AUSTRALIAN DENTAL PROSTHETISTS ASSOCIATION LIMITED

Questions and Discussion in relation to the
Review of the national Registration and Accreditation Scheme
ADPA Ltd

The Australian Dental Prosthetists Association Ltd (ADPA) is the peak professional association for Dental Prosthetists (DPs) in Australia. Our members are the various state bodies which represent dental prosthetists and as such, we represent over 90% of the Dental Prosthetists registered in Australia.

Dental Prosthetists treat patients requiring removable dental prostheses including full and partial dentures and mouth guards. Dental Prosthetists work independently and do not work under the supervision of dentists. Dental Prosthetists have been active members of the oral health workforce for many years, and members are engaged in the public and private sectors and in a range of educational and managerial capacities. Practitioners provide services for patients accessing benefits from The Department of Veterans Affairs, State Dental schemes and the former Medicare Chronic Diseases Dental Scheme, as well as through private billing arrangements supported by private health insurers.

Dental Prosthetists are registered with the Dental Board of Australia.

ADPA Ltd is, in general, satisfied with the operation of the scheme, and has benefited considerably from the move to a national scheme. Whilst it is acknowledged that there were some initial difficulties in the early days of the scheme, dental prosthetists are now able to operate under common standards and guidelines and have a single point of contact in relation to issues of relevance to the profession. We are therefore pleased to provide this response to your review questions. We have also set out below a specific opportunity in relation to the national scheme that we would encourage you to consider.

Opportunity re ‘Provider Numbers’

In recent months, the Department of Human Services has tightened its policy in relation to the issuance of Medicare Provider numbers. As a result, Medicare Provider numbers are now only issued to practitioners whose patients can claim benefits from Medicare or who can make a claim through the Department of Veterans’ Affairs (DVA).

Whilst provider numbers are ‘officially’ for use by Medicare, a significant number of the state government agencies and private health insurance funds also use these provider numbers in relation to patient claims. Unless a provider number is quoted, many of the health funds will not regard the service as ‘eligible’ and the patient’s claim will be rejected.

This has the consequence that a number of professionals registered with the national authority are not able to obtain provider numbers as their services are not covered under Medicare. For example, until recent months, dental prosthetists were able to obtain a provider number but can now only do so if they indicate that the service is being provided to a DVA patient. This has significant business impacts on that practitioner, as patients who have private health insurance coverage will move to another practitioner or professional (such as a dentist) who does have a provider number and can ensure that the patient’s claim will be paid by their health fund. The practice also has impacts on the patients who are not necessarily able to attend their ‘preferred’ provider and make a valid claim to their health fund if that provider has not been able to be issued with a Medicare provider number.

It would seem logical that the national registration scheme should be appropriately modified/amended so that the registration number for practitioners registered under the scheme ‘takes over’ the role of the Medicare-issued provider number and is promoted for acceptance and use by state authorities and private health funds. This would ensure that practitioners are not disadvantaged in relation to private health funds because they do not have a ‘provider’ number. It would have the significant benefit that patients could be assured that their health fund claims would be recognised as long as they were visiting a registered health practitioner.
Response to Consultation Paper and Questions

1. Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?

This would appear to be a good move. We see an overall need for independent advice and some relevant key performance indicators to assess and guide the ongoing performance and improvement of the national scheme.

2. Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?

If the Council were reconstituted, it would appear to be the appropriate vehicle through which cross-professional issues could be addressed.

3. Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? Estimated cost saving $11m per annum.

As this does not directly impact our profession, we have no preference between this option or the next option, but believe that one of these options should be chosen.

4. Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? Estimated cost saving $7.4m pa.

See above comment.

5. Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?

The fees for the nine professions are already considerably less than those of the largest five professional groups. It would therefore appear to be more equitable for the savings to be spread across all professions in the scheme, not just the nine smaller professions.

Rather than having a fee reduction, additional resources could be allocated to areas of identified issues or greatest need eg a reduction in the times taken to process notifications and complaints.

6. Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?

Yes

7. Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?

No comment

8. Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?

This would appear to be the appropriate body for the provision of such advice.
Complaints and notifications

Overall, our members are reasonably satisfied with the operation of the current complaints and notification processes, but do consider that the process for finalisation of complaints is far too slow.

9. What changes are required to improve the existing complaints and notifications system under the National Scheme?

We believe that significant improvements to this process could be achieved through a finer definition of what constitutes a ‘complaint’ (i.e. an issue where there is an element of overall public risk) and some guidelines on when a complaint needs to be referred to the formal complaints/notifications process. We believe that there is the opportunity for issues and grievances raised by individual patients which do not have a potential ‘public risk’ element to be handled more efficiently and quickly through some other avenue (e.g. through the relevant professional body).

For example, ADPA Limited is frequently contacted by patients who have not been able to achieve a satisfactory denture outcome from their treating dental prosthetist. Often, all that is required is a review by another practitioner and some minor changes to the fitting of the denture. These kinds of matters are best handled (we believe) by the relevant state ADPA professional association that receives the initial complaint. However, even in these cases, some guidelines on what might then ‘trigger’ or ‘elevate’ the issue to the national scheme would seem to be appropriate.

10. Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?

We have no specific comment on this aspect, given that the Queensland approach is still in the early stages. However, the concept of a central point for the lodgement and management of complaints has our support – see next point.

11. Should there be a single entry point for complaints and notifications in each State and Territory?

Yes. This point of entry could conduct a preliminary assessment of the complaint/notification and determine the most appropriate subsequent course of action. This course of action could, for example, simply refer the matter back to the relevant professional association for handling (see our comment to point 9 above).

Consistency in approach and operation across the various states and territories is also required. This is imperative not only for patients who may relocate, but also for professional associations who provide advice to individual patients and practitioners on how their issue or complaint will be handled.

12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

Yes – see above comment.

13. Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?

This transparency does not appear to be present at the current time. Greater communication, both initially and during the review process for the complaint, needs to take place, indicating the...
progress of the matter and the likely time-frame for resolution.

14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?

Yes. See also our comments above

15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

No comment

Public Protection and Advertising

16. Are the legislative provisions on advertising working effectively or do they require change?

17. How should the National Scheme respond to differences in States and Territories in protected practices?

18. In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

We have no specific comments or concerns in relation to the current provisions relating to advertising.

Mandatory Notifications

19. Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

Yes, this would appear to be a logical move.

Workforce Reform and Access and Identifying Workforce Priorities, and Assessment of Overseas Trained Practitioners.

We believe that, in any assessment of workforce reform and workforce priorities, there should be a nexus between workforce reform, workforce priorities, the assessment and admission of overseas practitioners, and future workforce projections. The former Health Workforce Australia body determined future workforce requirements for the Oral Health workforce, which indicated areas of surplus and shortage across the various professions constituting the overall oral health workforce. We believe it is essential that such projections be taken into account in any assessment of workforce priorities.

20. To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?

No comment

21. Should a reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?

Yes
22. To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?

The accrediting authority for the various dental programs (the Australian Dental Council) is currently reviewing the relevant accreditation standards. ADPA Ltd has been an active contributor to this process and we are satisfied that the process will achieve a good outcome.

23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

No comment

24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

The process of examining overseas trained dental prosthetists is currently under development by the Australian Dental Council. Whilst the outcomes of the process are not known at this stage, ADPA Ltd has again been provided with the opportunity to contribute to the process.

Governance of the National Scheme

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25. Should the appointment of Chairperson of a National Board be on the basis of merit?

Yes.

26. Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?

No comment

27. Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?

No comment

Cost and Sustainability of the National Scheme

We have no specific comments on the proposed amendments to the National Law.

Thank you for the opportunity of contributing to this process.

Cindy Tilbrook
CEO
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