, a number of potential problems were cited including:

- poorly prepared prescriptions for both contact lenses and glasses; and
- the missed diagnosis of diseases such as, glaucoma, diabetes, macular degeneration, lattice degeneration and uveitis.

Missed diagnosis of diseases is possible as a consequence of a poorly conducted consultation

These diseases are potentially serious health issues which would be less likely to be diagnosed if an optometrist did not undertake a full range of tests during an appointment, however, they occur only very rarely in the community. It is estimated that Australian optometrists refer approximately 110,000 patients to ophthalmologists or medical practitioners each year³². Moreover, the incidence rate of eye disease is significantly higher amongst specific sectors of the population, such as the elderly. Where these groups can be flagged, either through their appearance (eg the elderly) or through screening questions (eg diabetics), the risk of missed diagnosis from a shorter appointment is likely to be further reduced.

Evidence from the operation of corporate practices in Queensland suggests that, to date, the development of corporate practices has not had any identifiable effect on the perceived level of eye care. The number of complaints received by the Health Rights Commission against optometrists has remained at below ten per annum for the past ten years as detailed in Table 5.1.

³² Cockburn, D.M. et al, (1994), 'An Audit of Disease Diagnoses made by Optometrists, *Clinical and Experimental Optometry*, 77.2, March/April, p51.

Table 5.1: Number of Optometrist Complaints by Type, Queensland

Year	Access	Admin.	Costs	Comm.	Rights	Treatment	Total
1992	-	-	-	-	-	2	2
1993	-	-	2	2	1	3	8
1994	-	-	-	-	-	4	4
1995	2	1	-	-	-	3	6
1996	-	-	-	-	1	4	5
1997	-	-	-	1	1	3	5
1998	-	-	1	2	2	2	7
1999	-	-	-	-	-	2	2

Source: Health Rights Commission, May 1999.

Note: Admin. = Administration; and Comm. = Communication.

This low incidence level for complaints against optometrists is common to the majority of States and Territories in Australia, with the exception of Victoria, as shown in Table 5.2.

Table 5.2: Number of Complaints Filed Against Optometrists in Australia 1997/98

State	No. Complaints Filed by State Complaints Organisations 1997/98
QLD	7
NSW	4
ACT	4
Victoria	26
SA	9
NT	0
WA	6
Total	56

Source: Various State Health Rights organisations, personal communications. Tasmanian data not supplied.

The higher incidence of complaints in Victoria appears to be due to factors other than ownership provisions

The higher incidence of complaints in Victoria appears to be due to a combination of different reporting methods and the relatively high profile of the Health Services Commission in Victoria. Dentists, medical practitioners, physiotherapists and hospitals in Victoria all have significantly higher incident rates than those experienced in equivalent professions in Queensland.

Overall, the data on complaints against optometrists provide evidence that the perceived quality of care provided by optometrists to the community is of the required level. As would be expected, given the similarity in the training and professional registration of optometrists in Australia, the level of care provided to the community does not appear to vary significantly across the States.

The move towards more corporately-run practices has already occurred under the *Optometrists Act 1974* and to date there has been no identifiable reduction in the level of health care provided in Queensland. Moreover, differences in regulatory approaches across States are not associated with any variations in the quality of eye care.

US evidence suggests little impact on the quality of eye care

International Experience

The United States Federal Trade Commission found no evidence that the quality of eye care was lower in commercial practices than in non commercial practices. This is despite evidence that patient sessions were shorter in corporate practices. This conclusion is disputed by some US and Australian optometrists who, as quoted in the Zifcak Report, stated that 'the subjects of the study were not generally representative of the general population requiring eye care'³³.

If an optometrist was pressured into an extremely short session, there is a marginal potential risk that a diagnosis could be missed.

Summary- Health Implications of Shorter Patient Sessions

The available evidence suggests that optometrists employed in more commercial environments such as those which are likely to exist in corporate, practices, tend to have slightly shorter patient sessions. There is no evidence to date that this decrease in the length of time spent with patients has had any impact on the quality of health care provided to the public. If an optometrist was pressured into an extremely short session, however, there is a marginal potential risk that a diagnosis of an eye disease might be missed.

5.4.3 Effect of Ownership of Optometry Practices on the Number of Prescriptions Issued

Both the Optometrists Association and the Optometrists Board have suggested that commercial pressures in non optometrist owned optometry practices would result in more prescriptions for optical appliances being written.

To support this claim, the Optometrists Board and the Optometrists Association provided some anecdotal evidence from the experiences of optometrists operating in more commercial practices. There is, however, no specific evidence on the rate at which prescriptions are issued to patients by practice type.

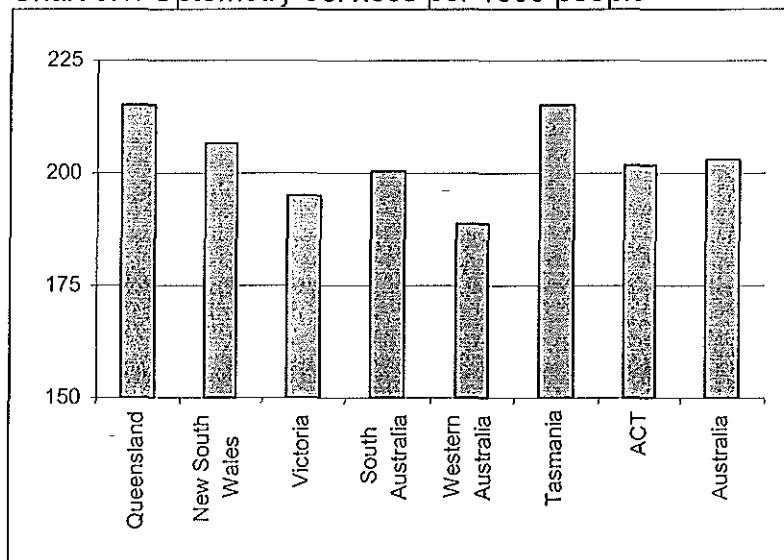
There is no evidence that over prescribing of optical appliances is likely to occur with deregulation

In analysing the impact of ownership on the rate at which prescriptions are issued, it was necessary to draw on secondary sources. The Health Insurance Commission collects and monitors data on the number of optometry services provided by Medicare in each state. Chart 5.1 summarises this data into the number of optometry services per 1000 people in each State. This data indicates that the State with the longest period of operation without significant ownership restrictions, Western Australia, has the lowest servicing rate, while the State with the highest level of sole practitioner operation, Tasmania, has the highest rate of servicing. This data, although not conclusive, does not support the assertions made by the Optometrists Association.

³³ Zifcak S, *Inquiry into Issues Affecting the Optometrical Profession - Final Report to Minister for Health*, Victoria, 1988, p60.

Futhermore, the HIC has a role in monitoring overservicing by optometrists (see section 3.1.3) but has not identified this as a key area of concern.

Chart 5.1: Optometry Services per 1000 people



Source: Health Insurance Commission.

5.4.4 Health Implications of Over Prescribing Optical Appliances

As noted in section 5.4.3, there is no evidence of over prescribing in either corporate or non corporate practices in Australia. In researching the health implications of over prescribing of optical appliances, through discussions with stakeholders, no major health impacts were identified.

This evidence indicates that there are no health implications related to this issue.

5.4.5 Impact of the Ownership of Optometry Practices on the Take Up of New Technologies

The OPSM submission states:

'Commercial ownership of optometry practices can bring major benefits in the form of improved access to the latest and often expensive technology³⁴.'

No specific examples of how this would occur were provided. Discussion with stakeholders identified equipment that would fall into this category as including:

- auto-refracting machines that provide initial diagnosis for spectacle prescriptions; and
- digital cameras that are used to record changes occurring in the eye.

Larger corporations that are involved in the provision of optometry services would be expected to have a greater capacity to purchase expensive equipment because of improved access to capital. They would also have the capacity to provide a specialist piece of equipment at one store and where necessary, refer patients from their other stores to the equipment.

5.4.6 Health Implications of Changes in the Take Up of New Technologies

The health implications of improved access to more expensive equipment appear to be negligible. The majority of difficult to detect eye diseases can be detected through an examination of the eyes with the standard equipment noted in section 3.1.6.

Expensive new technologies are typically justified on the grounds that they enable more speedy diagnosis of some conditions and therefore enable an optometrist to see more patients per day. Auto-refracting machines, for example, are useful tools for helping with quick diagnosis of a patient's focusing abilities, but it is understood that they have almost no role in the more complex diagnostic processes of optometry.

³⁴ OPSM, (1999), Submission to Review of the Business Ownership and Associated Restrictions under the *Optometrists Act 1974*, p5.

5.4.7 Ownership Structure and Quality of Health Care

In further considering the issue of ownership structure and its potential impact on the quality of eye health care, consideration was given to the Report of the National Advisory Group on Safety and Quality in Australian Health Care. This Report noted that, while the safety and quality of health services in Australia is high, there are some areas of the health system that require improvement. The Report outlined five key action areas to improve quality and safety in health services but, significantly, it did not identify the ownership structure of health practices as having any impact on the delivery of safe health services.

Furthermore, as outlined at section 3.2.7, the majority of States/Territories in Australia do not have ownership restrictions, and, as noted at section (5.4.2), the level of eye health care appears to be similar in all jurisdictions.

Summary of Health Risk Impacts associated with the Ownership of Optometry Practices

There is some suggestion that in a more commercial environment (such as that which is more likely to exist in a corporately owned practice) there may be the potential for a marginal increase in the risk of an optometrist missing a diagnosis over time. To date, however, the involvement of corporate optometry practices in the provision of optometry services in Queensland has had no noticeable effect on the quality of optometry services. This factor, combined with:

- a low incidence rate of eye disease in Australia;
- high standards of optometry care throughout Australia;
- low levels of consumer complaint about optometrists throughout Australia;
- the relatively small proportion of businesses which would be affected by a change in the removal of the ownership restrictions; and
- the ineffectiveness of the existing ownership restrictions.

suggests that there will be no adverse impact on eye health care, relative to the Base Case if the current ownership restrictions are removed as per Option 1.

Option 2 provides a means by which employers are prohibited from exerting 'undue influence' over the clinical practice of optometrists. It therefore provides an increased level of assurance that optometrists are not pressured into practices that could have a negative impact on the quality of health services provided to the Queensland public. While it is acknowledged that the health implications of a poor quality operator entering the market appear to be very low, the additional safety net provided by this Option suggests that it will produce a higher level of protection to the Queensland public than Option 1 and the Base Case.

*The statutory offence
Option should mitigate
any long run marginal
health risk of full
deregulation*

Under Option 4, optometrists would be required to own a minimum of 51% of any corporately owned optometry business, with the balance of 49% able to be owned by non-optometrists. The Optometrists Board could take disciplinary action against the optometrist owners, but it could not do so in respect of non-optometrist owners. However, it could be expected that potential disciplinary action against 51% of owners of a business would be a deterrent against owners placing undue influence on employees' clinical practices.

Option 5 is intended to achieve 100% ownership of optometry businesses, therefore the Optometrists Board would be able to take disciplinary action in respect of each individual optometrist owner in respect of undue influence on employees. However, the extent to which the 100% requirement could be enforced is unknown, and it is possible that "nominee" arrangements (for non-optometrist owners) may continue under this option.

In summary, the Optometrists Board would have powers under both Options 4 and 5 to take disciplinary action (for professional misconduct) against *optometrist* owners who exert undue influence on employee optometrists. These powers may provide a deterrent effect against undue influence by owners. These options therefore provide some assurance that employed optometrists would not be pressured into practices that could have a negative impact on the quality of health services provided to the Queensland public.

Table 5.3 summarises the health impacts of the various Options.

Table 5.3: Summary Health Impacts of Options

	Option 3: Base	Option 1: No Restriction	Option 2: Statutory Offence	Option 4: Controlling Interest	Option 5: 100% control
Safe Health Care	Current situation is seen to give a satisfactory level of eye care despite the lack of effective ownership restrictions.	No demonstrated evidence that impact is significant where deregulation exists, same quality of eyecare as Base.	Minimises the potential low risk of Base and Option 1 by providing a mechanism to prosecute owners who influence clinical practice. Potential marginal improvement in quality of eye care over Base.	Alleviates potential low risk of Base and Option 1 through the Optometrists Board's capacity to act against optometrist owners of optometry practices. Potential marginal improvement in quality of eye care over Base. (same as Option 2)	Alleviates potential low risk of Base and Option 1 through the Optometrists Board's capacity to act against optometrist owners of optometry practices. Potential marginal improvement in quality of eye care over Base. (same as Option 2)

5.5 Other Impacts on Consumers

5.5.1 Competition Benefits (Economies of Scale)

Under the existing system, access to economies of scale is provided by two means:

- the fact that nominee ownership allows corporations to operate in the industry; and
- the existence of the Optometrists Association of Australia, which facilitates activities such as bulk purchasing from suppliers by combining the purchasing power of smaller optometry businesses.

Access to economies of scale is partly related to the degree of restriction

Thus both the corporate operating structure and the more traditional ownership structure provide some access to economies of scale. It would be expected, however, that the economies of scale associated with the corporate structures would be more powerful than those provided by the traditional ownership model. Large scale operators allow scope for vertical integration and the development of management expertise in the provision of optometry services. They are also able to share accounting, legal and other administrative costs across a larger number of stores and this would be expected to generate some costs savings.

The cost savings associated with an increase in access to economies of scale could result in a marginal reduction in the price of optometry services and appliances, if operators pass some of their cost savings on to consumers.

For the Options under consideration the following access to economies of scale is anticipated:

- Under Options 1 and 2, current operators in the market expect that there will be a slight expansion of corporate ownership and involvement, thereby increasing the average size of the operations and implying the potential for increased access to economies of scale.
- Under Options 4 and 5, there is expected to be a slight decline in corporate involvement in the industry, potentially implying a lower access to economies of scale.

These impacts are summarised in Table 5.4.

Table 5.4: Access to Economies of Scale, Impact of Options

	Option 3: Base	Option 1: No Restriction	Option 2: Statutory Offence	Option 4: Controlling Interest	Option 5: 100% control
Access to Economies of Scale	Some economies of scale are currently being realised by large and small operators in Queensland.	Some potential for increased access to economies of scale.	Some potential for increased access to economies of scale (same as Option 1).	A reduction in access to economies of scale.	A reduction in access to economies of scale (same as Option 4).

5.5.2 Prices of Optometry Consultations and Cost of Appliances

Whilst the fee paid to providers of optometry consultations is fixed under the Medicare system, these fees are related to underlying costs. This review therefore had to examine how underlying costs may change under the different Options. These changes in underlying costs would also be expected to flow through to the cost of optometry appliances for which there is a competitive market.

As discussed in section 5.6.1, there are provider compliance costs that can be avoided under Options 1 and 2. These will be a direct cost saving for providers. In addition, the higher access to economies of scale under these Options would also be expected to reduce underlying costs.

This could have two impacts:

- reducing the need for any potential increase in the Medicare service provider fee for consultations; and
- potential reductions (only marginal) in product prices to the consumer.

Removal of ownership restrictions could result in marginal price benefits to the consumer

In an environment where Medicare sets service prices to consumers (for optometry consultations), these direct cost savings are likely to be initially a benefit for service providers. The strength of any impact on consumers depends on how much of such cost savings filters through to consumers in the longer term.

Under the more restricted Options (4 and 5) the opposite marginal impacts can be expected to occur. The higher compliance costs, noted in Section 5.6.1, would be expected to marginally increase the underlying costs of service provision. This marginal increase in costs would be expected to flow through to the consumer in the long term. A dramatic increase in prices, such as the 18% increase referred in US Federal Trade Commission study (noted in section 3.3.7) would not be expected because the competitive provision of optical appliance is expected to continue under all Options.

The relative impacts are summarised in Table 5.5.

Table 5.5: Cost of Optometry Consultations and Appliances, Impact of Options

	Option 3: Base	Option 1: No Restriction	Option 2: Statutory Offence	Option 4: Controlling Interest	Option 5: 100% control
Costs / Prices	Consulting prices set under Medicare, competitive provision of appliances.	Possibly marginally lower than Base.	Possibly marginally lower prices than Base, (same as Option 1).	Marginally higher prices than Base due to higher compliance costs and reduced access to economies of scale.	Marginally higher prices than Base due to higher compliance costs and reduced access to economies of scale (same as Option 4).

5.5.3 Consumer Choice

The impact of the deregulation of ownership on consumer choice is not clear-cut. A range of different impacts needs to be taken into account, such as the potentially wider choice which will be offered if different organisations provide a service in a given location, where there is currently only a single supplier.

From the consultations undertaken, it has been concluded that the level of consumer choice for optometry services and products is generally seen as acceptable at present.

The more traditional owner-operators and the larger corporate groups are providing sometimes different non price benefits to consumers. In the case of the larger groups, these non price benefits include a 'branded' reputation, national network and interchangeability ie the ability to exchange products at more than one location. In the case of owner-operators, non price benefits include access to goods and services that are provided by independent suppliers of optical appliances.

The continued existence of both owner operators and corporate service providers under Options 1, 2 and the Base Case implies little change in consumer choice under these Options. In the longer term, however, the removal of ownership restrictions could lead to the development of more innovative forms of service delivery in the industry. Corporate owners of health centres would, for example, be able to employ optometrists in their multi-disciplinary practices perhaps on a part time basis or by rotating them between different locations.

Under Options 4 and 5, however, the lower level of corporate involvement could reduce the non-price benefits available to consumers.

Service provision in regional / rural areas also impacts on consumer choice. See Section 5.5.5 regarding these impacts.

The current acceptable level of choice is not expected to alter significantly under deregulated Options

The consumer choice impacts are summarised in Table 5.6.

Table 5.6: Consumer Choice, Impact of Options

	Option 3: Base	Option 1: No Restriction	Option 2: Statutory Offence	Option 4: Controlling Interest	Option 5: 100% control
Consumer Choice	Current choice generally seen as acceptable.	Potential for more innovative forms of service delivery to be developed.	Potential for more innovative forms of service delivery to be developed (same as Option1).	Possible reduction in non- price choice factors due to restrictions in ownership structures.	Possible reduction in non- price choice factors due to restrictions in ownership structures (same as Option 4).

5.5.4 One Stop Shopping

Optometry business ownership restrictions in some United States jurisdictions have previously led to a situation where 'one stop' shops were not permitted. That is, whilst an optical dispenser and an optometrist appeared to be operating at the same location, they had to have separate entrances to the separate businesses. Where this restriction has been removed, there has been significant benefits. For example, an Industry Commission report³⁵ estimated that annual operating costs would fall by A\$10,000 per dispensary (based on data from the United States) if restrictions against being able to operate a single practice covering both optometry and optical dispensing were removed.

A continuation of the availability of one stop shopping is expected under all Options

This is not the current situation in Queensland, however, where one-stop shopping can be provided by all operations whether they have a corporate or traditional ownership structure. Stakeholders consulted did not believe that changes in ownership restrictions under any of the Options would alter the operation of practices as one-stop shops. The difference between the Options in the provision of one stop shopping would be in the underlying business structures. Under Options 4 and 5, optometrists could provide one stop shopping either as part of their own business, or in association with optical dispensers (ie by being located adjacent to, or within, an optical dispensing store).

Therefore no change is expected in the availability of one stop shopping to consumers under any of the Options.

³⁵ Industry Commission, *The Growth and Revenue Implications of Hilmer and Related Reforms: A Report by the Industry Commission to the Council of Australian Governments*, March 1995

5.5.5 Regional and Rural Impacts

A key issue in the analysis of the impacts of changes in the ownership restrictions is an assessment of the impact on regional communities.

The submissions of both the Optometrists Board and the Optometrists Association suggest that deregulation of the ownership restrictions has the potential to diminish the level of service provided to people in rural communities.

The Optometrists Association submission asserts:

- there are approximately 50 rural and remote towns in Queensland that are visited regularly by optometrists but do not have permanent optometry practices within them;
- the economics of optometric practices are such that these visiting locations are unprofitable or of marginal profitability;
- optometrists provide services to these communities because of traditional or family ties to the towns; and
- large corporations are unlikely to cross subsidise unprofitable rural practices with profits generated by their city practices in a similar manner to non-corporate optometry businesses.

Specific evidence for this assessment of the impact of the removal of ownership restrictions is not presented.

Discussions with optometrists provided anecdotal evidence that confirmed the overall picture presented by the Optometrists Association. Many rural communities are served by optometrists from regional centres that have a long-standing relationship with those communities. These optometrists stated that the returns from these trips were relatively low and because of the general decline in rural population, becoming lower. This evidence suggests that if such practices were run on a purely commercial basis, there would be a reduction in the level of service provided to some rural communities.

Accepting that this is the case, the impact of a removal of the ownership restrictions is dependent on any changes that will occur in the ownership of optometry practices in rural and regional Queensland. Corporate practices have already established a significant presence in Queensland and their expansion has not been significantly slowed by the existing ownership restrictions. Therefore, if a move towards more corporately run practices was going to have an impact on rural communities, it would be expected that this would have already occurred.

As can be seen from Figures 5.1 and 5.2, corporate optometry practices have spread to the larger towns of regional Queensland, but many of the smaller communities are served primarily by smaller optometry businesses.

The location of corporate optometry practices in regional Queensland would be expected to have already made the provision of optometry services more competitive and affected the ability of non-corporate optometrists in these towns to cross subsidise visits to more remote rural communities. It appears unlikely that a loosening of ownership restrictions under either Option 1 or 2 would have the effect of worsening this situation.

OPSM note in their submission that corporate optometry businesses are likely to be the first to set up in new areas and provide optometry services. The available evidence does not support this claim. A new area would be expected to be typified by a relatively small population and strong population growth. Typically corporate optometry practices are located in major shopping centres where there is a relatively high turnover and large surrounding populations. It would be expected that emerging populations would continue to be initially served by smaller optometry practices under all Options. There is, however, some scope for more innovative forms of service delivery to be developed under Options 1 and 2 (as noted in section 5.5.3) which may influence the level of service delivery in rural communities.

A tightening of the ownership restrictions under either Option 4 or 5 would be expected to slightly reduce the coverage provided by corporate optometry practices. This reduction may reduce competition in some regional centres and result in a slight increase in the ability of rural optometry practices to cross subsidise visits to the more remote areas of Queensland in the longer term. However, there are other factors contributing to the decline in the level of service provided in rural communities notably:

Secular decline in rural service provision will far outweigh any ownership impacts

- a well documented decline in the population associated with changing agricultural techniques and low commodity prices;
- the difficulties associated with attracting young professionals to rural communities; and
- the influence of enhanced transport networks which has led to the increased concentration of services in regional centres.

Any diminishing service in rural areas will be dominated by other factors

These factors are likely to far outweigh any long term effects associated with changes to the ownership provisions. There may be a continued decline in the level of service provided to remote communities under all scenarios, particularly to the aged, who are less able to take advantage of improvements in the transport networks. The preferred approach to this potential problem would be to examine ways of allowing remote communities to be serviced by optometrists without requiring the optometrists to cross subsidise the service.

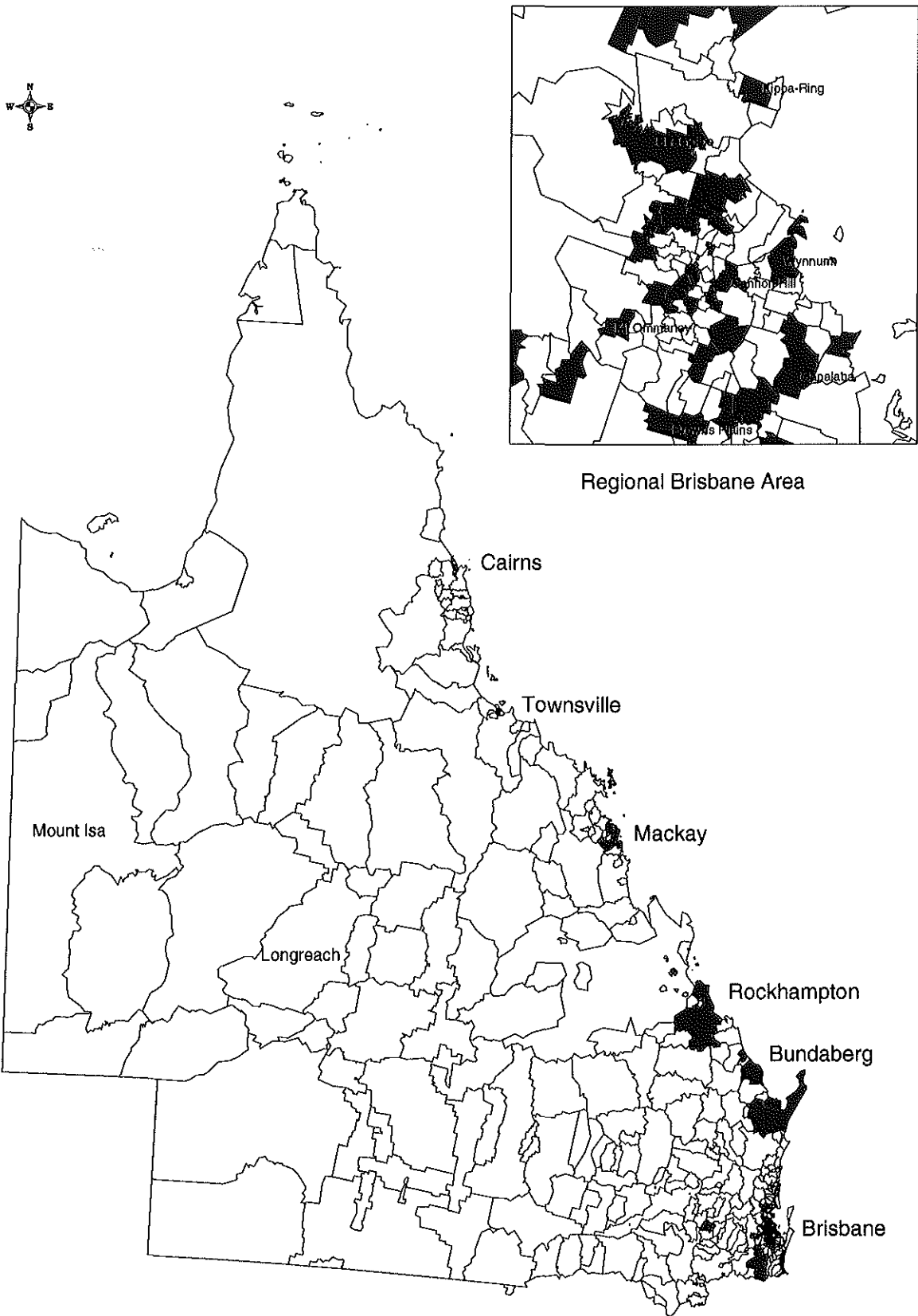
Section 129A of the *Health Insurance Act 1973* (Cth) already provides for special arrangements to be made with participating optometrists for the purpose of ensuring that adequate optometrical services are available to people living in isolated areas. The current arrangements are set out in a Ministerial Guideline³⁶ and provide for payment of travel and other associated expenses to optometrists that deliver service to remote areas. Under these arrangements, it should be possible for rural and regional communities to have access to adequate optometry services under all scenarios.

Table 5.7 summarises the impact of the various Options on the provision of optometry services in rural and regional Queensland.

Table 5.7: Regional and Rural Effects, Impact of Options

	Option 3: Base	Option 1: No Restriction	Option 2: Statutory Offence	Option 4: Controlling Interest	Option 5: 100% control
Regional Impacts	Secular trends in rural areas may see a decline in service provision.	Same as Base but some scope for innovations in service delivery.	Same as Base but some scope for innovations in service delivery.	Same as Base.	Same as Base.

³⁶ *Visiting Optometrists, Guidelines for Assessing and Paying Applications for Assistance Under Section 129A of the Health Insurance Act 1973.*



LEGEND

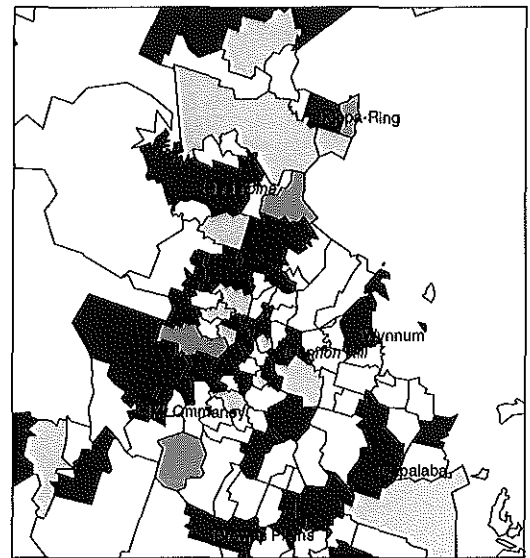
■ Corporate Business Locations

Source: Postcode boundaries have been obtained from the 1996 Auslig Postcode layer.

SKM ECONOMICS

"Corporate" Business Locations by Postcode

Figure 5.1



Regional Brisbane Area



Optometrist Density

- 6 or more
- 4 to 6
- 2 to 4
- 1 to 2
- 0

Source: Postcode boundaries have been obtained from the 1996 Auslig Postcode layer.

SKM ECONOMICS

Density of Optometrists by Postcode

Figure 5.2

5.6 Impacts on Service Providers

5.6.1 Compliance Costs

Compliance costs are costs incurred by the service providers in complying with the legislation. As with administration costs (see section 5.7), most of the time input by providers in relation to compliance would be related to practice rather than ownership provisions.

The requirement for nominee structures to be put in place under the Base Case (Option 3) has meant corporate operators incur compliance costs. For example, one major operator estimates the business costs associated with compliance for their company are of the following order:

- \$100,000 for initial set up costs (legal and administration charges); and
- \$20,000 for annual operating costs (separate phone line, stationery, annual returns etc).

These cost estimates can be used to calculate the ongoing cost of compliance for this company. The initial set up costs are not included in this assessment of the ongoing cost of the restrictions, as they are sunk costs of the current system and cannot be recouped. The operating costs saving are, however, included and over a twenty year period at a 6% discount rate, would be of the order of \$230,000 in present value (PV)³⁷ terms for this single firm.

Compliance cost savings of approximately \$½ million are estimated for Options 1 and 2

The evidence presented in Table 3.2 suggests that there at least two other companies operating in Queensland which have a similar operational profile and make use of nominee company structures. Given the relative size of the companies involved, it has been conservatively estimated that the industry wide operating cost savings associated with removing the ownership restrictions would be in the order of \$500,000 (PV).

Under the more restrictive Options (4 and 5), it is expected that optical dispensers that wish to maintain a direct link with a practising optometrist will choose to enter into a commercial arrangement whereby the optometrist is located within the boundaries of their store but remains self employed. This is the operational model that existed in Queensland prior to the use of nominee structures. It is likely that such operational structures would constantly be under review by the Optometry Board. Those companies and individuals that entered into such partnerships would pay additional compliance costs.

³⁷ The present day worth of a future payment that is calculated by taking into account the diminishing value of money over time.

Therefore under Options 4 and 5, there are likely to be increases in compliance activity required due to the effective tightening of requirements, and an associated increase in the compliance burden for service providers.

Some optometry business in Queensland would also be likely to incur a one off cost under both Options 4 and 5 associated with restructuring their businesses to conform with these ownership restrictions. The extent of these one off costs is not known but they are likely to include items such as:

- legal fees;
- accounting fees;
- time spent negotiating with employees and potential partners; and
- other administration expenses such as stationery etc.

For the Options under consideration, the compliance costs can therefore be expected to change as shown in table 5.8.

Table 5.8: Compliance Costs, Impact of Options

	Option 3: Base	Option 1: No Restriction	Option 2: Statutory Offence	Option 4: Controlling Interest	Option 5: 100% control
Compliance Costs	Some businesses incur compliance costs to conform with the current legislation. These costs amount to approximately \$1/2 million (PV).	Avoided costs of approximately \$1/2 million (PV).	Avoided costs of approximately \$1/2 million (PV).	Increased compliance costs for service providers. One off cost of restructuring some businesses to ensure that they conform with this ownership restriction.	Increased compliance costs for service providers. One off cost of restructuring some businesses to ensure that they conform with this ownership restriction (same as Option 4).

5.6.2 Small Business Impacts

The Optometrists Association submission states that:

'Lay ownership will promote monopolisation of optometry businesses and a subsequent reduction in the number of small businesses that are involved in the provision of optometry services'³⁸.

Evidence presented by the Optometrists Association supporting this assertion was derived from the experience in the United Kingdom, where a frame manufacturer has purchased the largest chain of optometry practices; and from the United States, where a frame manufacturer purchased the largest US chain to guarantee outlets for its frames.

³⁸ Optometrists Association of Australia, Queensland Division, April 1999, Submission to the Review of Business Ownership Under the Optometrists Act 1974, p14.

Australia already has a number of major optical appliance manufacturers in the optometry industry, most notably OPSM, which has 254 stores Australia-wide, employing an average of 5 people per store. To date, however, there has been no evidence that large firms have monopolised the optometry industry in any of the States / Territories that do not have strong ownership restrictions. As individual optometrists can establish an optometry business relatively easily, it is very unlikely that the industry will encounter such monopolistic practices in the future.

In analysing this issue, reference has been made to the ownership profile of optometry practices in the different States and Territories of Australia, as presented in Table 3.5. This data could be interpreted as suggesting that variations in ownership restrictions across the States / Territories may be an influence on the proportion of businesses that are run as either sole proprietorships or partnerships. As stated in Chapter 3, however, this data is not conclusive and there are clearly other influences on the operational profile of optometry businesses in the various State / Territories.

Discussions with optometrists have also suggested that there are factors more important than the ownership restrictions that influence the way in which optometry practices are operating.

Firstly, there is a trend in the Australian retail sector away from strip shopping to large shopping malls. Independent optometrists are finding it increasingly difficult to operate in these malls because the shopping mall owners require that tenants are significant advertisers and are able to exert financial pressure on businesses that do not fit the preferred profile of operation. As a consequence, chain style optometry practices, with close links to optical dispensing firms, are becoming a more common form of practice.

Secondly, women now have a strong presence in the profession (around 40% of registered optometrists in Queensland are female) and there is an increasing demand for more flexible working arrangements than are offered by a traditional practice. Whereas in the past most optometrists expected, and wanted, to own their own practice, an increasing proportion are choosing to become employees.

Given the ease with which the ownership restrictions have been circumvented in Queensland, there is little evidence that the growth of corporate optometry practices has been slowed by the current legislative restrictions. Therefore, it is unlikely that removal would result in a significant change in the operating profile of optometry businesses in Queensland. It is possible, however, that the move towards more corporate involvement in the provision of optometry services will speed up slightly if the restrictions are removed as per Options 1 and 2, particularly if small businesses choose to enter the industry via use of a corporate structure.

A tightening of the ownership restrictions, as per Options 4 and 5, would have a greater impact on the number of small businesses involved in the provision of optometry services. Under these Options there would be a shift towards more small businesses because some existing employees would be forced to set up their own businesses.

- Under Option 5, it may not be possible for companies to use the nominee structure described in Figure 4.1 and optical appliance stores would have to come to an arrangement with individual optometrists or groups of optometrists.
- Under Option 4 there would be scope for corporations to maintain an interest in a company that employs optometrists but expansion of this company would require continued capital investment from optometrists. This requirement is expected to preclude the development of a company that could operate in a similar way to the present nominee type model. The likely scenario is a very similar operating environment to that which would exist under Option 5.

Table 5.9 summarises the small business impacts of the various Options.

Table 5.9: Small Business Impacts, Impact of Options

	Option 3: Base	Option 1: No Restriction	Option 2: Statutory Offence	Option 4: Controlling Interest	Option 5: 100% control
Small business impacts	Majority of businesses are expected to remain as traditional small businesses but the gradual shift to more corporate ownership is expected to continue.	Same as Base.	Same as Base.	Shift away from corporate ownership due to restrictions on certain business structures.	Shift away from corporate ownership due to prohibition of certain business structures.

5.6.3 Employment Impacts

Under Options 1 and 2, impacts on employment, relative to the Base Case, will be a balance of potential positive and negative impacts.

There are many more significant factors than the single issue of optometry business ownership that will impact on the level of employment. These include overall economic growth in the economy and secular trends which are seeing the decline of service provision in rural areas.

An assessment of employment impacts relative to ownership restrictions is difficult to assess. To undertake the qualitative assessment, the employment impacts have been linked to the feedback from stakeholders on how they see the growth of the industry under each Option. This is therefore linked to the industry concentration impact (analysed under the Small Business Impacts in Section 5.6.2).

Overall employment impacts cannot be definitively predicted

The shift to more corporate ownership under Options 1 and 2, could increase employment if the overall level of supply is increased, but against this would be the influence of increased access to economies of scale, which could imply less employment per unit of output. The overall impact in terms of the number of people employed in the industry is expected to be neutral.

These two countervailing influences would be expected to operate in the opposite directions under Options 4 and 5. Therefore, it is not expected, as is implied in a number of the submissions, that there would be a significant reduction in the level of employment under these more restrictive ownership models.

As noted in Section 5.6.1, it is unlikely that under either Option 4 or Option 5 optical dispensing firms would cease to operate in Queensland. Rather, it is expected that these firms would revert to the operational structure whereby independent optometrists would operate within optical dispensing stores.

The compliance costs associated with this operational structure are expected to be higher than those of the current operational structure and could make a small number of stores financially unviable. While these stores would close under this scenario, the overall demand for optometry services is not expected to diminish and the impact in terms of total employment is expected to be neutral.

Options 4 and 5 would, however, have a significant impact on the 20% to 25% of optometrists that are currently employed by companies that use corporate nominee structures. Under Options 4 and 5, the nominee arrangements would no longer be allowed, and it is probable that there would be some dislocation amongst optometrists employed by such firms.

Some affected optometrist employees may be able to remain in employed positions within optical dispensing stores/businesses, however they would be obliged to renegotiate their terms and conditions of employment, possibly through contracting-out arrangements with another (optometrist owned) business structure.

Other former employee optometrists may obtain employment through setting up their own business or with an optometrist-owned optometry store. These optometrists are unlikely to be able to obtain the same flexibility of employment conditions that they presently enjoy (eg part time/salaried arrangements), as these conditions are more commonly available within corporate businesses than within more traditional practices.

Non-optometrist staff in the industry would not be as seriously affected by the change in ownership restrictions. Only those employed in stores that actually ceased trading would be required to find new employment. In the long term those workers that were displaced would be expected to be able to find jobs elsewhere in the industry because the total demand for optometry services is expected to remain unchanged.

Overall, Options 4 and 5 are expected to result in a level of dislocation and stress to some optometrists currently employed by firms that use corporate nominee structures. There may also be a long term reduction in the flexibility of employment options available to optometrists. Options 1 and 2 are not expected to have any significant impact on employment in the industry. They may, however, result in a slight increase in the variety and flexibility of positions available to optometrists as a result of increased corporate involvement in the industry over time.

Table 5.10: Employment, Impact of Options

	Option 3: Base	Option 1: No Restriction	Option 2: Statutory Offence	Option 4: Controlling Interest	Option 5: 100% control
Employment Impacts	There are currently approximately 1,600 people employed in Queensland's optometry industry.	Slight increased flexibility of employment options for optometrists. No net change in employment levels expected.	Slight increased flexibility of employment options for optometrists. No net change in employment levels expected (same as Option 1).	Long term reduction in employment flexibility for optometrists. Some dislocation of some existing employee optometrists. No long term change in employment levels expected.	Long term reduction in employment flexibility for optometrists. Some dislocation of some existing employee optometrists. No long term change in employment levels expected. (same as Option 4).

5.7 Impacts on Government/Regulators

The current costs of administering the ownership provisions of the *Optometrists Act 1974* are the relevant costs incurred by:

- The Optometrists Board of Queensland;
- The Queensland Government (NCP review costs).

Most of the costs incurred by the Optometrists Board are incurred in relation to clinical practice not ownership issues

Most of the costs incurred by the Optometrists Board are incurred in relation to clinical practice, rather than in relation to the ownership provisions of the legislation.

- At a broad level, some of the Optometrists Board's administration costs would be avoided under Option 1. However, they may not reduce to zero as it is likely that the Board's historical role in dealing with ownership related complaints would make it the initial contact point for ownership related issues in the future.

- Under Option 2, any reduction in costs may be offset by the extra costs of statutory offence investigation and enforcement.
- Under Option 4, administration costs are expected to be higher than the Base Case, as additional resources will be required to investigate ownership complaints and enforce restrictions. They are also expected to be marginally higher than Option 5 due to the potential complexities associated with assessing corporate ownership structures.
- Under Option 5, administration costs are expected to be marginally higher than the Base Case, as additional resources will be required to investigate complaints about ownership and enforce the relevant restrictions.

In addition, ongoing NCP review costs would be required under the Base Case and Options 4 and 5. The Competition Principles Agreement requires a further review within 10 years of any anti-competitive legislation provisions retained after a NCP review is conducted. These costs would be avoided under Options 1 and 2.

The tightening of restrictions under Options 4 and 5 is expected to result in an increase in the costs incurred by a number of businesses that are currently operating in Queensland and other jurisdictions (see section 5.6.1). These Options also raise issues of jurisdictional inconsistency and the potential for the affected parties to attempt to gain compensation. The avoidance of any such potential costs is therefore a benefit attributable to Options 1, 2 and the Base Case.

Overall the administration costs can be expected to vary across the Options as shown in Table 5.11.

Table 5.11: Administration Costs, Impact of Options

	Option 3: Base	Option 1: No Restriction	Option 2: Statutory Offence	Option 4: Controlling Interest	Option 5: 100% control
Administration Costs	Existing costs plus ongoing NCP review costs.	Lower than Base, and no NCP review costs.	Little change and no NCP review costs.	Higher than Base, due to higher enforcement costs associated with assessing legally complex ownership structures. On going NCP review costs and potential for compensation claims by adversely affected businesses.	Higher than Base, due to higher enforcement costs associated with assessing legally complex ownership structures (possibly lower than Option 4). On going NCP review costs and potential for compensation claims by adversely affected businesses.

5.8 Impact Matrix - Summary

The impacts analysed are summarised in Table 5.12.

Table 5.12: Impact Matrix

Objective / Impact Group	Impact	Base Case: - Option 3 Existing Situation	Option 1: No Restrictions	Option 2 : No Restrictions with Statutory Offence for Undue Influence	Option 4: Controlling Interest	Option 5: 100% Ownership and Control
Impacts on Consumers Safe Health Care	Quality of eye care	Current situation is seen to give a satisfactory level of eye care despite the lack on any effective ownership restrictions.	No demonstrated evidence that impact is significant where deregulation exists (same quality of eyecare as Base)	Minimises potential low risk of Base and Option 1 by providing a mechanism for prosecuting owners unduly who influence clinical practice. Potential marginal improvement in quality of eye care over Base.	Alleviates potential low risk of Base and Option 1 through the Optometrists Board's capacity to act against owners of optometry practices. Potential marginal improvement in quality of eye care over Base. (same as Option 2)	Alleviates potential low risk of Base and Option 1 through the Optometrists Board's capacity to act against owners of optometry practices. Potential marginal improvement in quality of eye care over Base. (same as Option 2)
Cost of Service / appliances	Access to economies of scale	Some economies of scale are currently being realised by large and small operators in Queensland.	Some potential for increased access to economies of scale.	Some potential for increased access to economies of scale (same as Option 1).	A reduction in access to economies of scale.	A reduction in access to economies of scale (same as Option 4).
	Price of service / appliances	Consulting prices set under Medicare, competitive provision of appliances.	Possibly marginally lower prices than Base.	Possibly marginally lower prices than Base (same as Option 1).	Marginally higher prices than Base due to higher compliance costs and reduced access to economies of scale.	Marginally higher prices than Base due to higher compliance costs and reduced access to economies of scale (same as Option 4).
	Consumer Choice	Current choice generally seen as acceptable.	Potential for more innovative forms of service delivery to be developed.	Potential for more innovative forms of service delivery to be developed (same as Option 1).	Possible reduction in non- price choice factors due to restrictions in ownership structures.	Possible reduction in non- price choice factors due to restrictions in ownership structures (same as Option 4).
	One stop shopping	Currently no barriers to existence.	No change – continued access to one stop shopping.	No change – continued access to one stop shopping.	No change – continued access to one stop shopping.	No change – continued access to one stop shopping.
Regional / Rural areas	Service provision	Secular trends in rural areas may see a decline in service provision.	Same as Base but some scope for the development of new forms of service delivery.	Same as Base but some scope for the development of new forms of service delivery.	Same as Base.	Same as Base.
Impacts on Service Providers Cost of Service	Compliance costs	Some businesses incur compliance costs to conform with the current legislation. These costs amount to approximately \$1/2 million (PV).	Avoided costs of approximately \$1/2 million (PV).	Avoided costs of approximately \$1/2 million (PV).	Increased compliance costs for service providers and a one off cost of restructuring some businesses to ensure that they conform with ownership restrictions.	Increased compliance costs for service providers and a one off cost of restructuring some businesses to ensure that they conform with ownership restrictions (same as Option 4).
Small Business Impacts	Industry concentration	Majority of business are expected to remain as traditional small businesses but the gradual shift to more corporate ownership is expected to continue.	Same as Base.	Same as Base.	Shift away from corporate ownership due to restrictions on certain business structures.	Shift away from corporate ownership due to prohibition of certain business structures (possibly higher than Option 4).
Employment Impacts	Employment levels and conditions	There are currently approximately 1,600 people employed in Queensland's optometry industry.	Slight increase in the flexibility of employment options for optometrists. No net change in employment levels expected.	Slight increase in flexibility of employment options for optometrists. No net change in employment levels expected (same as Option 1).	Long term reduction in employment flexibility. Dislocation of some existing employee optometrists. No long term change in employment levels expected.	Long term reduction in employment flexibility. Dislocation of some existing employee optometrists (same as Option 4). No long term change in employment levels expected.
Impact on Regulators Cost of Regulation	Administration costs	Existing costs, plus ongoing NCP review costs.	Lower than Base, and no NCP review costs.	Little change and no NCP review costs.	Higher than Base, due to higher enforcement costs associated with assessing legally complex ownership structures. On going NCP review costs and potential for compensation claims by adversely affected businesses.	Higher than Base, due to higher enforcement costs associated with assessing legally complex ownership structures (possibly lower than Option 4). On going NCP review costs and potential for compensation claims by adversely affected businesses.

6. Conclusions

Key results of the Public Benefit Test are summarised

6.1 Key Results

The key results of the Public Benefit Test assessment of ownership restrictions contained in the Queensland *Optometrists Act 1974* are now summarised.

Impacts on Consumers

- Stakeholders consulted in the review agree that the level of eye care currently being delivered in Queensland is at the required standard. Very few complaints (fewer than 10-per year) are made about optometrists to the HRC.
- There is some evidence that there is a marginal difference between the way in which optometrists undertake their consultations in a corporate environment, compared to an owner-operator practice, but there is no evidence that this has an impact on eye health care.
- Under the 'no ownership restrictions' Options (1 and 2), no adverse effects on the quality of health care is expected relative to the Base Case. No adverse impacts have been reported in jurisdictions where ownership restrictions have been lifted.
- Secular changes in rural and regional areas are likely to dwarf the impacts of changes in ownership restrictions on the quality of optometry services provided to these communities across all the Options.
- No major change in the price of optometry services is expected under any of the options, although marginally higher prices are expected under Options 4 and 5. Medicare establishes benchmark prices for optometry consultations, and there is already a competitive market for optical appliances. In the long term, however, a marginal reduction in the underlying costs associated with running an optometry practice is expected under Options 1 and 2. This reduction in underlying costs may help reduce any increase in consultation costs in the future and may also flow on to reduce the cost of optical appliances.
- Under Options 1 and 2 it is expected that a slight increase in access to economies of scale in the industry, may also work to reduce the price to consumers of optometrical goods and services under these Options.
- Options 4 and 5 could lead to a restriction of consumer choice. This would result from reduced corporate participation in the market, lessening access to non-price choice benefits currently enjoyed by consumers, such as access to national networks and the ability to exchange optical appliances at different geographic locations.

Impacts on Service Providers

- Despite the existing ownership restrictions, commercial incentives currently apply to all service providers. This is due to the reliance on the retail side of business for a significant proportion of total income generated by a typical optometry practice.
- Small businesses dominate the industry at present and this is expected to remain if ownership restrictions are removed.
- The existing ownership restrictions are, in fact, circumvented by corporate arrangements whereby optometrists act as the nominees of non-optometrist owners. Thus the current situation could be described as a "defacto" or constrained form of ownership deregulation.
- Under Options 1 and 2 there are more significant impacts on service providers than on consumers. These include the trade-off between higher profits through scale economies and avoided operational costs achieved by corporate groups, as compared to sole operators.
- No net change in terms of total employment in the industry is expected under any of the Options.
- Options 4 and 5 are expected to result in some dislocation of the 20% - 25% of the optometry workforce who are presently employed under arrangements that would no longer be legal. This dislocation is likely to be disruptive and stressful to some members of the profession.
- Options 4 and 5 are expected to result in a slight decrease in the flexibility of work conditions in the industry in the longer term. For example, there could be a decrease in the number of part time positions available.

Impact on Administrators / Regulators

- Ownership restrictions represent a small share of the administrative burden of the legislation.
- Removal of ownership restrictions may see some reduction in administration, but little overall change is expected if administrative and monitoring processes rely more on supporting legislation (eg the statutory offence clause under Option 2).
- Under the more restrictive Options (4 and 5), there may be an increase in the cost of administering the ownership restrictions and some potential for compensatory issues associated with restricting or eliminating existing companies, which can operate in other jurisdictions. These costs would appear to exceed the potential benefits of these Options that are marginal at best.

6.2 Summary and Conclusions

The Public Benefit Test guidelines require that the results for the Options be judged against the following criteria:

- the objectives of the legislation – that is, protection of public health and provision of safe, competent and up-to-date health care;
- the overall net benefit of each Option (Clause 5(1)(a) of the Competition Principles Agreement); and
- the objectives of the legislation can only be achieved by restricting competition (Clause 5(1)(b) of the Competition Principles Agreement).

Table E.1 summarises the overall net benefit of each Option. The conclusions thereafter provide a summary of the results of this Public Benefit Test in the context of these criteria.

Table E.1: Net benefit – Summary by Option

Option	Net Benefit	Ranking*
1: No Restriction	Some avoided costs Some competition benefits Slight increase in the flexibility of employment options in the industry Same quality of eyecare as base Positive net benefit (lower than Option 2)	2
2- Statutory Offence	Some avoided costs (less avoided costs than Option 1) Some competition benefits Slight increase in the flexibility of employment options in the industry Potential marginal improvement in quality of health care Positive net benefit (higher than Option 1)	1 (Highest)
3 - Existing (Base)	Base – for comparison purposes	3
4 – Controlling Interest	Higher costs than Base Some dislocation of existing workforce Long term decrease in the flexibility of employment options in the industry Potential marginal improvement in quality of health care No net benefit	4
5 – 100% Ownership/Control	Higher costs than Base Some dislocation of existing workforce Long term decrease in the flexibility of employment options in the industry Potential marginal improvement in quality of health care No net benefit	4

*Rankings reflect each Option's ability to meet the review criteria, Option 2 best meets these criteria.

Option 2 – No ownership restrictions, with a statutory offence clause is the preferred Option under the Public Benefit Test.

In explanation the following conclusions are made:

- Under Option 1 (no ownership restrictions) a minor potential health risk is identified that undue pressure could be applied by an owner on the clinical practice of an optometrist. This minor risk also exists under the Base Case. This risk can be effectively mitigated, by implementation of supporting statutory offence legislation (Option 2) or a tightening of the ownership restrictions (Options 4 and 5).
- Option 2 (statutory offence model) prohibits optometry owners from exerting undue commercial pressure on employee optometrists, and is expected to provide the same quality of health care as would be expected under either Options 4 or 5, and a marginal improvement over the Base Case and Option 1.
- Options 1 and 2 are expected to lead to marginal cost savings and some competition benefits compared to the Base Case. The cost savings under Option 2 will be slightly lower than Option 1, due to the additional costs of administering the statutory offence legislation.
- The slightly lower costs of Option 1, compared to Option 2 are not expected to be large enough to offset the potential additional health risk of Option 1. Option 2 will therefore be expected to result in higher net benefit than Option 1 (and the Base Case).
- The tightening of ownership restrictions (Options 4 and 5) are expected to have higher administration and compliance costs than the Base Case and some negative impacts on employment conditions in the industry.
- Removal of ownership restrictions, under Options 1 or 2, is expected to create marginal net benefits compared to the existing situation, with Option 2 expected to provide marginally higher benefits than Option 1. In accordance with Clause 5 (1)(b) of the Competition Principles Agreement, the objectives of the legislation can be achieved under Option 2, without a restriction on ownership being in place.
- Overall, Option 2 (No Ownership Restrictions with a statutory offence clause) is the preferred Option because under this Option:
 - the optometry industry is expected to be able to provide at least the same quality of health care that would be provided under any of the alternative Options and potentially a higher quality of health care than would be provided under the Base Case and Option 1;
 - the net benefits are expected to be higher than the net benefits of the alternative Options; and
 - the objectives of the legislation can be achieved without restricting competition.

Appendix A - Value Management Workshop Participants

Thirteen participants attended the workshop, namely:

- Peter Lenehan, Group General Manager - Optics, OPSM;
- Ann Webber, President, Optometrists Association of Australia (Queensland Division);
- Ron Bowden, Executive Officer, Optometrists Association of Australia (Queensland Division);
- Ian Kent, Chairman, Optometrists Board of Queensland;
- Carolyn Evans, Member, Optometrists Board of Queensland;
- Greg Smith, Managing Director, The Now Group;
- John Gimpel, Operations Manager, Laubman and Pank;
- Karla MacDonald, Queensland Health;
- Angela Handley, Queensland Health;
- Steve Kanowski, SKM Economics;
- Barry Nicholls, SKM Economics;
- Tom Frost, SKM Economics; and
- Dr Jan Lovie - Kitchin, Associate Professor, School of Optometry, Queensland University of Technology was also in attendance to provide independent assessment of any health and safety issues that were brought up during the discussion process.

Appendix B - Major Information Sources

1. Australian Bureau of Statistics
2. Commissioner for Health Complaints - Australian Capital Territory
3. Department of Health - New South Wales
4. Department of Health - Victoria
5. Department of Health and Aged Care - Tasmania
6. Department of Health and Community Services - Australian Capital Territory
7. Department of Human Services - South Australia
8. Health Care Complaints Commission - New South Wales
9. Health Rights Commission - Queensland
10. Health Services Commission - Victoria
11. Laubman and Pank
12. Office of Health Review - Western Australia
13. Ombudsman Office - Tasmania
14. OPSM
15. Optometrists Association of the Australian Capital Territory
16. Optometrists Association of Australia (Queensland Division)
17. Optometrists Association of Western Australia
18. Optometrists Board of Queensland
19. Optometrists Board of the Northern Territory
20. Optometrists Board of Victoria
21. Queensland Health
22. The Now Group
23. Health Insurance Commission
24. Office of Rural Communities

Appendix C - Definition of Optometry Terms

REFRACTION is a basic eye test to assess the power and degree of the required spectacle correction. Measurements are taken for both far and near vision. Combinations of computer and manual techniques can be used.

BINOCULAR VISION tests analyse the ability of the eyes to coordinate the separate images seen by each eye into a single image.

SLIT LAMP BIOMICROSCOPY is a diagnostic procedure for comprehensive evaluation of the front of the eye.

OPHTHALMOSCOPY - examination of the retina or the area inside the eyes.

TONOMETRY - a measurement of the pressure inside the eyes.

Appendix D - Business Register Classifications

Proprietary Limited:

A Proprietary Limited company is one that is not allowed to invite the public to subscribe for shares. The company ending is 'PTY LTD'.

Sole Proprietor:

This classification is used when individuals set up and carry on business without the need to notify corporate registration authorities. Even where registration for business purposes is required by other government authorities, the strict Legal Entity under the common law is still the individual - the business having no separate legal recognition.

For this reason an individual proprietorship covers all of the business interests of the owner or proprietor, irrespective of how many different businesses are carried on by that single individual.

Family Partnership:

A Family Partnership is the relationship which exists between family members carrying on business in common with a view to profit. The persons who have entered into partnership with one another are sometimes called collectively a firm, but the firm name, as such, is only a short way of expressing the names of all the partners. Although the partners may sue and be sued in the firm name, this sort of firm has no legal existence separate from its individual family members.

Other Partnership:

This classification is used for all other partnerships that exist between persons who are not members of the same family. It should also be noted that partnerships could exist between unincorporated and/or incorporated entities.

Trust: A Trust is an obligation binding a trustee to manage assets on behalf of beneficiaries. Generally a trust is as an Enterprise Group with the trust as a Principal Legal Entity of the Management Unit and the trustee as a Non-Principal Legal Entity of that Management Unit. The major types of trusts are:

FAMILY TRUST - Where beneficiaries of the trust fund are members of the same family.

UNIT TRUST - The entitlement of the unit holders (beneficiaries) to participate in the benefits of the trust (income distribution) is proportional to the number of units held. This trust is very similar to the holding of shares by shareholders in a company.

DISCRETIONARY TRUST - The trustee has the discretion to determine from all beneficiaries, which beneficiaries should receive a particular benefit. For example, 'the wife and present and future children of John Citizen'.

SERVICE TRUST - Service trust operations are established for the supply of office equipment, personnel etc. The actual trust operation could be either a unit trust or an ordinary trust and could have either discretionary or fixed activities specified by the trust deed.

MOTHER TRUST - This term is applied to the 'head' trust when more than one trust is used in a structured business operation. In such an operation there is a 'head' trust, then several subsidiary trusts which are either the beneficiaries or unit holders of the 'head' trust. Separate trustees are required for the 'head' trust and the subsidiary trusts. The trustees may either be a sole proprietor or a company.

Other Registered Organisation:

This classification is used for any other registered companies that cannot be classified.