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POLICY PAPER

Competition in Primary Healthcare in Ireland: More and Better Services for Less Money

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Abstract: Understanding precisely the nature of competition in primary healthcare has an important role to play in understanding how to improve the delivery of healthcare services. This is particularly the case in Ireland, where the private sector plays such a large role in primary care. If we do not understand competition, well-intentioned regulations and policies are less likely to be effective and more likely to result in excessive costs and under-utilisation of primary healthcare. This in turn can increase Ireland's overall health expenditure and contribute to a higher cost of living in Ireland and thus lower competitiveness. This paper shows how well-designed regulations and systems for State funding of primary healthcare can ensure that competition works well and contributes to the better availability and quality of services at the lowest possible cost. The most common barriers to entry and expansion in primary healthcare markets are outlined and price-setting mechanisms examined. Examples are used to illustrate the benefits to consumers and the State where these obstacles to competition have been removed, and the difficulties where they remain. Conclusions are drawn on the implications of this analysis for the governance of regulatory bodies, for regulatory Codes of Conduct, and for achieving value for money. It is time for the culture of the healthcare professions to move towards one where it is no longer considered "unprofessional" to provide a competitive service.

I INTRODUCTION

Over the past decade the Competition Authority has examined competition across a range of primary healthcare services – with particular focus on general medical practitioner ("GP"), pharmacy, dental and optometry (eye

* The views expressed in this paper are those of the author and should not be attributed to the Competition Authority except where expressly referenced. Thanks to colleagues in the Competition Authority for helpful comments on earlier drafts.

care) services.[1] This paper summarises the common themes and learning gained from that work,[2] and the key implications for the delivery of affordable, high quality primary healthcare services in Ireland.

Understanding precisely the nature of competition in primary healthcare has an important role to play in understanding how to improve the delivery of healthcare services. This is particularly the case in Ireland where the private sector plays such a large role in primary care. If we do not understand competition, well-intentioned regulations and policies are less likely to be effective and can even be harmful. Regulations and administrative decisions about State funding of services can go too far in their attempts to protect consumers and end up depriving consumers of the benefits of ethical competition between suitably qualified providers – lower prices and better availability and quality of services.

If competition is unnecessarily restricted, consumers and the State face higher costs and less availability of primary healthcare services. This can lead to under-utilisation of primary healthcare and this increases overall health expenditure (most likely due to lower prevention rates and greater use of secondary care). Excessive costs in primary care also contribute to a higher cost of living in Ireland, and push up wage demands – making Ireland less competitive.

This paper shows how well-designed regulations and systems for State funding of primary healthcare can ensure that competition works well and contributes to the better availability and quality of services at the lowest possible cost. First, the relationship between competition and regulation in Ireland is set out. Second, the obstacles to competition identified by the Competition Authority as harmful to consumers and the State are outlined. Finally, conclusions are drawn on the implications of this analysis for regulatory structures and rules, and value for money for consumers and the State.

[1] There are four eye-care professions in Ireland – optometrists, dispensing opticians, orthoptists and ophthalmologists. The main functions of the eye-care professionals are as follows: optometrists carry out eye examinations and dispense spectacles and contact lenses; dispensing opticians dispense spectacles and contact lenses as prescribed by optometrists or, less frequently, ophthalmologists; orthoptists are involved in the assessment, diagnosis and management of disorders of the eyes, extra ocular muscles and vision; and ophthalmologists are medical practitioners who treat diseases and conditions of the eye. This paper concentrates on the services offered to consumers by optometrists and dispensing opticians. Many consumers refer to these two professions collectively as opticians.

[2] The Competition Authority's views and analysis are available from the Authority's website www.tca.ie

II WHAT DOES COMPETITION HAVE TO DO WITH PRIMARY HEALTHCARE?

In Ireland, anyone in need of a tooth filling, an eye test, medicines, or the advice of a GP, for the most part obtains these services from a private business.[3] Some businesses are sole traders, some are partnerships among qualified professionals, some are corporate entities – but they each charge private fees to private clients. As with all businesses, primary healthcare providers compete for customers.

Even where the State is paying for the service on the customer's behalf, it is largely the patient who decides which healthcare provider to attend and the money follows the patient. Thus providers also compete for "public" patients. The Irish State operates three main schemes whereby, generally, certain goods or services are provided free or at a reduced rate to the patient and the supplier is reimbursed (the balance) by the State:[4]

(i) Medical card scheme: persons with incomes below a certain threshold receive GP care, prescription medicines, eye tests and a limited range of eyeglasses and dental services entirely free of charge.
(ii) Pay Related Social Insurance (PRSI) scheme: persons who have paid a certain level of social insurance payments over a number of years are entitled to subsidised eye tests and dental services.[5]
(iii) Drugs Payment Scheme (DPS): all residents of the State who do not have a medical card have their monthly expenditure on prescription medicines capped at €120.

Each business (the pharmacy, opticians' practice, GP or dentist) must have a relevant contract with the State to participate in each scheme.[6] The Irish system whereby some residents pay the full cost of GP care and medicines and others pay nothing, is unusual in Western Europe – where primary care is generally free or subsidised at a greater level for all residents. Also, some other European countries have ownership restrictions – such as restrictions on who may own pharmacies and the number of pharmacies they may own (Indecon, 2003a, Chapter 4).

[3] Some primary care services are provided through a very small number of direct employees of the State; for example, children's dental care.
[4] Many other schemes exist which provide free or subsidised goods or services to certain groups of people: e.g. Long Term Illness Scheme, Mother and Baby Scheme, GP Visit Card scheme.
[5] The dental services available under this scheme were drastically curtailed in 2009 following the economic crisis, and currently consist only of one free check-up, scale and polish per year.
[6] For example, a dentist must have a contract with the Health Service Executive to be reimbursed for treating medical card holders and another contract with the Department of Social Protection to be reimbursed for treating PRSI beneficiaries.

Primary care businesses compete through normal business methods, that is: the quality and range of the goods/services they provide, the location and standard of their premises, customer care, the advertising and promotion they undertake to attract customers, and – in the case of private patients – the prices they charge. Of course they do this in a highly-controlled environment (compared to many other non-health services).[7] However, essentially, GPs, pharmacists, opticians and dentists all provide their services in an economic marketplace that remains subject to the laws of supply and demand.

A recent OECD study put the issue well:

> *The issue for policy makers… is not whether markets are good or bad, but whether fostering some aspects of competition and markets in the health sector can lead to more rational use of resources, and which aspects of competition have the greatest potential to get results.* (OECD, 2009.)

If competition is unnecessarily restricted, consumers and the State face higher costs and less availability of primary healthcare services.[8] Healthcare prices in Ireland rose substantially faster than general inflation (the consumer price index) during the "Celtic Tiger" boom years, and even after the recession hit in 2008 (as Figure 1 shows). This was particularly true for dental services.

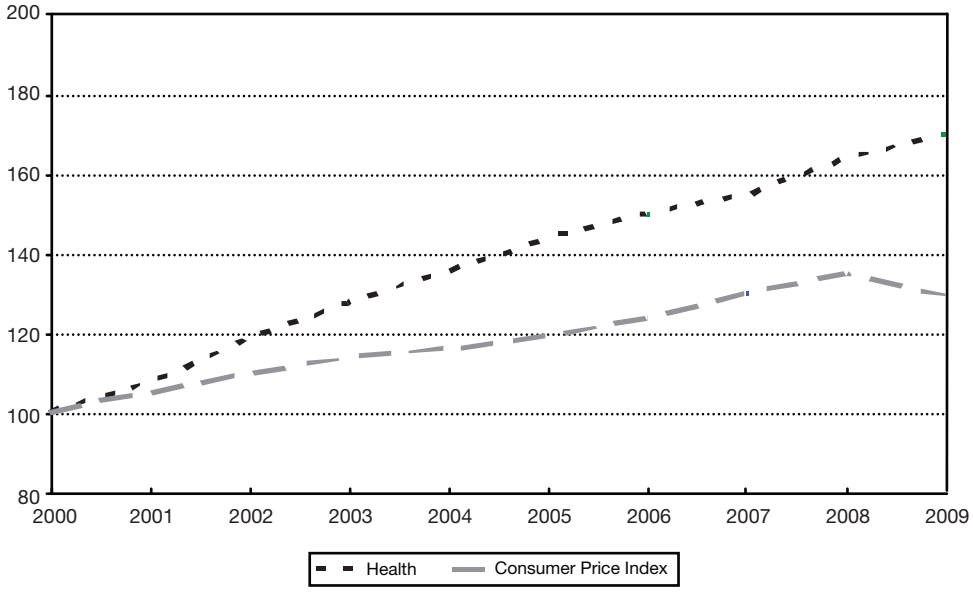
Excessive cost of healthcare services can lead to "under-utilisation" of services by some people. For example, a number of recent studies and surveys suggest that a substantial proportion of private patients in Ireland have put off visiting their GP due to the price, thus potentially letting a health problem become worse (O'Reilly *et al.*, 2006).[9] This in turn is associated with higher overall health expenditure (Brick *et al.*, 2011, p. 89). Excessive costs in primary care also contribute to a higher cost of living in Ireland, and push up wage demands – making Ireland less competitive. It is not only about money. Better understanding of competition, and appropriate regulation of competition in primary healthcare, can also promote better availability of services, better quality services, and innovation, as this paper will show.

[7] GPs and pharmacies could be viewed as less-controlled in Ireland compared to their European counterparts as they have free rein to charge whatever price they wish to private patients and there are no ownership controls.

[8] Studies of the effects of lifting restrictions competition by advertising or from competing professions have shown the beneficial impact on cost. See for example: Benham (1972), Benham *et al.* (1975); Bond *et al.* (1980), Love *et al.* (1996), Rosenstein (1985), and OECD (2004).

[9] O'Reilly *et al.*, (2006) found that 18.9 per cent of patients had a medical problem during the year but did not consult their GP due to cost. A national survey of 100 GPs, carried out by the *Irish Medical Times*, reported that 63 per cent of respondents believed that patients are delaying visits to their GP due to financial constraints – *Irish Examiner,* 2 March 2009. A similar pattern was reported in a survey carried out by www.rollercoaster.ie in August 2008 on behalf of the HSF Health Plan.

Figure 1: *Health Inflation and the Consumer Price Index, 2000-2009*



Source: Central Statistics Office. Data for 2009 are the average for January-August 2009. All other years are annual averages.

III IRELAND'S REGULATORY MODEL

GP, pharmacy, dental and opticians' services are all heavily regulated and do not operate in "free" markets, for good reasons. First, a typical consumer of healthcare services will not have enough knowledge to evaluate either the quality of the service on offer prior to purchase or the quality of the service they actually receive.[10] If high quality service providers cannot distinguish themselves from low quality service providers, the average quality of service tends to be lower and the average price higher. It is also difficult for consumers to spot rogue (unqualified) service providers. Second, a person's health could suffer substantial, and even life-threatening, damage if they received poor quality healthcare from a GP, pharmacist, dentist or optometrist.

Therefore, to protect consumers, each of these four professions has traditionally been regulated by a dedicated statutory regulator that sets minimum standards of qualifications required to practice medicine, pharmacy,

[10] Economists refer to such goods and services as "credence goods".

dentistry and optometry. This is a common approach in other EU countries. The four regulators are, respectively: the Medical Council, the Pharmaceutical Society of Ireland, the Dental Council and the Opticians' Board.[11] Each regulator keeps a "register" of all those who have obtained the appropriate qualifications for the relevant profession and approves educational institutions' courses and qualifications as sufficient for entry on to the register. In the case of GPs, the Medical Council has approved a number of institutions for the provision of university degrees in medicine, and the Irish College of General Practitioners' four year programme of hospital-based and in-practice training as leading to the specialist qualification of General Practitioner ("MICGP").[12] Dentists are trained in two universities,[13] pharmacists in three universities[14] (with a year of supervised practice also required for qualification), and optometrists in just one school.[15]

Minimum standards of entry to a profession aim to ensure that the professional is capable of providing a high quality service. To avoid situations where capable (suitably qualified) professionals cut corners, or make exaggerated claims about their abilities, or unethically encourage a client to purchase more services than they really need,[16] regulators operate codes of conduct and ethics that the regulated professionals must follow. Pharmacies are subject to additional regulatory standards regarding their premises. Where the State has contracts with primary healthcare providers, to provide free or subsidised services to certain people, these contracts are also used to impose certain quality standards, such as minimum opening hours and appropriate record keeping. Unfortunately, sometimes regulations go far beyond what is needed to protect consumers from harm and, perversely, also cause harm. They can unnecessarily restrict competition between businesses in ways that reduce the availability of services and raise the cost of services to consumers and the State. The administration of State contracts for primary healthcare services also has a huge impact on the availability of services and competition between providers. This impact can have both positive and negative aspects.

[11] The regulators operate under the Medical Practitioners Act 2007, the Pharmacy Act 2007, the Dentists Act 1985, and the Opticians Acts 1956 and 2003.

[12] Technically, any fully qualified doctor can legally set up a practice in general medicine and begin treating patients. However, an increasing number of GP practices are headed by a doctor who has completed specialist GP training, though not all the doctors working in the practice will have done so.

[13] Trinity College Dublin and University College Cork.

[14] Trinity College Dublin, University College Cork and Royal College of Surgeons.

[15] The Dublin Institute of Technology.

[16] This is known as "supplier-induced demand."

IV WHEN DOES REGULATION EXCESSIVELY RESTRICT COMPETITION?

In analysing the four healthcare professions from a competition perspective, the Competition Authority identified three areas where there were obstacles to competition that were impacting negatively on the delivery of healthcare services:

1. Getting in.
2. Getting customers.
3. Price-setting.

The Authority also questioned the membership structure of the regulators in Ireland – who is regulating the profession and putting these obstacles in place? It found that the regulators were wholly or almost entirely composed of members of the profession itself and this created significant potential for conflicts of interests to arise within the regulator.

The rest of this paper outlines the issues in each of these four areas.

4.1 *Getting In*

In Ireland, it is illegal to call yourself a "dentist", "pharmacist", or "optometrist" (optician) unless you are on the relevant regulator's register. These professional titles are "reserved" for those whom the regulator deems to be appropriately qualified.[17] In addition, it is illegal to practise dentistry, medicine or optometry, or to dispense medicines without being on the appropriate register.[18] Thus the number of qualified professionals available to provide services in these highly-regulated markets is largely determined by the courses and qualifications recognised by the relevant regulator for registration.

The Competition Authority identified four kinds of barriers to entering the markets for optometry, dental, pharmacy and GP services:

[17] This type of regulation is called "reservation of title" and is becoming increasingly common in Ireland, especially in the health sector. For example, the Health and Social Care Professionals Act 2005 created legal protection for the titles of "clinical biochemist", "dietician", "medical scientist", "occupational therapist", "orthoptist", "physiotherapist", "podiatrist", "psychologist", "radiographer", "social care worker", "social worker" and "speech and language therapist". The title of "general medical practitioner" is not reserved, however, the Medical Practitioners Act 2007 provides that the Minister for Health and Children may at some stage in the future introduce regulations to reserve the title.

[18] This level of regulation is called "reservation of function" and is a heavier level of regulation than "reservation of title". For example, under the Health and Social Care Professionals Act 2005, only those on the relevant register are entitled to call themselves a "psychologist" but others are entitled to provide services similar to those provided by a psychologist, such as counsellors and psychotherapists.

1. Limited numbers of training places in Ireland;
2. Non-recognition of equivalent training in Ireland;
3. Non-recognition of equivalent foreign qualifications;
4. Non-recognition of related or "para" professions.

In each instance, the barrier reduces the availability of service providers in Ireland and in turn reduces competition. This is in part because primary healthcare services are locally supplied – consumers are generally not willing to travel far to obtain these services.[19] Thus an overall reduction in numbers leads to less competition between professionals at local level. In the case of related professions, however, there is also an outright restriction on competition between related professions.

4.1.1 *Number of Training Places in Ireland*

The largest determinant of the number of dentists, optometrists, pharmacists and GPs in Ireland is the number of education and training places available on recognised courses in Ireland. Increasing the number of places available to study a particular primary healthcare profession in Ireland would increase the number of qualified persons providing these services in Ireland, and thus promote competition. In each of the professions examined, the Competition Authority found that the number of training places had not been increased for a long time – sometimes decades – despite escalating demand.[20] Training of orthodontists had been "stop-start" (Department of Health, 2006). Until recently, Ireland had only one school of pharmacy.

In most cases, the Competition Authority recommended that the number of training places available in Ireland be reviewed. The Authority did not recommend a precise number of places as this decision requires a weighing up of a variety of factors, only one of which is competition and the demand for graduates. Factors that need to be considered include: the cost of the additional training places (which is generally high[21]), the expected future

[19] Though the emergence of the phenomenon of "dental tourism" suggests otherwise – whereby Irish people have travelled to Northern Ireland, Hungary and other countries to obtain dental work at substantially lower prices – this is peculiar to certain high-end services and reflects large differences in the economies of these countries (including their healthcare delivery model) and increased travel to Northern Ireland and Europe generally. Most people will visit a local dentist for most services, for example, when they have a toothache or require a check-up and clean.

[20] Over half of the additions to the Register of Dentists in 2006 were trained outside the State. Competition Authority (2007, p. 19).

[21] According to the Higher Education Authority, dentistry is the most expensive undergraduate course in Ireland, followed by veterinary medicine, engineering and human medicine. Competition Authority (2007, p. 49).

demand, and whether it would be better to apply scarce resources to training another healthcare professional instead. For example, assigning more hospital training posts to GP training means not assigning those posts to another medical specialty.

4.1.2 *Non-recognition of Equivalent Training in Ireland*

As registration by the relevant regulator is key to entering the four primary healthcare markets, it is important that all appropriate routes to achieving legal recognition in Ireland are recognised by the regulator. The Competition Authority found that a particular route to becoming a fully-qualified GP – "self-structured training" – is not recognised by the regulator, even though this route is recognised in all other medical specialties. Self-structured training refers to junior doctors completing a set of six-month posts in recognised training hospitals, in relevant areas of medicine for their chosen speciality, by applying for such posts themselves rather than going through an organised ("structured") training programme.

4.1.2.1 General Practitioners (GPs)

Nowadays, most GPs undergo four years of post-graduate on-the-job supervised training in addition to their university degree and one year hospital internship.

- The first two years of this training is undertaken by working as a junior doctor in hospitals, in four six-month designated training posts covering four key areas of medicine required for general practice, such as paediatrics.
- The following two years involve working in a GP practice under the supervision of a fully qualified GP.

The four year programme is overseen by the Irish College of General Practitioners ("ICGP") and leads to the qualification of "MICGP", which is the qualification recognised by the Medical Council for entry on the register as a GP.

The Competition Authority found that some of the GP trainees who successfully obtained one of the 120 sought after ICGP training places[22] were repeating hospital training that they had already obtained. For example, a GP trainee can end up working in a six months paediatrics training post as part of their training even though they held the exact same post previously. This is

[22] In 2009, the ICGP received 360 applications for 120 training posts. This is typical and demonstrates that there is certainly no shortage of doctors who would like to become GPs. (In 2010 the number of ICGP training places increased to 157.)

because many doctors who do not get an ICGP training place immediately upon completing their internship apply for other junior hospital doctors posts, some of which are identical to the GP training posts. Even doctors who have completed all four required six month hospital rotations, in identical training posts, have to begin the four year GP training programme from the start.

The requirement to repeat training extends the length of training for these doctors. This in turn delays and limits the number of new GPs available to treat patients in Ireland. All other medical specialties have traditionally recognised self-structured training and the ICGP is an anomaly in this regard. The main reason for this anomaly is that, unlike other junior hospital doctors, GP trainees also attend a weekly workshop to increase their understanding of practising medicine outside of the hospital setting.

The Competition Authority recommended a fast-track GP training course for doctors who have already acquired relevant hospital training and experience. Suitable applicants would be able to proceed directly to the final two years of the training programme, subject only to completing a short general practice orientation course (to replicate the learning gained from the weekly workshops). This recognition of prior learning would enable more GPs to be trained as quickly and as cost-effectively as possible, while eliminating unnecessary duplication of training. It would help alleviate the serious shortage of GPs that Ireland is facing.[23] The ICGP welcomed this recommendation and is currently in discussions with the Health Service Executive ("HSE") regarding the availability of funding.[24] In November 2010, the Irish Government agreed a Programme of Financial Support with the EU/IMF and committed to a range of actions to manage the public finances and to promote the competitiveness of Ireland's economy. This included a commitment to … *eliminate restrictions on the number of qualifying GPs* by the end of Q3 of 2011.[25] Implementing the Competition Authority's recommendation would remove the restrictions.

4.1.3 *Non-recognition of Equivalent Foreign Qualifications*

As places on recognised Irish courses are limited, some Irish people travel abroad to train as a pharmacist, dentist, general medical practitioner or optometrist and later return to Ireland. More generally, foreign-trained

[23] Competition Authority (2010a). See also, for example, Layte *et al.* (2009) and Behan *et al.* (2009).

[24] GP trainees continue to be paid salaries by the HSE when they do their two years supervised practice in a GP practice. Payments from private patients seen by the GP trainee, and payments from the State on behalf of public patients seen by the GP trainee, go to the trainer GP (not the trainee). The trainer GP also receives a direct payment for training the GP trainee.

[25] *EU/IMF Programme of Financial Support for Ireland,* revised May 2011, available from www.finance.gov.ie

professionals can be an important source of supply, especially in times of (rapidly) increasing demand.[26] Any lack of recognition of foreign qualifications that are truly equivalent to the recognised Irish qualifications cuts off this source of supply. Such barriers limit the availability of service providers in Ireland.

The Competition Authority found such a barrier in the pharmacy profession.[27] This barrier has since been removed and Ireland now has one of the most open (though still highly regulated) regimes for opening a pharmacy in Europe. More generally, EU Directives ensure the mutual recognition of many equivalent professional qualifications to facilitate the free movement of people across the EU. Also, Ireland has a number of reciprocity arrangements in place to recognise certain health professionals trained in Australia, New Zealand, Canada and the US.

4.1.3.1 Pharmacy

Every pharmacy in Ireland must be supervised by a registered pharmacist on the premises at all times. In 1985, Ireland obtained a derogation from an EU Directive[28] so that a pharmacist who trained in another EU country could not supervise an Irish pharmacy that was less than three years old.[29] This restriction applied equally to Irish nationals who trained in another EU country. To be clear, the derogation was not that a foreign-trained pharmacist must have three years experience in Ireland before they could take on a supervisory role; it was that the pharmacy must be three years old in order to have a foreign-trained supervising pharmacist. Thus, the function of supervising pharmacies that were less than three years old was reserved to Irish-trained pharmacists. Foreign qualifications were recognised as equivalent when it came to supervising pharmacies that were at least three years old but not for newer pharmacies. As the number of Irish-trained pharmacists was limited to the graduates of the one school of pharmacy Ireland had at the time, the derogation made it more difficult for new pharmacies to open up.

[26] Over half of the additions to the Register of Dentists in 2006 were trained outside the State. Competition Authority (2007, p. 19).

[27] Also, the Medical Council in 2010 invited submissions on its draft new rules for assessing the equivalence of foreign qualifications for the purposes of getting on to its various registers, including the GP specialist register, and the Competition Authority made a submission to the public consultation. Competition Authority (2010b).

[28] EU Directive on the Mutual Recognition of Qualifications in Pharmacy (Directive 85/433/EEC of 16 September 1985) – in Article 2.2.

[29] European Communities (Recognition of Qualifications in Pharmacy) regulations, 1987, 1991 and 1994.

This "three-year rule" was lifted on 25th July 2009 when the Minister for Health and Children commenced the remaining provisions of the Pharmacy Act 2007. It did not lead to any major jump in pharmacy numbers in Ireland. Ireland already had a high number of pharmacies per head of population relative to other European countries (Department of Health, 2003, Appendix 1, p. ii). The Irish authorities placed less ownership restrictions on pharmacies and paid retail pharmacies the highest margins in Europe (Bacon *et al,* 1999), which the Minister for Health reduced later in 2009, and so had attracted a relatively high level of investment in pharmacies. Many other EU countries continue to avail of the three-year-rule derogation.

4.1.4 *Non-recognition of Related Professions*

Though "practising dentistry" and "practising optometry", for example, are reserved by law to dentists and optometrists, respectively, the legislation allows for a wider group of professions to be recognised as legally entitled to practice particular aspects of dentistry or optometry. Some of these related professions operate under supervision – for example, dental nurses aid dentists and orthodontists to treat patients, e.g. by sterilising equipment. Some can operate independently – for example, a "dispensing optician" can supply and fit spectacles and contact lenses without supervision by an optometrist (only optometrists can perform eye tests).

Any unnecessary barriers to related professions operating in Ireland reduces the overall availability of services. Recognising related professions can free up professionals with higher qualifications to supply those services that only they are qualified to provide. Where a related profession is trained to operate independently of the core profession, they compete with the core profession for the particular subset of services they are trained to provide. The Competition Authority found that a lack of recognition of certain professions in dental and optometry services had led to reduced availability of these services, long waiting lists for some services, less choice for consumers, and less pressure to keep prices competitive.

4.1.4.1 Dentistry

The Dentists Act 1985 specifically envisaged the recognition of an independent profession trained to provide dentures to members of the public, known as a Clinical Dental Technician (a "CDT").[30] A dental technician is trained to make dentures and is not allowed to supply them directly to the

[30] This followed the publication of a report in 1982 which recommended the introduction of the new profession in Ireland, Restrictive Practices Commission (1982).

public.[31] A *clinical* dental technician has undergone additional training to have the clinical expertise required to safely take a mould of a person's mouth and fit the dentures to the person.[32] A CDT is qualified to offer dentures directly to the public, in competition with dentists.

CDTs were finally recognised in Ireland in October 2008, following a recommendation by the Competition Authority. As of April 2011, there were 15 clinical dental technicians registered with the Dental Council.[33] Now denture wearers have a choice as to whom they obtain dentures from – a dentist or the "one-stop-shop" option of a CDT – and dentists face competition from clinical dental technicians. The Dental Council has also moved to establish courses in clinical dental technology in Ireland – another recommendation of the Competition Authority. Those CDTs currently registered with the Dental Council all obtained their qualifications abroad.

The long delay in recognising CDTs in Ireland was in part due to disagreements between the Dental Council and the Minister for Health and Children (who had to sign off on any new scheme for recognising CDTs). For example,[34] the Dental Council wanted a system whereby consumers could only visit a CDT after they had obtained a "Certificate of Oral Health" from their dentist. It was claimed by the Council that this was necessary to ensure patients were checked for oral cancer and made aware of all options available to them to replace missing teeth. The Competition Authority's analysis was that those patients considering dentures for the first time should certainly consider all their options but they are likely to attend a dentist in any case for that very reason. Also, CDTs are trained to detect abnormalities and inform the patient that they should visit their dentist. There was no evidence that a repeat denture wearer would require a general check up anymore than any other patient.

In the intervening 20 years, anyone needing dentures had to go to a dentist and pay a double margin on their dentures – one margin to the dental technician who made the denture and one to the dentist who fitted the denture. There was no legitimate "one-stop-shop" option of a CDT in Ireland, though there were a number of dental technicians practicing dentistry illegally by offering to fit dentures for members of the public. CDTs exist in the UK, Australia, New Zealand, the USA, the Netherlands, Denmark, Sweden and Finland.

[31] This is a not considered to be practising dentistry.
[32] This is considered to be practising dentistry.
[33] Source: Dental Council of Ireland.
[34] More issues were involved but only one is presented here for illustrative purposes. See Competition Authority (2007).

A study of the rate of inflation for dental treatments in Oregon in America found that it was lower for dentures, where dentists faced competition from CDTs, than for all other dental treatments (Rosenstein *et al.*, 1985).[35] The establishment of a register of CDTs in Ireland should similarly help keep down the rate of inflation for dentures in Ireland while providing an important signal to the public as to which dental technicians have appropriate clinical training.

The Competition Authority also recommended the introduction of another independent profession in dentistry called Advanced Dental Hygienists – dental hygienists with additional qualifications to allow them to offer their services directly to the public (as exist in the US and other countries). This recommendation requires a change in the primary legislation (the Dentists Act 1985) and has not yet been implemented.

4.1.4.2 Optometry

Children identified in national school exit health screening as requiring an eye exam are being referred to highly qualified Health Service Executive ("HSE") ophthalmic physicians (specialist doctors) and face long waiting lists for these appointments in a number of areas (Kelly, 2008). The Competition Authority's examination revealed that there was unanimous agreement across health professionals that these children could instead be seen and treated by optometrists, and referred on to ophthalmic physicians in the relatively few cases that required such expertise (Competition Authority, 2006, p. 24). The Competition Authority recommended that children identified at national school exit screening should be referred to optometrists in the first instance. This recognition of the qualifications of optometrists, and the role they can play in eliminating waiting lists, has been piloted but not implemented. Implementing this recommendation would free up the time of ophthalmic physicians to focus on the services which only they are qualified to provide, e.g. treatment of disease of the eye. All children would be seen by an appropriate professional straightaway – thus eliminating waiting lists – and those children who have a more serious issue and really need to see an ophthalmic physician would be seen quicker.[36]

[35] CDTs are known in America as "Denturists".

[36] In addition to optometrists being more plentiful in supply than ophthalmic physicians, with virtually no waiting lists, they cost the State less than €25 per eye test. Salaries paid to community ophthalmic physicians by the HSE in 2006 were between €83,000 and €87,000 per annum. Competition Authority (2006).

4.2 *Getting Customers*

Two restrictions on competition have made it difficult for new primary healthcare providers to grow their business and compete with established businesses:

1. Lack of access to State contracts for providing State-subsidised services;
2. Regulations regarding advertising.

These factors can completely deter new businesses from opening. They have reduced the availability of services, made it more difficult for consumers to make informed decisions about their health, and dampened price competition between service providers.

4.2.1 *Access to State Contracts*

Obtaining a State contract for reimbursement for providing services funded under State schemes can be vital to establishing a successful primary care business. If access to these contracts is unnecessarily restricted, the number of businesses is reduced and the threat of competition from a new business removed. This reduces the availability of primary care services in Ireland and reduces competition between established businesses. Access to State contracts arose as an issue in GP, pharmacy, and dental services.

4.2.1.1 General Practitioners (GPs)

Obtaining a State contract to treat public patients is vitally important to having a successful GP practice. Without a contract, GPs who want to set up in practice are denied access to one-third of the population (who account for half of all GP visits) and miss out on the significant financial benefits that accrue to contract holders.[37] Payments to State-contracted GPs effectively subsidise the entire practice of the contract holder, making it very difficult for non-contract holders to compete on price for private patients. For example, GPs with State contracts received, on average, €65 from the State per visit made by a public patient in 2008;[38] the average GP fee per private patient visit

[37] GPs receive capitation payments for treating their "list" of public patients but also various allowances and fee-per-item payments (e.g., for administering the swine flu vaccine) as well as superannuation contributions. The average amount received by a GP from the State in 2008 was €220,000 (the GP may have employee GPs working in their practice who treat public patients and this amount includes the services of such GPs). Competition Authority (2010a, p. 53).

[38] This figure takes account of all payments received by GPs from the State under the GMS contract, not just the capitation fee; see Competition Authority (2010a, p. 53 and footnote 96). Since 2008 the Minister for Health and Children has twice reduced the amount of payments to GPs under the GMS, using the Financial Emergency Measures in the Public Interest Act 2009 (the "FEMPI Act"), so this figure is likely to have fallen.

in 2010 was €51.[39] It is therefore not surprising that only a tiny proportion of GPs in Ireland opt to set up a private-only practice.[40]

So how does a GP go about getting one of these essential contracts? Completion of professional training, and registration with the Medical Council as a GP, does not automatically entitle a GP to apply for a State contract to treat public patients. A GP has to wait for the Health Service Executive ("HSE") to advertise for a GP to take up a contract in a specified location; usually the contract comes with a list of public patients who need a GP.

The HSE awards contracts in three situations:

(1) Retirement, death or resignation of a GP who is an existing contract-holder;
(2) Creation of a position as an "Assistant with a view to Partnership" within an existing State-contracted practice; or
(3) Creation of a new position where the HSE has identified a gap in the services available to public patients.

However, even where an existing contract-holder GP dies, retires or resigns, the HSE may suppress the position and give the GP's patient list to other existing contract-holders. Moreover, the marking system for assessing candidates explicitly favours giving patient lists to existing contract-holders.[41] The HSE also has to give *"due regard"* to the *"viability"* of practices in the area.[42] This "viability" factor can often lead to a patient list being given to an existing local practice instead of to a GP wishing to set up in competition with the existing practice. Ensuring that the HSE system for making GP services available to all public patients is viable is a valid objective but it is not the same as protecting the viability of particular practices.

A key factor that is absent from the whole process is that the HSE does not take into account the needs of private patients. The mandate given to the HSE is to ensure that public patients have access to GP services and, where

[39] NCA (2010).

[40] The percentage of GPs in private practice alone fell from 11 per cent in 1982 to just 4 per cent in 2005, with most of the fall occurring in the period after 1992. There are no precise up-to-date figures available on the number of private-only GP practices in Ireland. In 2008, three out of every four GPs in Ireland held a GMS contract and thus one in four GPs do not hold a contract. Most of the latter GPs are younger GPs who work as employees or locums in GP practices under State-contracted GPs. Competition Authority (2010a, p. 24).

[41] GPs with a GMS contract are awarded 20 points for each year working in general practice. Non-GMS GPs with their own practices receive 15 points for every year in practice. GP assistants are awarded 10 points per year. Competition Authority (2010a, p. 55).

[42] Department of Health and Children, *Circular on Entry to the GMS, Circular 3/96*, 19 June 1996.

possible, a choice of GP. The impact on private patients of the system for awarding State contracts in Ireland is often overlooked. It is generally assumed that "the market" will take care of them. This ignores the fact that the market for private patients is itself significantly affected by the restrictions on State contracts. The rules governing access to State contracts impact directly on the commercial behaviour of almost every GP practice in the State – affecting decisions on where GPs locate, the number of GP practices established, the nature of such practices and the profitability of individual practices. This, in turn, affects the availability of services for private patients and influences the prices GPs charge private patients.

The Competition Authority found that, overall, the system protects established GP practices from competition from new practices. As a result:

- Both public and private patients have fewer GP practices to choose from.
- There is less pressure on GP practices to compete on price for private patients and to be innovative in the service they provide.

As the contracts are location-specific, the supply of GP services is slow to respond to changing demographics (Layte *et al.*, 2009, p. 61). Ironically, the rationale generally given for restrictions on access to State contracts is that the State wishes to ensure a geographic spread of services across the country and to avoid "blackspot" areas that are without services. The concern is that allowing GPs to choose their own location will lead to them all locating their practices in popular residential areas. However, the restrictions on contracts do not solve this problem. Ireland continues to have blackspot areas and the restrictions are creating further underserved areas (Layte *et al.*, 2009, pp. 66-69). It also ignores the business need for GPs to locate where the demand is and to avoid locating near to competitors, as well as exacerbating the problem of GPs emigrating to the UK and hindering the HSE's efforts to attract Irish GPs working in the UK back to Ireland.

The Competition Authority recommended the opening up of State contracts to all fully qualified GPs and the removal of the requirement on the HSE to consider the viability of existing practices as well as the removal of the location restriction on contracts. This is not as radical as it might sound as there are a number of features of the market that continue to drive it in a certain direction and make it unlikely that there will be a huge increase in the number of new GP practices:

- To fully qualify as a GP takes 10 years and such GPs are scarce.
- GPs are used to training and working in teams and increasingly prefer to work in multi-partner practices (O'Dowd *et al.*, 2006).

- There are high costs associated with setting up a new practice (Layte *et al.*, 2009, p. 61).

The implementation of these recommendations will lead to some increase in the number of GP practices and also to GP services being more responsive to changing demographics and consumer demands, and to more competition between GP practices. Even the threat of the establishment of a competing GP practice can help keep existing GP practices competitive – a threat that is currently thwarted by the system for awarding State contracts.

In November 2010, the Irish Government agreed a Programme of Financial Support with the EU/IMF and committed to … *removing restrictions on GPs wishing to treat public patients* by the end of Q3 of 2011.[43] Implementing the Competition Authority's recommendations would remove the restrictions.

4.2.1.2 Pharmacy

Similar restrictions on State contracts for pharmacy services existed until 2002. Under the Health (Community Pharmacy Contractor Agreement) Regulations 1996 ("the Regulations"), a new pharmacy could not obtain a State contract if it was located within 250 meters of an existing pharmacy in urban areas or within 5 kilometers in rural areas.[44] In addition, the new pharmacy could "*not have an adverse impact on the viability of existing community pharmacies in the area*".[45] The Regulations created a clear barrier to entry in that new pharmacies faced a cost not applied to existing pharmacies. We thus had a situation where there were pharmacists willing to supply services to consumers but were prevented from doing so. Before the Regulations, from 1991 to 1996, the growth in contracted pharmacies was greater than the growth in population. Between 1996 and 2001, the growth rate in the number of contracted pharmacies dropped below that of the population growth rate (Competition Authority, 2001b).

In 2001, the Competition Authority recommended the removal of the location restrictions within the Regulations. In 2002, following advice from the Attorney General's office during ongoing legal challenges to the Regulations, they were revoked by the Minister for Health and pharmacy numbers began to grow at a greater rate, to 1,300 pharmacies in Ireland in 2003 (Department

[43] *EU/IMF Programme of Financial Support for Ireland,* revised May 2011, available from www.finance.gov.ie

[44] In 2001, only 22 of Ireland's 1,200 pharmacies operated without a State contract. Competition Authority (2001b).

[45] Health (Community Pharmacy Contractor Agreement) Regulations, 1996, Section 2(1).

of Health, 2003). Other EU countries continue to maintain restrictions on who can own pharmacies and where they can locate.

4.2.1.3 *Dentistry*

The Competition Authority recommended that once the independent oral healthcare professions of "clinical dental technician" and "advanced dental hygienist" were legally recognised by the Dental Council, they should be able to be reimbursed under State schemes for providing their services. Thus State-subsidised patients would also be able to avail of the option of going to see a clinical dental technician or advanced dental hygienist directly. These recommendations required that the Health Service Executive ("HSE") and the Department of Social Community and Family Affairs[46] draw up State contracts for these professions. Though Ireland now has registered clinical dental technicians, Ireland's changing economic fortunes has led to severe cut backs in the State schemes and dentures are no longer subsidised for private patients. Medical card holders can still avail of free dentures but the HSE has not yet implemented this recommendation. (Advanced dental hygienists are not yet legally recognised.)

4.2.2 *Restrictions on Advertising*

Excessive restrictions on truthful advertising and the supply of information to patients, prevent consumers from shopping around and chill price competition between healthcare providers. They also make it difficult for new primary healthcare businesses to attract customers by informing them of their existence, services and prices. The Competition Authority found numerous excessive restrictions on advertising in the dental and GP professions. In contrast, the Competition Authority found few unnecessary restrictions on advertising of optometry services.[47] Both the Medical Council and Dental Council have since revised their advertising rules. The new rules provide for much more freedom for GPs and dentists to advertise their services, should they wish to do so.

Advertising restrictions on GPs have been withdrawn or relaxed for some time in a number of countries. The British Medical Council, the Australian Medical Association, the Canadian Medical Association and the German Medical Association permit advertising by GPs. In 2003, the rules on advertising for health services were liberalised in Denmark and this lead to more price consciousness among consumers (OECD, 2004).

[46] Now called the Department of Social Protection.
[47] Advertising by pharmacies has not been examined by the Competition Authority.

4.2.2.1 General Practitioners and Dentistry

Traditionally the healthcare professions, and their regulators, have been wary of advertising. They were, justifiably, concerned that some suppliers would make exaggerated or unscrupulous claims about their abilities and encourage the over-consumption of medical treatment and medicines. Another concern put forward was that advertising would simply lead to an increase in costs and that the additional costs would ultimately be passed on to consumers (OECD, 2004; Competition Authority, 2007, p. 61). Some of their reluctance also came from a belief that advertising was purely a marketing ploy and that it was just not "professional". The Dental Council, for example, asserted that: … *[the] tradition in dentistry as in allied professions has been to avoid advertising and to rely on word of mouth and quality of service to build a practice* … (Competition Authority, 2007, p. 61).

Unfortunately in the case of dentists and GPs, the combination of these legitimate concerns and outdated views had resulted in an outright ban on almost all forms of advertising. For example:

- The only sign dentists and GPs were allowed to use to attract attention to their premises was the traditional brass plate, of specified dimensions.
- A new dental practice was only allowed to advertise its existence by placing a notice in the press six times in its first year of operation and these notices could not exceed a 5 centimeter single column. Flyers, leaflets, posters, etc. were all forbidden. Similar restrictions applied to GPs.
- Advertising of prices was expressly forbidden by the Dental Council. The Medical Council also discouraged it. In addition, dentists were not allowed to advertise discounts.
- In general, GPs and dentists were encouraged to provide information to customers and potential customers within the walls of their practice. This is really information provision, not advertising, as it does not attract custom.

The restrictions were very harmful to competition.

- First, they severely constrained the ability of new practices to publicise their existence and, therefore, reduced the likelihood that consumers would be aware of a new dentist or GP in their area. This simply protected the position of dentists and GPs already established in the locality.
- Second, they limited price competition for private patients. It is extremely difficult for consumers to make price comparisons and shop around for the

best value when price advertising is forbidden.[48] This allows businesses to charge more than they would in a more transparent, competitive environment.

- Third, they reduced the incentives for GP and dental practices to offer new or innovative ways of delivering their services. Dentists and GPs who wished to differentiate themselves by making such investments were unable to use advertising to effectively promote their new services and facilities in an effort to attract new patients and recoup their investment.

The analysis of the Competition Authority pointed out that there are different types of advertising and that while some are harmful to consumers, others are actually beneficial. Truthful, informative advertising – for example, a new GP practice distributing a flyer in the local area to raise awareness of their existence, location, standard consultation fee and opening hours – can help consumers to choose the best practitioner for them. It can also stimulate price competition between practices.

International experience has shown that truthful advertising of professional healthcare services does not have a negative impact on the quality of care provided. Far from increasing prices to consumers, informative advertising of the services provided by healthcare professionals has been found to lower prices. Evidence in support of the pro-competitive effects of advertising in markets for professional healthcare services dates back to studies in the 1970s.[49] On the other hand, misleading advertising – for example, claiming specialist expertise that you do not actually have – frustrates the competitive process and is harmful to consumers.

The Authority also showed how it is possible for the regulatory rules to distinguish between these different types of advertising and thus to relax the regulatory rules on advertising in a way which would improve the delivery of primary healthcare. The Competition Authority was able to point to the experience of the Opticians Board, who imposed relatively few restrictions on advertising by opticians.[50] Opticians have been working in normal-looking

[48] A survey carried out by Indecon International Economic Consultants in 2002 revealed that the majority of consumers considered that there was virtually no, or very little, price competition among dentists in Ireland, and the public felt that they did not have access to adequate information on the fees charged by dentists. Indecon (2003b, Section 10).

[49] Benham (1972), and Benham *et al.* (1975) both examined optometry which was at the time one of the few professions in the USA with significant State to State variation in permissible advertising. Using data from a national survey of consumers it was found that advertising resulted in significantly lower prices. Other studies of the time reported similar findings and more recent studies have confirmed them. See also Bond *et al.* (1980) and Love *et al.* (1996).

[50] The Competition Authority identified two restrictions on advertising by optometrists, and these were removed by the Opticians Board and the Association of Optometrists in March 2010.

shops in main street locations and advertising their services and prices relatively freely in Ireland for many years now, without any harm to patients' health.

Following the Competition Authority's analysis of the Dental and Medical Council's rules on advertising, the rules have been substantially revised and no longer impose such severe restrictions.[51] The Medical Council's new guidelines explicitly recognise the positive role advertising can play in the delivery of healthcare services:

> *The provision of information about the availability of medical services through the media, internet or other means is generally in the public interest provided that the information is factually accurate, evidence-based and not misleading.* (Medical Council, 2009, p. 49)

The relaxation of the rules on advertising has not led to an avalanche of advertising by GPs and dentists. It will take time for awareness of the new rules to develop and the culture of the professions to change. Where we are starting to see advertising is precisely where you would expect to see it – new GP practices advertising locally through leaflets and flyers. Over time, basic advertising should become the norm and consumers will be better informed and better able to seek out value for money.

In May 2010, the National Consumer Agency ("NCA") conducted a survey of the extent to which GPs and dentists display a schedule of their charges inside their practice. The survey found that only 32 per cent of dentists and 50 per cent of doctors surveyed displayed a schedule of fees on their premises (NCA, 2010). In June 2011, the Dental Council brought in a new Code of Practice requiring all practising dentists in Ireland to display a price list for routine dental procedures (NCA, 2011). Transparency in the fees charged by dentists and GPs to their existing customers is an important consumer protection that complements advertising to facilitate competition. For example, a flyer from a new dental practice outlining its fees is of less use to a potential customer if they do not know the fee schedule of their existing dentist. The NCA hopes that a similar agreement will be reached on price display by GPs shortly.

4.3 *Price-setting*

EU and Irish competition law protects consumers, businesses, and the State from collective action designed to force them to pay higher prices than they would otherwise have to. In the GPs report, the Competition Authority

[51] Dental Council (2008) and Medical Council (2009).

identified a problem in the State contract between the Health Service Executive ("HSE") and GPs which could get in the way of this important protection.

4.3.1 *General Practitioners*

The contract between GPs and the HSE provides that any changes in the fees paid to GPs under the contract require the agreement of the Irish Medical Organisation (the "IMO"), the main representative body for doctors in Ireland. This gives an extraordinary level of power to the IMO, akin to a veto on change. Collective negotiations by GPs on fees, for example through the IMO, are prohibited by Irish and European competition law.[52] This means that GPs, who are businesses and not employees of the State, cannot collectively decide through the IMO what price to charge the State and collectively refuse to accept any less. GPs with State contracts do not enjoy the protections of employment law, such as the right to strike, but they are also free to charge private patients whatever they think the market will bear. Competition law protects the State from paying excess prices for GP services purchased by the HSE.

Thus the Competition Authority recommended that payments to GPs by the State should be decided, not on the basis of agreement with the IMO, but unilaterally by the Minister for Health and Children. Of course the Minister can consult the IMO, and individual GPs, on their views, but the IMO cannot force the Minister to accept a particular price. The Competition Authority pointed to a recent judgment of the Irish High Court which set out an approved approach to fee-setting ("the Hickey approach") that does not conflict with competition law.[53] A judgement in the European Court of Justice has similarly provided legal clarity regarding another mechanism for fee-setting that does not conflict with EU competition law.[54] The Minister for Health has already implemented the Authority's recommendation, though not by changing the contract. Under the Financial Emergency Measures in the Public Interest Act 2009 (the "FEMPI Act"), the Minister has unilaterally cut the payments made to GPs under State schemes, twice.

[52] The Competition Authority stated that it was of the view, on the basis of legal advice, that GPs contracted to provide services to public patients under the terms of their contract with the HSE are "undertakings" for the purposes of the Competition Act 2002 and thus fall within the remit of the Act. Competition Authority (2010a, p. 62).

[53] Hickey and others v HSE [2007], judgement of 11 September 2008.

[54] Case C – 35/99 Arduino [2002] ECR I – 1529, [2002] 4 CMLR 866.

4.3.2 *Exemption from Competition Law*

However, in the 2010 "Croke Park Agreement", the then Government committed to discussions with the IMO about granting them an exemption from competition law when engaged in collective negotiations with the State (Department of Finance, 2010, p. 8).[55] This would be a complete reversal of the Competition Authority's recommendation. More importantly, it would give the IMO the legal authority to block the implementation of any Government policy seeking to change the way primary care is funded. Pharmacists, dentists and others are lining up behind the IMO and seeking a similar exemption from competition law.[56]

The harm that would be caused by such an exemption is evident from the disruption to pharmacy services in August 2009, when the Minister for Health and Children moved to reduce the mark-up paid to retail pharmacies by the State under the Drugs Payment Scheme from 50 per cent to 20 per cent under the FEMPI Act. A third of pharmacies closed their doors in protest and the Health Service Executive had to set up emergency pharmacies across the country to ensure patients had access to medicines. Under competition law, the pharmacies could not collectively agree on what mark-up they would accept from the State, nor could they collectively agree to withdraw their services. If the pharmacies had an exemption from competition law, they would have been legally entitled to freely agree among themselves to collectively boycott the State's drugs schemes to try to force the Minister not to lower the mark-up to 20 per cent. Collective action by pharmacies would have removed the risk for each individual pharmacy of losing valuable customers to those pharmacies that did not boycott the scheme. After eleven days, the pharmacies climbed down and the new arrangements went through, creating estimated savings of €133 million each year on medicines for the State (Department of Health, 2009).

[55] This commitment was a restatement of a previous commitment to pursue amendments to section 4 of the Competition Act 2002 … *to enable the representative body for GPs, the Irish Medical Organisation, to represent its members in negotiations with the HSE and the Department of Health and Children in respect of services provided to the public health service in a manner consistent with the public interest,* Department of Health (2008).

[56] IPU (2010): "*Rory O'Donnell, Donegal Pharmacist and newly elected IPU Vice-President put forward the motion: '*That this AGM calls on both the Minister for Enterprise, Trade and Innovation and the Minister for Health and Children to ensure that any exemption that may be granted in the new Competition Act to the Irish Medical Organisation should also apply to all representative bodies for healthcare professionals'." Also, "Service cuts by stealth", *Irish Medical News*, 24 May 2010, page 13: … *the [Irish Dental] Association met Health Minister Mary Harney … [and] offered to engage in intensive negotiations over three months, to allow for the necessary amendments to competition law.*

Giving the IMO (or similar representative bodies, such as the Irish Pharmaceutical Union or the Irish Dental Association) an exemption from competition law when engaged in collective negotiations with the State would be akin to giving them a blank cheque. They would be legally entitled to use anti-competitive means, such as a collective boycott, when engaging with the State on fees for the treatment of medical card holders, the administration of flu vaccines, etc. It is also unnecessary. Competition law creates no barrier to the State setting the prices and fees it is willing or able to pay primary healthcare providers, nor to the IMO being consulted on its views on fees and indeed all other aspects of the contract. Also, in addition to the court-approved approaches mentioned earlier, the Competition Authority has published guidance on some models that enable the healthcare providers themselves to engage with the State on the matter of fees while maintaining compliance with competition law (Competition Authority, 2009).

All parties agree that a new GP contract is needed. Competition law does not prevent the Department of Health and the HSE from discussing all the relevant issues with the IMO or any other group of GPs. In May 2011, the new Irish Government agreed a new revised Programme of Financial Support with the EU/IMF and committed that … *no … exemptions to the competition law framework will be granted unless they are entirely consistent with the goals of the EU/IMF supported programme and the needs of the economy*.[57] The new Government has not yet indicated whether it plans to exempt the IMO or any other group from competition law.

V WHO REGULATES THE PROFESSIONS?

The Dental Council is almost entirely composed of members of the dental profession or those involved in the education of dentists; two of the 19 members are appointed to represent consumer interests. The Opticians Board has a similar membership structure with no consumer representative. Before the enactment of the Medical Practitioners Act 2007 and the Pharmacy Act 2007, the Medical Council and the Pharmaceutical Society of Ireland were similarly structured.

The Competition Authority took the view that it was not … *necessary, proportionate or transparent*[58] for a regulator to be run mainly by the profession being regulated and thus these regulatory structures were

[57] *EU/IMF Programme of Financial Support for Ireland,* First Review revised May 2011, p. 15, available from www.finance.gov.ie
[58] See, for example, Competition Authority (2007, p. 69).

inconsistent with the Government's White Paper *Regulating Better*.[59] It pointed out that other professions and other countries were moving to structures that favoured a broader range of interests. Indeed, the Health and Social Care Professionals Act 2005 favoured a majority of non-members of the profession. The Competition Authority was concerned that, in the case where the vast majority of the members of the regulator come from the core profession being regulated, this can raise conflicts of interests regarding the regulation of the profession in the interests of consumers and furthering the interests of the profession. The Competition Authority recommended that the composition of the regulators be amended to reflect a larger number of interests, none of whom should be in a majority. For example, the Dental Council should have dental hygienists, clinical dental technicians, and experts in regulation and consumer protection in its membership, and not a voting majority of dentists.

The composition of regulators in the medical and pharmacy professions has been rebalanced following the Competition Authority's recommendations. For example, the Medical Council is now composed of 25 members with equal voting rights: at least nine of whom … *are not, and never have been, a medical practitioner* …; ten are required to be medical practitioners; and the remaining six may or may not be medical practitioners but at least four of them could be expected not to be as they are nominated by An Bord Altranais, the Health and Social Care Professions Council and the Health Service Executive.[60] The Fitness to Practice Committee, which inquires into complaints from the public about doctors, must have a majority of persons who are not medical practitioners.[61] The Pharmaceutical Society of Ireland is similarly balanced and, furthermore, must refer drafts of its code of conduct to the Competition Authority for its opinion as to … *whether any provision of the draft code would, if given effect, be likely to result in competition being prevented, restricted or distorted*.[62] The Opticians Board and the Dental Council require similar reform.[63]

[59] Department of The Taoiseach (2004).
[60] Section 17 of the Medical Practitioners Act 2007. An Bord Altranais regulates nurses and the Health and Social Care Professions Council regulates 13 healthcare professions, including: psychologists, physiotherapists and chiropodists.
[61] Section 20(10) of the Medical Practitioners Act 2007.
[62] Section 12 of the Pharmacy Act 2007.
[63] The Government has indicated that the Opticians Board will be brought under the Health and Social Care Professions Council, which should give effect to this recommendation. *Dáil Éireann Debate* Vol. 731 No. 1, 3 May 2011.

VI CONCLUSIONS

Several over-arching conclusions can be drawn from this body of work by the Competition Authority. First and foremost, understanding how primary healthcare businesses compete – and recognising that they do compete – has an important role in understanding how to improve the delivery of healthcare services in Ireland. If we do not understand competition, well-intentioned regulations and policies are less likely to be effective and can even be harmful. In particular, the interaction between public regulations and contracts and private behaviour by businesses, and the resulting impact on private patients, needs to be fully appreciated.

Second, competition policy is entirely compatible with healthcare policy. The above examples show how allowing more competition in some areas – such as allowing competing professions and truthful advertising – can actually improve healthcare delivery and reduce Ireland's healthcare expenditure.[64]

Third, regular reviews of regulatory and administrative systems in healthcare are vital to ensuring they are appropriate to the task at hand. This is particularly important in the area of related professions. As education and qualifications change, regulatory and administrative systems need to adapt, otherwise they risk excluding qualified professionals from offering their services in Ireland and reducing the availability of services. The Dental and Medical Councils' decisions to allow dentists and GPs much more freedom to advertise shows how regulators also need to be in touch with the research on best practice in regulation.

Fourth, the regulation of healthcare professions should not be handed over to the profession itself. Traditionally, the councils and boards in charge of the rules for each profession were comprised wholly or in the majority of people from the profession. A more balanced membership and variety of voices is required.

Fifth, there is room for the State and consumers to get better value for money in primary healthcare. Value for money for consumers and the State in primary healthcare is assured where (a) there is the widest possible pool of qualified professionals available, and (b) the State has the protection of competition law in setting the prices it is willing and able to pay primary healthcare providers.

Recent policy changes – to rebalance the membership of regulators away from a majority of the profession itself; to recognise new para-professions; to

[64] The Competition Authority's recommendations are also fully compatible with Ireland's Primary Healthcare Strategy and different models for State-funding of primary healthcare (which vary across primary care providers).

focus advertising rules on preventing misleading advertising rather than preventing any advertising; to allow pharmacies to locate where they wish; and to unilaterally decide on the fees payable under State contracts – have all contributed to making primary care services, and the regulations governing them, more flexible and responsive to the needs of the general public and the exchequer. Increased recognition of qualified professions (in dental and optometry services) and the opening up of State contracts to all eligible suppliers (in GP and dental services) would further build on this and provide the potential for a greater supply of services and competition to existing primary care businesses. These changes, together with greater price transparency through price display, all encourage a change in the culture of the healthcare professions towards one where it is no longer considered "unprofessional" to provide a competitive service.

Appropriately designed regulation and systems for State funding of primary healthcare can ensure that competition works well for consumers and contributes to the better availability and quality of primary healthcare services at the lowest possible cost. This in turn helps curb Ireland's overall health expenditure and improve our competitiveness.

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