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Thank you for the opportunity to contribute to the ACCC’s report to the Senate which provides an annual assessment of ‘any anticompetitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical or other expenses’.

In this report, the ACCC will inquire into a perceived lack of recognition of certain allied health care providers by health funds. The ACCC has identified circumstances where certain providers of health care are not recognised by private health insurers while others providing the same or similar services, with different qualifications, are recognised. It has been suggested that in some circumstances this distinction is not justified and places allied health care providers at a competitive disadvantage, and has the potential to impact negatively on consumers.

I am led to understand that the ACCC would like to examine the effects of distinction between different providers of the same or similar services and understand whether the distinction is warranted in all cases.

Background Information: Dental therapists, dental hygienists and oral health therapists perform a range of preventive and operative dental procedures on children, adolescents, adults and older persons throughout Australia. The number of training institutions has grown to 11 in 2012. These include 3-year bachelor degrees at Central Queensland University, the University of Queensland, Griffith University, the University of Newcastle, the University of Sydney, Charles Sturt University, the University of Melbourne, La Trobe University, the University of Adelaide and Curtin University of Technology. A 2-year Advanced Diploma in Dental Hygiene is also offered in TAFE SA. Through National Competition Policy Review, restrictions that limited their employment to the public sector only have now been removed. Oral health professionals can now own and operate their own dental practices and employ their own staff, including dentists. With more training programs, more graduates and a more open market, more oral health professionals are providing their services in both the private and public sectors. Dental therapists, dental hygienists and oral health therapists work in a variety of ways in the private sector but the most common method of payment is a 60:40 split with 60% of the fee going to the practice and 40% of the fee going to the provider of the dental service.

Submission:
I. Examples where allied health care providers offer the same or similar services as other providers and are not recognised by health funds:

As a registered dental practitioner – dental therapist – I know that most health funds do not provide scope for consumers to claim rebates from dental therapists, dental hygienists and oral health therapists for preventative and operative dental procedures. The only fund that recognises our profession is NIB. I can assure you that the services we provide are of the same quality as those similar services provided by dentists. In fact, as they are the same services, they have been claimed under dentists’ provider numbers for approximately 30 years.

This is a strange situation where consumers can claim private health insurance rebates from massage therapists, Bowen therapists, naturopaths and homeopaths but not from registered dental practitioners - dental therapists, dental hygienists and oral health therapists. The sooner that dental therapists, dental hygienists and oral health therapists are granted Medicare and private health insurance provider number, the better.

2. In each instance referred to, whether this lack of recognition is warranted. In particular, are there any regulatory, medical or other reasons for this lack of recognition? As a dental therapist who has taught oral health therapy students at the University of Queensland and Queensland University of Technology (QUT) since 1998, it is my considered opinion that this lack of recognition is unwarranted.

In particular, are there any regulatory, medical or other reasons for this lack of recognition? There are a few reasons for this. Firstly, the private health insurance funds have a long and respected working relationship with the Australian Dental Association and members of the dental profession – it is almost impossible for newer professions to compete with historical ways of working. Secondly, the fact that dental therapists (DTs), dental hygienists (DHs) and oral health therapists (OHTs) are prevented from working independently by the Dental Board of Australia (the regulatory body) is a significant factor in the lack of recognition for DTs, DHs and OHTs in Australia. Dentists, dental specialists and dental prosthetists can work independently but not DTs, DHs and OHTs – yet all are registered ‘dental practitioners’ in Australia. Thirdly, the fact that consumers do not have direct access to DTs, DHs and OHTs means that dentists and dental specialists are maintained as the gatekeepers of the consumers and of the payment mechanism via rebates to consumers from private health insurance funds via dentists and dental specialists.

3. Whether this lack of recognition places allied health care providers at a competitive disadvantage. Yes, the lack of recognition for DTs, DHs and OHTs in Australia places these allied health providers at a competitive disadvantage. DTs, DHs and OHTs do not have access to provider numbers with health funds and they
do not have direct access to Item Numbers for dental and oral health services in Australia. These are structural constraints which prevent DTs, DHs and OHTs from providing services direct to consumers. When invoices are written and given to dental consumers, they often question why the invoices are written as if the dentist provided the service, and not the DTs, DHs and OHTs. This makes consumers confused and raises the possibility that the DTs, DHs and OHTs may not be trained or registered to provide these dental services – it makes consumers question the legitimacy of the providers.

The structural constraints which prevent DTs, DHs and OHTs from providing services direct to the public are multifactorial in nature – legal in terms of not being allowed access to provider numbers and Item Numbers; procedural in terms of not having anyone to arbitrate in matters relating to health funds; and de-facto or informal impediments of an anti-competitive nature from the close and long-standing relationship between the health funds and professional bodies such as the Australian Dental Association.

It also places consumers at a competitive disadvantage as DTs, DHs and OHTs are forced to charge the same fee as dentists and specialists as the invoice has to be generated in the name of the dentist or dental specialist and with their private health insurance provider number.

Apparently, the Australian Dental Association (ADA) owns or holds the copyright on the ADA dental Item Numbers. Whether an association can ‘own’ or have exclusive use to these Item Numbers needs to be explored. This ownership effectively excludes anyone except for a dentist or dental specialist to use the ADA dental item numbers. Through their provision of dental services (partial and full dentures) to Veterans’ Affairs patients, dental prosthetists are able to utilise a modified version of the ADA dental item numbers. The issue of ownership needs to be explored for oral health professionals such as therapists, dental hygienists and oral health therapists to ascertain if this amounts to “anti-competitive” behaviour by the ADA and the health funds.

If so, how are allied health care providers disadvantaged by the practices of health funds? DTs, DHs and OHTs are disadvantaged by the practices of health funds as they are not recognised and involved in any discussions with the funds. Examples include the exclusion of DTs, DHs and OHTs in review of the item numbers, the level of rebates and in issues that arise from time to time. For the Item Numbers that DTs, DHs and OHTs use most often, they need to be involved in the discussions to review the level of rebates – some of these Item numbers have not risen for years.
Most health funds have dental advisors and, to my knowledge, there are all dentists or dental specialists. This is a significant disadvantage for DTs, DHs and OHTs as our voice is not heard or listened to in relation to annual monitoring and review.

The ‘preferred provider’ arrangement with dentists and specialists is not extended to DTs, DHs and OHTs – this leads to further marginalisation. A recent example is the Teachers Union Health’s (TUH) August Newsletter 2012 that says –

*Did you know?*

*When treatment is performed by a dental prosthetists, benefits are only payable for selected dental items at 75% of the benefit that would have been paid if the treatment had been provided by a registered dentist, who is not a TUH preferred provider.*

This news item stressed that a dentist is registered but fails to mention that a dental prosthetist is also registered. The connotation is that dental prosthetists are not as good as dentists and this is not the case at all. They are competent within their scope of practice to provide the services they do direct to the public. In my view, this is blatant anti-competitive advertising by TUH to discourage members from seeking the services of a dental prosthetist.

If and when DTs, DHs and OHTs are given access to provider numbers and direct access to Item Numbers, mechanisms need to be in place to disallow anti-competitive advertising by the funds to discourage consumers from using the services of DTs, DHs and OHTs.

4. **Whether this lack of recognition results in a reduction in the extent of health cover or an increase in the out-of-pocket medical expenses of consumers.** Yes, this lack of recognition results in a reduction in the extent of health cover or an increase in the out-of-pocket medical expenses of consumers. A specific example of a reduction in the extent of health cover involves the inability for DTs, DHs and OHTs to consult and treat patients at the bedside in residential care facilities. This then equates to an increase in the out-of-pocket medical expenses of consumers as they are forced to seek services provided by dentists in their dental surgeries or in hospitals under general anaesthetic. DTs, DHs and OHTs are very well placed to provide high quality dental and oral health services in an effective and efficient manner. There should not be any impediments to DTs, DHs and OHTs being able to provide these services directly to consumers. If there was a more competitive market, many more consumers could access care from DTs, DHs and OHTs.

Improved oral hygiene will lead to improved oral health and ultimately improved general health. Oral health’s immediate impact is on an increased ability to speak, eat, express emotion and feel better about one’s appearance. Quality of life issues are particularly important for older Australians in residential care facilities.
As DTs, DHs and OHTs do not have access to provider numbers and Item Numbers, they can only provide services to consumers with the use of a dentist’s provider number. This gate-keeping role is anti-competitive. There is no avenue to provide reduced out-of-pocket medical expenses to consumers as everything is channelled through the main competitors themselves.

If DTs, DHs and OHTs were allowed access to provider numbers and Item Numbers, there would be an environment in which more medical services could be provided to consumers as well as an environment in which competition in pricing or out-of-pocket expenses for consumers would be allowed to exist. Consumers should be allowed to choose their provider and have direct access to them – they should not be prevented from making a choice of health care provider or discouraged from choosing specific providers. This can only happen when supervisory conditions are removed for DTs, DHs and OHTs in Australia with the Dental Board of Australia. The current system hurts consumers as they are being denied direct access to medical services provided by DTs, DHs and OHTs.

**If so, what is the detriment or loss suffered by consumers?** The detriment or loss suffered by consumers is reduced access to dental services and/or at a reduced rate.

It would be a more competitive market if oral health professionals were able to offer a range of preventive and operative dental procedures at prices different to, or lower than, the ADA Schedule of Dental Services. A more competitive market could reduce prices and lower out-of-pocket dental expenses for consumers. I also thought that lower prices had the potential to reduce costs of the health funds for dental services. In 2002, I spoke with the Chief Executive of the Australian Health Insurance Association about this idea and it was explained to me that this could not happen as “it would upset dentists”. I then realised that I had been very naive in thinking that this idea would be appealing to the health funds. I had not even thought that the potential savings for health funds was outweighed by the maintenance of higher fees for private dentists and owners of dental practices. I now realise that with the 60:40 split in fees for dental services, if fees were lowered, the dental practice and the provider of the dental service would both receive lower payments. This then acts as a disincentive for lower fees being established to compete with the ADA’s Schedule of Dental Services.

**General Issues:**
1. Unfortunately, the services of oral health professionals are not recognised or counted in any private health insurance data as all their treatments are recorded under the name and provider number of the dentist with whom each one operates. This is an important issue in itself as the data assumes that all treatment is provided by a dentist or dental specialist – this is incorrect and misleading information. Private health insurance data should recognise and
report on the rise in dental services provided by dental therapists, dental hygienists and oral health therapists. Correct data will be crucial when using current data to estimate what consumer needs will be in the future with different age demographics, i.e. an ageing population.

2. Health funds have had close relations with the ADA for many years. Furthermore discussions or relationships between health funds and the professional associations representing dental therapists, dental hygienists and oral health therapists are nearly non-existent. This is an effective strategy that works to exclude the voice of the Australian Dental and Oral Health Therapist Association (ADOHTA) and the Dental Hygiene Association of Australia (DHAA). There needs to be some mechanism whereby ADOHTA and DHAA can have a voice in the private health insurance industry to promote their services to consumers. These Associations should also be approached by the ACCC to provide advice and comments when, and where, necessary and appropriate.

3. May I suggest that a health fund Ombudsman be established in order for access and rebate issues to be discussed and solutions found. At the moment, there is no avenue to take or anyone to go to when these disputes arise for DTs, DHs and OHTs.