Without Prejudice

"Murderous Empiricism and Ignorant Ambition Everywhere Now Hold Out Traps For Trusting Pain.."

Reign of Terror observer Physician Fourcroy 1794

This submission is dedicated to the courage and efforts of all those dentistry students who remained in secondary school for an additional 3 years studying difficult science subjects as a prerequisite to entering University to study and often suffer without remuneration for 5 (some 8 years) to achieve the level of competency required to "protect the public" and it is written also as a tribute to the memory of those that bravely accepted their failure and expulsion from dental school again, because it was "in the public interest" and 'to protect standards of practice'. It is also dedicated to all those 99% magnificent dedicated ethical WA dentists, Australia's finest.

I have chosen in the first half of this paper to use an extract from the guidelines written by the Productivity Commission Chairman to highlight the problems currently being faced by the Western Australian dentist profession. One area in particular being in relation to the legislative lobbying antics and advertising by an open slather cartel of 'no limits' Perth dental prosthetists.

Secondly, the paper also attempts to discuss the historical analogies of other players trying to enter the market by avoiding the existing training called *Dentistry*.

Thirdly, I shall mention the new potential egregious destabilising factor for quality dentistry – a participating provider Health Insurance Schemes to be introduced in January 2005 by the insurer Hospital Benefits Fund WA. This ideologically driven scheme may create dentist millionaires in the first years and then bankrupt them later because their fees are frozen at the behest of the insurance computer and simply because it *warps* the valid reasons that consumers traditionally and wisely used to select a provider. It seems to me that it may constitute a conspiracy between HBF and probably a large dental chain of clinics to tortiously interfere with the existing contractual doctor-patient relationship between family practitioners and their recall patients. The goodwill of a practice is its patient base which is "property" and for many dentists, a source of additional borrowing funds. The concomitant pressure will be for dentists to freeze their staff wages, reduce the price/quality of inputs such as ceramic fees, perhaps even employing Asian laboratories and to covertly drop standards. An enforced discount for HBF members (74% market share) will force an

increase in dentist production by decreasing operative time spent on each patient with a resultant drop in standards of care. Discounts to the majority of patients will mean that the other poorer uninsured patients will fund the discount through the necessary higher fees. The result will be a private health care monopoly with conscripted dentists, deprived of any collective bargaining power, funding *apparent* patient discounts, resulting in dentists having to absorbing costs by altering the quality of patient care which can easily be done without the patient's knowledge.

This will be a middle class heist funded by the working class uninsured poor just to allow a corporation to appear as a generous fee moderator when in fact the 10 year nil increase tardy rebater HBF will be a *consumption stimulator*, market warper and a self-appointed ham dictator wielding unfettered power to make or break providers or clinical practice by *its* simplistic perception of "heroes". HBF by perhaps ripping apart community rating principles, will most likely be discriminating against its members who remain with non-participating providers by freezing rebates to the 1994 level; it will require dentists to insure HBF's risk by taking a loss on each event as the dentist is denied the right to charge their customary, reasonable and usual fee – that is the likelihood of a member requiring an event or for a treatment procedure – and it can suddenly tortiously interfere with out of network providers goodwill by stampeding -patients out of the pre-existing contractual doctor –patient relationships. HBF's new financial gulag has the potential to deny members no recourse or appeal other than to its own internal committee which could become a *Star Chamber* devoid of guidelines, democratic protections, openness or legal processes for discovery, representation or cross-examination of witnesses. Ditto for a dentist who will be subjected to a total fee freeze, no permitted increase of the enforced co-payment amount, draconian unilateral corporate control over a dentist's participating status and reputation, its alteration or the corporation's withdrawal of certain procedural rights ("you have exceeded your profile limit for crowns or root canals, so we are watching and we may….") plus the opportunity for intimidation will be magnified by their intention to write to all the dentists patients informing them that the dentist is "no longer acceptable and enclosed is a list of acceptable providers in your area" without due process and no reason given. The possibility for the adoption of corporate Fascist tactics will allow no *equality* for the protection of neither the members' right to choose their assessed best dentist nor does it allow a dentist conditions for unencumbered clinical practice based on dental theory rather than corporate expectation, computer profiles and direction by clerks. It seems contrary to the community-rating concept as it *quantum discriminates in rebates* against classes of patients either those of an in-network provider or those of an out-of network provider: Dr Cheap-Out's patients receive a different rebate from patients of Dr Expensive- In. The result is differential rebates of up to $300 for say a crown merely based on the selection criterion dictated or unduly influenced by HBF. The other amazing

totalitarian aspect is that there is no actual contract document outlining procedural or protective processes just a request to sign up. The whole apparent cartel hijack smacks of John Ralston Saul's "unfettered capitalism". Worse, it could be a *grand marketing illusion* as the annual limits are *not* increased not have they been for 10 years, rather a *new rabbit out of the hat* process disguising the trimming off of certain procedures and the application of limits or ceilings on certain types of procedures such as prevention or limitation of rebates to 6 fillings.

The last section comprises an assortment of articles and extracts supporting the argument that these matters are complex and not the province of quasi-trained auxiliaries or corporate Gestapo MBA's or slick marketing apparatchiks.

No apology is given for the style of compilation as it was written between patient visits and family time.

Now, the new national thrust calls for *The New Denti$t* , learning and reprogramming about NCP dogma that health is just a business, free trade, corporate expansions, shareholders, legal advances, legislative changes all on top of the existing layers of practice complexities. Formally, my free time was spent absorbing dental research papers and pondering clinical cases, but alas, *The New Denti$t* must be distracted from his patient care by unnecessary kindergarten interference by ignorant new meddlers intent on hijacking an efficient cottage model for their own profit, egos and immortality. Lots of new *looking good* intruders but a huge covert threat to patient care and dentist focus whilst gaily the profit cowboys party and plot.

For clarity the Chairman's text is in black, mine in blue. I am President of WA Dental Implant Society – Australiasian Osseointegration Society (WA) Inc., however, my opinions do not necessarily reflect those of the Society or its 90 dentist and 6 dental technician/ceramist members. Be assured that many dentists are depressed, angry, disillusioned and feeling forsaken of political logic. My opinions are my own, and I appreciate the democratic opportunity to express them on an important painful complex subject that I passionately feel has been grossly misunderstood. The consequences of NCP and State legislative revisions will have disastrous consequences for the health and well being of Australians. Once *the genie* is out of the bottle, it may take a generation of effort to claw back attitudes, structure and standards that have been cultivated and grown since 1894 when dentistry was organised on a basis of " academic fitness and evaluation for the task". Survival was designed for the fittest and competent, not the most brazen. Yet, today's new hero has to appear cheap, never mind the shortcuts, hype and hidden advantage by association with other players. Formerly dentists competed on a fair simple basis; tomorrow

one's success will depend on *who* is actually funnelling patients into the glossy spider's web.

Often one hears people accuse dentists of limiting competition by limiting the number of dental students being trained. The history of the WA School shows that it was actually initially set up and funded by the private practitioners; many of their present day counterparts are now teaching and tutoring at the school, formerly sacrificing any salary to the Dental School i.e. their contribution was without pay and "for the greater good". So should the accusation be true, perhaps the conspiracy theory would need to demonstrate that dentists are demanding a high fee for their departure from their business premises, thus limiting the Schools ability to educate more dentists. Yet the opposite is true, they work for no net benefit, having to pay their nurse and receptionist, which just about depletes their stipend! Dentists have been indoctrinated *to public service* and the facts speak for themselves, as there is certainly **no conspiracy to limit the influx of new graduates, which will be 50 graduates December 2005 instead of the usual 20-30 due to increased government funding lobbied by dentists and certainly not due to any tardiness or conspiracy by dentists**.

The other hobbyhorse of the uninformed is that dental fees are expensive. I have just paid $800 to 2 tradesman to spend 2 hours installing an air conditioner. That is $200 per hour, a charge mirrored by most service call charges on refrigerators, washing machines and leaking toilets. When a denture might last 20 years and when the cause of dental problems – sugar and not flossing – is a guaranteed prevention, those dental costs are certainly small compared to other expenditures and they are easily prevented. The fact that a pensioner cannot afford to replace a 20-year-old denture is not necessarily a national calamity rather a failure to budget. Don't find me heartless for I do provide a *pro bono* service to the worthy, but these matters are often accompanied by unnecessary hand wringing by politicians when the fact is often that the victim has lead a *Candy, Coke* & *Cadbury's* lifestyle rather than using the lolly jar for coins.

My initial assumptive thrust is to expunge the word "professional" as it is misused in health. A *health professional*, to me, is someone with a broad science base of understanding and knowledge, a person with higher learning evaluated by examination by an outside independent assessor. A prostitute, a real estate salesman or an ancillary delegated health worker may claim to be a *professional*, but that word does not connote the same as my understanding of the learned professions of law, medicine and theology. This work is about addressing the problem of *the true professional standards*, as Parliamentary registration in health is an imprimatur of competency, a signal to the public that the operator within holds minimum

qualifications for the envisaged task. The history of *elevated* health delivery has been the elimination of false prophets, dangerous modalities and unscientific claims for health is the harbinger of falsehood, quackery and *pretence with grandest style*.

All changes to dental legislation and regulation must pass this test:

"Is this change going to increase the market opportunities of the majority ethical, empathetic, skilful and committed dentists or is it going to favour the minority greedy, unethical and profit centred renegades and cowboys who may appear to be charging a lower fee but are actually going to rort the system?"

The asymmetric (dentally ignorant) nature of the consumer market favours the greedy group for they can and will prey upon the unsuspecting public with remarkable style and fanfare. The time honed restrictive model created in the 1890's favoured the former honourable group. The intended changes under NCP with diluted entry and expanded "freedoms" will be *a reign of terror* upon Australians.

The good, the bad and the ugly: economic perspectives on regulation in Australia*

Gary Banks
Chairman
Australian Productivity Commission

http://www.pc.gov.au/research/speeches/cs20031002/index.htm

So what is 'good' regulation?

Defining what is good regulation is a starting point for doing better. To qualify, regulation needs to exhibit several characteristics (ORR 1998).

It must actually do good. It must have a sound rationale and be shown to bring a *net* benefit to society, requiring costs as well as benefits to be brought into account.

The good dentist, the bad mouth and the ugly unregulated Perth prosthetist

The traditional model of the dentist practitioner was a self-employed cottage model, often working solo but certainly, I contend, committed to the higher values of skill acquisition, ethical behaviour and "the patient's interest' foremost. Those practitioners considered themselves servants to the public, empathetic healers following a vocation of giving, and curing ailments. The public trusted the advice offered "You're the Doctor" and these moments reaffirmed the role of being an adviser without a profit motive.

The traditional model was with no net cost to the taxpayer as dentist registration fees funded the regulation of the market place. Dentists not only funded aberrant behaviour litigation by the Board, but accusations of malpractice associated with adverse outcomes, informed choice and consent which were often erroneously launched by patient's seeking later financial compensation from insurers for perceived injuries.

The new NCCC model declares that those aspirations are void, that the new way is purely that dentistry and medicine are just another business. The new spin has a "Gordon Gecko" taint, hardly plausible to Dr Livingstone or Florence Nightingale were they to have been told that they were actually in the jungle or Crimea just for the "business" motive? Humans do move to, and remain in higher levels of motivation than just *profit.* They do see themselves as helping and caring for humanity, and it is true that many dentists unheralded and humbly see patients after-hours or *pro bono* as *healers*, purely to assist another human.

"Remission Impossible"
Ron Williams (1992)

whether Australians like it or not, and they certainly will not, the new century will see the Australian Health industry controlled by overseas megacorps, part of an international oligopoly, whose primary concern will be measured in terms of the profits derived from its exploitation of the local population and its indigenous labour force"

Sadly, the NCP spin has shifted the subtle higher ideals of the profession, to automatically authenticate avarice and cupidity. Examples could be purchase of machines guaranteed to quickly generate profits for dentists or smile makeovers with expensive and often unnecessary brittle facings. Tooth Whitening Laser machines or Air Abrasion for $80,000 plus a free sandwich board to place on the pavement advertising "No needles, no drill" have suddenly become the norm. In my 5 years at dental school, *money* was never discussed, other than in the final term of 5th year, when a senior private dentist gave 6 lectures on how to run a practice general ledger, and how to borrow money to set up a practice. However, those moments were always in the context of doing the "correct thing" for the patient. Our indoctrination was that dentistry strove to attain the highest level of patient care, treatment planning and service.

There were no barriers to entry in the marketplace. A new dentist could set up or "squat" anywhere and await a clean un-enmeshed parade of potential patients. By impressing those patients with one's diagnostic and caring skills, the good survived and grew their practices and their reputation.

The new NCP intended model which has concentrated on a false premise of easier entry for an independent auxiliary with dubious short weekend training will distort a simple market with easy entry into one where arrangements, toutings, referral distortions and joint ventures strangle the viability of good dentist practitioners and reward the conspiracies of the entrepreneur money kings.

A new graduate will now be required to put his academic books aside, concentrating on how to compete against hidden rings of referral between competitor dentists who survive by co-

feeding patients to “Tooth Cleaning Spas” and non-science trained prosthetists gnawing away at their restraining scopes of practice restrictions.

A dentist intent on setting up a practice in a country town containing a prosthetist and a part-time hygienist at the finger-nail clinic would wisely avoid such a layered and distorted market, its inherent professional conflicts around patient care and the necessity to subjugate principles relating to standards of care in order to survive in such a distorted delivery mechanism.

Ownership of a dental practice extended to prosthetists and hygienists sounds like a warm fuzzy idea but it is actually fraught with market stupidities and consumer dangers.

What knowledge based professional would want to work for someone less qualified? Would an architect want to be employed and directed by a bricklayer or a curtain hanger? Dr Bad and his ilk would not “cut the mustard” on a level playing field so they need leverage to exist! Dr Good however, is able to attract patients based upon his integrity and skill and nothing else. Whatever changes are made to the market place, they must never encourage the unworthy, rather, they should maintain a silent presence where the consumer is not inundated with complex *leaders* to buy services mislead by advertising slogans “Painless Parker”, insurance funnelling and commercial enmeshments.

Other stupidities arising from NCP competitive “reforms” and not addressed in East Coast open slather legislation re hygienist, therapists or corporate practitioners (sic):

1. Who would want to purchase a hygienist’s 20% equity in a practice?
2. How do dentists rid themselves of a hygienist-owner who is underperforming? A buy-out funded by patient fees or profit share to an expelled owner. Good thinking. Now? Dismissal after following due process. Simple.
3. If the dentist dropped dead, retired or moved, would the hygienist continue the practice without a dentist? Would patients be informed? Would the hygienist be taking radiographs and other delegated procedures, knowing that the dentist was no longer present? Good thinking, rather *nil* thinking by legislators!
4. What machinations would occur between the 2 dentists both holding 40% and what would be that “business” projection on the street or to patients via signs, letterheads or recall notices?
5. Would it still be a “dental surgery” if the dentist was absent for a day or 6 months?
6. Will the hygienist remove teeth or make diagnostic decisions?
7. Will the patient be told that the operator is not a dentist but the hygienist or prosthetist?
8. Will a patient be told they need a cleaning yet the hygienist is a part-owner and will receive a share of the profits on the advice and products recommended?
9. Will staff and nurses all be on sales commissions for selling a patient a smile makeover of a bridge?

10. Will Dr Bad become the front man for numerous hygienist “dental surgery” outlets, billing the patient in his name but never seen by the dentist?
11. Will hygienist set up at finger nail clinics and spa cleaning shops doing maraschino picking of the cherries and profit centres of the legitimate practitioner struggling to employ auxiliaries for legitimate activities in a holistic centre down the road? Drop in income = expand the envelope of skill and competency or over-service. Good economist and political thinking again!
12. Will dental prosthetists and hygienists employ enslaved dentists ‘out the back’ like in Italy, feeding their sub-standard labs just because they occupy a strategic site. What if the dentist abhors the standard of laboratory work? Can he select the best technician for his patients when employed by another technician? No, so the patient is deceived and conned by the structure and the upside arrangement.

Previous ethical requirements were that a dentist could not fee split, but that, like the baby, seems to be out the door. Good for the established providers, bad for the unsuspecting patients. The whole application of these warm fuzzy stupidities expunged since 1894 has been conveniently ignored in the hope of lower fees driven by assisting the profit takers. Madness.

The horrendous requirements by the State Radiological Council for testing of dentist’s machines has been ignored by NCC review, suffice to say that the regulations have resulted in many good machines being scrapped due to some small percentage electrical aberration and **the tester** then selling the distraught dentist a new machine. No repair facilities exist in Australia for x-ray heads, so a new $10-15,000 machine is the regulatory outcome. The cost and complexity of compliance would be far in excess of the benefit of locating *dangerous* asymptomatic machines. The underlying assumption was that a dentist would *not* know if his machine was malfunctioning albeit exposing an image on film. Preposterous because the silver emulsion would be either too dark or too light! This unnecessary layer adds to consumer costs and has no valid basis for its imposition upon dentists who are required to scrap their machines because the technicians testing the machines are not capable of fixing the **small** timer and component gliches.

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Compliance testing of medical diagnostic x-ray equipment: three years' experience at a major teaching hospital in Western Australia.

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The impact of a formal compliance testing program has been evaluated three years post-implementation on a major teaching hospital (Sir Charles Gairdner Hospital) with 46 x-ray tubes located throughout 37 rooms. The mandatory program, implemented by the statutory authority in January 1997, called for all medical (including chiropractic and dental) equipment used in human diagnosis to be tested at prescribed frequencies using established protocols. The application of the required test methods demonstrated various non-compliance issues. Notices of non-compliance were received for approximately 60% of the equipment in the hospital following the equipment's first annual test. The reasons for, and the significance of, failure varied according to equipment category, test category, equipment use and equipment age. However, at the end of the third year of testing, approximately 75% of the tested x-ray units satisfied the compliance criteria. The main reasons for non-compliance were found to be design limitations of old technology and the current radiation legislation that makes it difficult for some older equipment to meet the relatively stringent criteria.

My comment to that would be that a machine might expose for 4.5 seconds rather than 4.6 seconds… hardly a reason to destroy the valuable machine "… but we can sell you a new one". This regulation aspect was ignored by NCP and it is an unfair and illogical impost on dentists leading to increased overheads and thus patient fees.

The advent of a new player in 1984 - the dental technician, introduced the delegation of certain tasks to a 'tradesman TAFE certificate apprentice' – namely; full dentures, mouthguards and repairs.
The grandfather provisions allowed them to practice without any clinical training, instruction, and theory examination or literacy evaluation.
In the public interest dentists delegated certain procedures to mechanics or now called technicians as a team based cost saving measure – but if the delegated is now to be an equal competitor with fake training, this illogical creation has altered the view or importance of the *public good* for dentists. These dental technicians who were grandfathered into "practice" as the new dental prosthetists were not indoctrinated to follow those same dentist principles. Namely; they could not take or understand a medical history – the foundation of diagnosis, nor could they survey the mouth for pathology, as they did not have radiographic or biological science skills nor did they know anything about real pulsing human teeth as they had only worked on Plaster of Paris models of teeth. This political movement suddenly said to dentists: YOU must be excellent or you will be sued, **but** others may operate on a different basis. YOU have been charging too much, so these people will charge *less*. Tragic assumption because prosthetists now charge *more* by claiming to be specialists and they lobby to enter the field of head pain and breathing diagnosis because the market and politicians are asymmetrically ignorant and because they can get away with it.

"The worst thing that bad people can do is make us doubt good people".

Jacinto Benavente (1866-1954); Spanish dramatist.

To dentists with knowledge of medicine's barber surgeon roots in Europe, and Australian dentistry's founding educational sentiments, none of this fence jumping by action seekers expunging the value of education and training is new but merely a repetition of each generation.

"Dentist on a Camel" written by Keith Mattingley, describes the state of Victoria's 1928 dental political trouble. In 1910 when the practice of dentistry without Board registration was made illegal, 30% of all those in practice, namely 266 men, were recorded but not registered, because they did not hold dental diplomas or degrees. While the Board allowed them to continue practicing, they were barred from calling themselves dentists. However, to the annoyance of registered dentists, they got round this restriction by calling their places of business "dental surgeries'. The recorded men in turn became upset when professional bodies refused to admit them as members, but they joined forces with registered dentists to protest that so many dental mechanics were working as dentists. …Dr Bill Morrison added "The Board's policy…is this – **no registration without qualification, no qualification without examination and no examination without education"**. To register recorded men would amount to betrayal of the professional ideal"…The Secretary of the Australian Labour Party, Mr. A Stewart supported him " I do not want to go unwittingly to a bum dentist any more than I desire to go to a bum lawyer". Some years later a WA politician stated in the Parliament "that the best thing that happened in WA was when all the unqualified men had either died or retired ". Another stated " I want it so that a patient sees a qualified dentist and was interrupted by " He's probably across the road in the pub". Perhaps the horror stories of dentists in the 30's and 40's came from those unqualified providers working at their 'dental surgery', the very scenario that we will leave our children – unqualified or quasi-trained pretenders? Modern dentistry is reformed because of training –real arduous 5 years of study, not short weekend courses or remote learning apprenticed to an untrained non-science person grandfathered into instant professional (sic) respectability.

Today's double speak, like Orwell's totalitarian catchcry *Ignorance is Strength*, is where regulators and legislators pretend to uphold the values of health excellence, yet manifest simultaneous acceptance of providers acting without conscience against the public benefit. *Profit* is ennobled by giving it the gown of respectability called "*competition*". Profit taken by corporations is grander, more acceptable and in the national interest. The new corporate darling dentists will fly Business Class (I have *never* been Business Perth to Melbourne in 32 years); all the top knobs will receive golden handshakes and client entertainment allowances from the off-shore corporate headquarters stacked with accountants, tax haven advisors and sales motivators, yet the cost of a filling might drop? Unlikely. Coles or Woolworths, Hospital Benefit Fund or Australian Pharmaceutical Industries under the Soul Pattenson banner or even the English Boots or an American corporation under the Free Trade agreement can buy up all the struggling cottage practices, replace Dr Good with quasi-trained auxiliaries and then sell them jacked up consumables via an entity like the recently purchased 600 million business Halas Dental? Profits repatriated overseas to a low tax haven. And dental fees will drop? Impossible. Throughout history Legislatures have a penchant for making policy decisions that backfire with unintended, sometimes very damaging consequences -- largely because lawmakers don't take the time to fully explore the potential ramifications of what they decree.

Audacious utterances, like aberrant behaviours should cause outrage, yet at the same time, they do allow a fleeting moment to view the dysfunctional soul of the vocal offender.

Conscience is a Jewish invention.
It is a blemish, like circumcision....
There is no such thing as truth,
either in the moral or
in the scientific sense.
The new man would be the antithesis of the Jew."

Herman Rauschning *Hitler Speaks*

So the new man, free of science and truth, the purveyor of mechanical dentistry is and will continue to be devoid of *conscience* about not using an autoclave to kill HIV and prions because they don't believe in its scientific truth or just because no regulator has the testicular fortitude to say "You have had 20 years to get an autoclave and not one of you have purchased one. This experiment has failed"? With no moral or scientific conscience in dentistry, how can an ethical Dr Good survive? Must he become Dr Bad- over-servicing and rorting the alphabet soup of item number rebate schedules? The British National Dental Health system is a graveyard of philosophical warm fuzzies with disastrous oral epitaphs.

The contradiction of public health quackery and corporate greed is summed up aptly by John Steinbeck in *Cannery Row*

> "It has always seemed strange to me," said Doc. "The things we admire in men, kindness and generosity, openness, honesty, understanding and feeling are the concomitants of failure in our system. And those traits we detest, sharpness, greed, acquisitiveness, meanness, egotism and self-interest are the traits of success. And while men admire the quality of the first they love the produce of the second."

Heather MacDonald in her book *"The Burden of Bad Ideas – How Modern Intellectuals Misshape Our Society"* postulates that

'the very people who claim to be solving public health problems have embraced an ideology that can only make them worse. Public health revisionists are generating a remarkable body of excuses for the most avoidable and dangerous behaviours, particularly those relating to HIV/AIDS ".

Perth regulators ignore prosthetist failure to autoclave whilst Canberra regulators insist on increased scope for potential disease harbingers. For the provision of a denture with say 10

visits, a dentist's autoclaving/staff costs would be about $250. For a prosthetist, most do not employ nurses or THE ESSENTIAL autoclaves, so their cleaning cost would be zero. Competition? No, an unfair unfettered racket for a cartel of opportunists picking the cherries in an asymmetrical market.

Today these same peripheral people seek broader scope to move from a gummy mouth to the forest of *teeth*, similar to Arabs in the sand dunes suddenly becoming Foresters. The damning paradox is that this imminent decision has occurred in the corridors of power (and money), and not in the realm of scientific reality or logic. Economically, these trade trained operators have exceeded dentist fees by 30%-400% on their own self assessment that they are *specialists* when every dentist and technician knows that the most skilled and highest earning artisans are crown and bridge ceramists and that specialists with higher learning, these plastic moulder are definitely *not.*

The prosthetist credo must also mirror the NCC view that dentistry is just a business, so that is why some charge 4 times a dentist's fees. Because they can! Following the NCCC thinking, all dentists should increase their denture fees by 4 times? My credo has been to provide the highest standard often to my own financial detriment "for the patient's welfare", which, to an economist or lawyer, I must agree seems a bit silly. If the new axiom is "charge what the market will bear", so be it. That's obviously what one's competitors are doing. Conspicuous market failure, except to economists and the John Steinbeck stereotypical consumers?

My calculation is that a dentist has to make 14 dentures to match the profit of a prosthetist denture sold for $3000 cash. So if a dental fee is for time, skill, care and judgement, a dentist should charge more than a prosthetist just because the dentist has greater skill and judgement, honed through 5 years of University study in one of the most difficult and long courses. If a denture is just a product, then like a house, there are many variations that need to be defined. A million dollar marble mansion cannot be compared to a corrugated iron shack, they are both products but the prices should be different and the differences in houses can be **seen by the consumer**. Not so for a professional service, nor a denture, nor a filling. Just as the Arts and Craft movement was a political statement warning of the likely loss of craftsmen skills, dentists shout that standards are dropping in denture services, techniques and materials, education and clinical methodology.

<u>A consumer's yardstick for a denture or filling can only be:</u>

1. Does it hurt?
2. Has it fallen out?
3. Does it look ok?
4. Was the price similar to what my friend paid?

If the list above, was all there is to the task, there would be only ONE dental textbook, which would consist of only 4 pages. There is more to dentistry than the consumer can

comprehend in both choosing a provider, and in the evaluation of the result. A full denture or especially a partial denture may fulfil the above 4 requirements but may be designed with ghastly areas of unhygienic decay, bacterial plaque traps and enclosed gum liabilities. As with all constructional challenges, there is an easy way or the difficult way. The provision of a comfortable partial denture is easy – just cover all the teeth and gums. The hard way is to design a minimalist structure with as few as possible tooth or gum contacts. My observation of prosthetist illegal partial dentures over the last two decades has shown that there has been a blatant lack of consideration for the biology of the dental structures, a complete disregard for the physiology of the jaws and their movement and contacts with each other. Acres of metal, high in the bite covering forests of decayed and unsatisfactory worn-out old fillings and yet the denture was made 'by a friend' 3 months prior for cash. I have even seen dentures with metal bits cast into cavities!

The NCC failure to appreciate that dentists self-educate at huge expense (lost income, paid idle staff and high ticket price) to improve their level of care, *not* to make money. That failure or lack of insight by mandarin observers has shifted dentists' subtle software or *esprit* which has been inherited from the mid-1850's as the medical and dental professions attempted to hoist themselves from the barber surgeon charlatan beginnings, onto a platform of science and understanding of what and why a treatment. Now under NCC ideology must we move onto a new pedestal engraved with **" Business = more profit = competitive edge"?** Worse, the State government is penalised for *not* dropping the barriers to entry on the assumption that those safeguards were contrary to the public interest. Wrong thinking.

A dentist cannot register as a prosthetist. A *barrier to entry* ignored by all the reviews. WA Prosthetist Committee has rejected applications from overseas-qualified dentists to become prosthetists, perhaps denying overseas graduates a more dignified existence than washing dishes as many are forced to do as they sit the arduous 12-month sequenced examinations again, voluntarily submitting themselves in the public interest of Australians.

> **WA PARLIAMENT EDUCATION AND HEALTH STANDING COMMITTEE)ADEQUACY AND AVAILABILITY OF DENTAL SERVICES IN REGIONAL, RURAL AND REMOTE WESTERN AUSTRALIA TRANSCRIPT OF EVIDENCE TAKEN AT PERTH MONDAY, 12 NOVEMBER 2001**
> **http://www.parliament.wa.gov.au/Parliament%5Ccommit.nsf/(Evidence+Lookup+by+Com+ID)/7D138A7F22A9B52348256B13000E5EDF/$file/eah1211.9.pdf**
>
> **Mr Rikhraj (an overseas trained dentist testifying)***:*
> *I tried to gain registration to work in other fields of dentistry and I failed. I tried to seek registration in prosthetics, but I could not get permission. I could not even obtain registration as a dental technician. A dental technician is one who works in a laboratory making dentures and who does not see patients. surprisingly, in my private practice I trained my dental technician. He has no formal qualifications other than the knowledge that I gave him. Within a week of his migrating to Western Australia he was able to get a job purely on his ability to perform his duties. A short while later he was given registration as a dental technician, again, purely on the basis of his work. He did not sit a formal examination, and he did not attend a formal course. It sounds strange that a dentist is notable to gain registration as a dental technician but the very person he has*

> *trained - who was held in high regard by his employer - is able to practice as a dental technician.*
> *The reason was that my qualifications (Indian/Malaysia dentist) were not adequate. When I applied to work as a* ***prosthetist/dental*** *technician, I was asked to get a transcript of my course. ..When I compared it with that for an Australian course, I found it far exceeded the requirements of a* ***dental*** *technician or* ***prosthetist****. Yet, I was sent a letter stating that in the view of the committee, I did not meet the criteria. The clinical and practical training hours required for prosthesis work in Western Australia is half of what I accomplished 27 years ago as a dentis*t.

That huge untapped resource of overseas dentists and remote rural need remained unexamined by the stereotypical reviews under the NCC credo which concentrated on trying to turn the profession into a business circus because of a false assumption about perceived competition and its apparent absence. Competition by quality? Yes, fierce. By price? Dangerous.

Research publications and self-education is the most conspicuous yardstick of the vibrancy of the dentist profession. The Dental calendar is crammed with courses on “how to provide better patient care”. Pubmed lists 500,000 dental articles, 5 about prosthetists. Each self-employed dentist pays $350 to $400 for a day course and a good course would attract 100-200 Perth dentists. In November I travelled to Sydney for an Implant Bone Grafting course, which cost $1500 for 2 days. In December I am doing another 1.5-day course on Implants, cost $1500. Many nights I attended a 3-hour lecture on implants. An informed dentist community costs money, so it would be folly to institute changes for *ideological* reasons if those changes were to either remove the incentive or the financial ability of dentists to fund their on-going education and commitment to excellence. *More players* equals less experience and less available funds for time out attending courses. Fake trained providers disempower the values of the true committed conscientious provider not to ignore the stupidity of allowing them entry in the first place.

My interest has ranged over many dental disciplines during my 32 years of private practice, but those indulgences of knowledge would *not* occur under an employed arrangement were a dentist to be working for a dental technician or a corporation. My Army CO was sparing with his permission for me to attend any course. The intensity of the thirst for knowledge amongst Perth dentists is truly amazing, but the reality of quasi-corporation chains or government-employed dentists is that their dentists *do not attend* these courses. Thus corporate ownership of dental practices will throttle the viability of post-graduate courses. Interestingly, the most viable of all the courses run by the University Extension program are those courses run for dentists. The attendees are predominately self-employed, not salaried.

The French Revolution 1792 decision to allow anybody to practice Medicine and Dentistry so long as they paid their registration fee resulted in an epoch of suffering referred to as the ‘Reign of Terror’. With new market place alignments between the cowboys, corporations and “entrepreneurs”, they will fabricate behaviours to entice patients, over-service, refer to in-house pathology and company radiographic facilities - all to magnify their own

shareholder profits in a Wonderful Business Reign of Terror instituted by eco-money-mandarins who had no knowledge of dentistry, other than perhaps having laid in a dentist's chair.

An analogous proposition for trade trained dental technicians to be dealing directly with the public would be regulation allowing drug traffickers to operate as pharmacists just because they know about drugs, or plumbers- they know all about leaks and water works so let's make them urologists. The proposition is ridiculous in its assumption of that 5 years education can be conjured with a quick course.

Over the last 20 years, the market failure exhibited by prosthetists shows the opposite of good: rip-offs and posturing of magnificence as self proclaimed "specialists" prance through newspaper and TV advertisements, claiming cures for ailments they have neither been trained for nor do they possess the basic scientific subjects to understand, selling dubious products for sensitive teeth and bad breath.

A Prosthetist denture may fill the spaces but it may be incorrectly designed for hygiene, support and passivity. Prosthetists will have **no diagnostic tools** or skill, because they have not received the adequate training to take radiographs or evaluate old fillings, gum disease, medical conditions or advise on science. Nor do they, or should they, be able to cut hard or soft tissue to enhance fit and function of a denture, and its supporting teeth. Every day every dentist is perplexed by the question "is that filling OK?"…. for every dentist including myself, that's extremely difficult and legally daunting, even **with 32 years of experience**. One missed cavity and I could be sued. Their customised Trenorden 2002 legislation would have allowed them to cut hard and soft tissues of the mouth – yes, a drill and scalpel – and it lay in Parliament for 5 months without anybody realising its covert intention. The embarrassed politician who had been boasting his assistance from the prosthetist group then withdrew the Bill claiming it was a drafting error, when in fact, it was an intentional Trojan horse implanted inside the gates of stupidity.

A partial denture is analogous to constructing a high rise building, the ground being the teeth and gums. An engineer would validate the ground and bedrock prior to construction. Tests would be performed to assess the suitability of the foundation. Similarly, a dentist requires an intimate knowledge of the teeth supporting a partial denture, or the implant supporting a structure to correctly design the construction. An engineer who did not seismically or "techno" check a site's suitability or a prosthetist who CANNOT check teeth and bone with radiographs and reading skills, should not be in the business.

The net benefit to society would only occur if the majority of providers (dentists) saw a benefit. As the market demand for dentures is reducing due to more teeth being retained (by dentists and their smarter materials and techniques) plus the public's expectation to avoid extractions, the activities of prosthetists has been to over-service their patients – replacement and maintenance rates exceeding dentists - surreptitious extension of their scope of activities in defiance of the Act and a "free for all" advertising campaigns on TV, regular newspaper adverts and radio spots on "care of teeth". These activities and claims by

quasi-trained millionaires posing as self-appointed specialists is dispiriting to those who actually did the hard yards for 5 years at University and must then enter a warped marketplace.

The indisputable fact of the previous model, created in 1894 was that a new graduate *could* set up practice *anywhere* with an assurance that busyness was related to *competition by quality*. Location was never restricted as in pharmacy, alliances were deemed "unprofessional" and fee splitting was prohibited by ADA ethical guidelines. That model allowed true competition as a new graduate did attract patients by being better skilled and more caring than the older dentists down the Main Street.

The new model was born when 1984 legislation allowed prosthetists to make full dentures and repair full and partial dentures. The third model will be if prosthetists are allowed to provide partial dentures. The 2 new overlays with competition implications have been advertising and the intended "corporations" entry. Letter drops, exclusive closed shop deals such as "dentist for the West Coast Eagles", expensive campaigns promoting fringe equipment of dubious scientific benefit "Laser Whitening" and glossy brochures promoting Harvey Norman white fillings or McDentures both with a free petrol coupon will only make the life of a new graduate setting up practice a more difficult and less viable excursion. Difficult to borrow funds from the bank, difficult to leave the practice to attend a course, difficult to pay the $400 for a day course, plus $20 per hour for the 2 idle staff left at the office. The key to competition is easy entry for competing younger dentists. The lock to competition is advertising brand identity to curry customer loyalty, closed exclusive purchasing agreements, cross subsidies to allow loss leadering such as petrol coupons or discounts for ancillary corporate services – spa, tooth cleaning and fingernails all for $120. A new graduate, fresh from the bank with a loan will then spend time at the advertising agency trying to trump the competitors TV and radio campaign, time at the lawyers to write a contract to sell a profit share to an Indonesian businessman who is funding his Laser machine and then home to the wife and kids to study implantology? Unlikely.

NSW Hansard Articles : LA : 17/02/2004 : #34
2/03/2004

Mr BOB CARR (Maroubra—Premier, Minister for the Arts, and Minister for Citizenship) had these misgivings about being *forced* to do the wrong thing:

The simple purpose of the **National Competition** Policy Amendments (Commonwealth Financial Penalties) Bill is to enable New South Wales to avoid penalties being imposed by the Federal Government on the advice of the **National Competition** Council [NCC]…. **The Dental Practice Act 2001 and the Optometrists Act 2002 currently restrict the ownership of dental and optometry practices, with some exemptions when consumer protection is assured. The New South Wales Government believes this is a balanced approach, but again the crusaders at the National Competition Council and the Federal Treasurer— who was not overruled by the Prime Minister—have branded our fair, practical system as anticompetitive. The bill therefore reluctantly provides for the removal of restrictions on the ownership of dental and optometry practices. At the same time the bill retains health and safety protections and**

prohibits employers from directing or inciting a dentist or optometrist in their employ from engaging in unsatisfactory professional conduct, including over-servicing.
The pharmacy industry is another area in which successive New South Wales governments have retained sensible regulation. The dispensing of often dangerous drugs needs an ethical, patient-centred approach. That is why the Pharmacy Act 1964 contains various restrictions, including restricting the entry of new friendly societies into the market and restricting ownership to pharmacists. These provisions prevent unrestricted corporate consolidation in the pharmacy sector and ensure that consumers are protected. The National Competition Council is—surprise, surprise— not happy with this…. Whose fault is it?….. The simple purpose of the **National Competition** Policy Amendments (Commonwealth Financial Penalties) Bill is to enable New South Wales to avoid penalties being imposed by the Federal Government on the advice of the **National Competition** Council [NCC]… urge the Commonwealth Government and the **National Competition** Council to take a more balanced view of **competition** policy.

The advent of dental implants has seen the emergence of 2 groups intent on “cornering the market” through advertising and secret alliances. A few greedy dentist - wishing for more surgery experience in implants, and either the fee for the placement of the implant or the rent paid by the prosthetist - has aligned with the aggressive prosthetists intent on extending their scope to implant by touting for the provision of “over-dentures”. One prosthetist runs a TV campaign costing hundreds of thousands of dollars per year. Another runs weekly ads for “implant dentures” although he has no real knowledge or training of this surgical modality.

6 • WEDNESDAY, SEPTEMBER 29, 2004

Health and Medi

Dental

IONIC DENTAL.COM
'The new Revolution in Oral Hygiene'
Great News for Natural Dental Care
..... The Ionic Toothbrush is Here!
HyG Ionic toothbrush.... clinically proved to remove plaque up to 48% more effectively than ordinary brushing.
Purchase two and receive a **FREE pack of brush heads**.
Credit card order hotline 1800 654 414
or for more information go to
www.ionicdental.com and order online.

WHEN QUALITY MATTERS
*** New Dentures * B.P.S Dentures**
*** Quick Fix Repairs * Quality Guaranteed * Relines ***
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BENCHMARK DENTURE CLINIC
1 Marsh Ave (cnr Manning Rd) Manning
Telephone: 9450 7888

Dental/Prosthetics

Denture Professionals
Robert Mateljan & Assoc
Denture Repairs While You Wait
- **Implant Dentures**
- **Cosmetic Restoration**
- **Functional Enhancement State of the Art Dentures**
- **Lower Denture Solutions**
- **Gentle Treatments**

Balcatta 1/30 Erindale Rd
Vic Park 2/734 Albany h'way
Northam 2/210 Fitzgerald St
FREECALL..... 1800 772 775

SWAN DENTURE CLINIC
Brendon Sheffield A.C.C.D.P. (WA)
Denture Specialist Estab 1985
New Cosmetic Dentures
Repairs and SAME DAY Relines
Rebates from Veteran Affairs and Health Funds
9272 7788

Others advertise with fake university qualifications, others claim to be specialists or grab lines of "quality guaranteed, repairs while you wait"; all meaningless attention grabbers without validity or the use of terms which cannot to be verified. The above advertiser does not use the reserved by statute title of prosthetist, writes a TAFE certificate as if it were a tertiary degree and then claims to be a specialist which in health connotes someone with *special competence* and *approved* training in a narrower field of the discipline of his peers. A TAFE certificate is not a degree of higher learning from a recognised tertiary institution.

The international brotherhood of denturists also tout with fake DMDqualifications – Doctorate of Medical Denturity from a non-existent mystery "university" they have called Mills Grae. It does not exist yet they still use the title on their websites and in publications.

http://www.denturestudio.com/tds_aboutme.htm

The Denture Studio is your designer denture specialist. All full and partial dentures are designed, fabricated and delivered to you the patient within a private Office / Laboratory setting.

Ron Farris started his dental education in 1970. Completed Naval training in fixed and removable dentures. Ron has owned Farris dental laboratory for 14 years prior to graduating from Oregon Denturist College. Licensed Denturist 1989.

* Post graduate degree from Mills Grae University
* First chairman of the State of Oregon Board of Denture Technology
* Member / Officer (ICD) International Congress of Denturist
* Active member (OSDA) Oregon State Denturist Association
* Numerous presentations and seminars promoting dental education throughout the US
* **DDM, Doctorate of medical Denturity** not reconized in Or, Me.

Nice guy but have a closer look at the qualifications?
Specialist: with higher qualifications by examination at a tertiary institution?
Started his dental education? As a dentist or an apprentice?
Oregon denturist college does not issue degrees.
Mills Grae University is a sham, it does not exist
"promoting dental education" sounds vague?
Doctorate of medical Denturity: no such degree

Why would any self-respecting dentist want to be associated with this guy?

The first location for mechanical/trade providers was Tasmania, the second Oregon. The battle was won through campaign contributions from a war chest, the method internationally

advocated and tracked by sites such as “Follow the Money”. The relevance of international activities is important because those techniques are exchanged internationally, Perth apparently sharing the same adviser as Washington State.

MAINE SUPREME JUDICIAL COURT

STATE OF MAINE AND MAINE BOARD OF DENTAL EXAMINERS

v.

RALPH B. DHUY

January 16, 2003

The State introduced evidence of numerous examples of Dhuy's advertisements during these times that were deceptive and misleading. For example, Dhuy was described in a print advertisement as having earned "a doctor of medical denturity degree," magna cum laude, from Mills-Grae University in Kalispell, Montana in 1995. He also announced in radio commercials that he had recently received from Mills-Grae University a doctor of medical denturity, which he referred to as a "D.D.M. degree." These print and radio advertisements are easily recognized as misleading because the common understanding of a medically related doctorate degree is four or more years of graduate work and Dhuy's degree was earned after only four weeks of instruction (with credits given for previous experience!).

> “Steven J. Diogo in the March 2002 AGD IMPACT, (3) Mills Grae University supposedly was based in Kalispell, Montana, but there is no brick-and-mortar school there. Montana is one of the few states where denturists are permitted to practice. Cort C. Jensen, an attorney for the Montana Office of Consumer Affairs, said the operation is one of dozens of Internet-based "diploma mills" operating in Montana and other states that have slim resources for hunting them down”. *Quackery, Fraud and Denturists By Robert B. Stevenson, DDS, MS, MA*

The international war chest antics modelled on Washington State denturists have been exposed by whistleblower denturists and journalist Keith Allison with fearless passion:

> “because of just such judicial/legislative/bureaucratic immorality and fraud, that this state (Washington) will soon find its self in Federal District Court, facing the probability of a judgment mounting into the billions of dollars. This lawsuit names individual state employees, agencies and private citizens involved in fraud, conspiracy, restraint of trade, civil rights violations, extortion and racketeering.

This denturist’s expose of the conspiracy blueprint involving money, politics and examination shams can be found at http://www.patriotist.com/miscarch/ka20030224.htm

The potential for prosthetists to feed patients to dentists warrants further examination as *initially* it appears to be acceptable but in its detail, it is open to abuse and corruption of one of the most honest decision - the referral - a practitioner under the previous model was required to make: “You need the skills of an expert for your problem. *Who* would be best suited to treat you?”

The new model could be: “You need to see someone else. To whom would it be best **for me** to send you for treatment?” thinking quietly, “To my tenant prosthetist who is behind in his rent, to my prosthetist mate who sends me all his toothache patients or to the prosthetist next door in the company facility because I am nearly at my target for in-house referrals and the company will send my family and I to Dunk Island for the next AGM and all expenses paid or will I send you to the best specialist in that field?” Who will be the chosen recipient? The best man or the one with the most lucrative cunning or subtle inducement?

In my 32 years of practice as a “general practitioner” the only think I have ever received from all the specialists to whom I refer patients was a Wayne Dwyer Christmas gift of a paperback book “The Sky is the Limit”. How come I remember? Because it was the *only* time a *possible* inducement was ever offered.

Referrals are an honest selection transaction based on a keen observation of the receiver’s skill. Prior to my surgical implant training, I visited, watched and assisted all the implant surgeons, preferring to send my patients to the best operator, not the one who was the friendliest or the most benevolent.

In Perth today, a patient attending a prosthetist for “implant dentures” would be whisked off to one of 2 dentist practitioners who would CERTAINLY not be the most skilled or ethical operators. Suffice to say that Perth’s two best and most skilled implant surgeons would **not** be considered because firstly they would not ethically agree that it would be in the patient’s interest that a prosthetists should be placing an illegal and potentially destructive structure on his implanted work and secondly, he is busy enough dealing with dentists who are sufficiently knowledgable to understand the modality without having to waste time dealing “out the back door” with illegal non-biological advertisers who would be intent on one outcome: implants that can support a denture. The prosthetist would become a vector influencing the treatment plan outcome. “This one had better be for me” is an expectation unwarranted and perhaps the patient would be better served by implant supported bridges. The net result, ignoring the potential for influence and kick-backs is contrary to the patient’s interest.

Implantology is a complex and rapidly changing field. To keep abreast of developments, the best implant dentists cris-cross the nation and the world attending lectures, conferences and consensus meetings. Those experts freely lecture to our AOS Implant Society at no fee, sharing their knowledge and skills in an academic and critical environment. **Training their own competitors,** in fact, a readiness not appreciated by economists or money mandarins who claim to understand the “dental market place”. A selfless expression of the underlying ethos of the profession: “to raise standards of care” – even if it is to one’s own detriment “in the marketplace”. Hard to explain unless it is an extension of the higher values of the profession as a vocation or calling rather than “a business”?

The foundations of an implant consultation involve assessment of the available bone height and width by reading of OPG, periapical and CT scans and then relating that beginning to possible final options.

The bone volume and the restorative possibilities determine the plan of action. A prosthetist *cannot* decide if a patient is a suitable candidate to have or **not** to have implants. Neither can a prosthetist determine the ideal number or the design, for those complexities involve lengthy discussions, measurements from multiple radiographs and construction decisions. The giving of "informed consent" or the failure to provide this comprehensive explanation has a dramatic legal importance should the patient suffer unexpected infection or eventual loss of the investment. Even saying "you don't have enough bone" requires an expert assessment and such a statement could deny a potential implant patient the opportunity of superior treatment than a partial denture. A knowledge firstly of the existing bone shape, the surgical options for bone grafting or ridge alteration and secondly the crown and bridge options is essential for the patient to understand. If the operator has no skill in this surgery, then it is impossible for them to consult a potential implant patient without breaching the patient's legal and common sense right to "informed consent" or "informed denial" of treatment.

Prosthetists should **not** be the *first portal of entry* to the dental health system. The proposition is as ridiculous as having dentists advertising brain surgery and then choosing who is the best neurosurgeon. "Stick with the knitting" (Tom Peters told Nancy Astor) or 'stick with what you know' or 'the more you know, the less you know' are all sayings which exhibit the importance of knowing one's knowledge boundaries. Law makers should be alert to any group that wants extended scope without true training. Most prosthetists/denturists have sought the dangerous "grand-fathering" entry with limited one day training or quasi-training for later entrants. The journalist denturist Keith Allison was the whistleblower over the antics of Washington prosthetists who bribed officials, arranged reciprocal registration via the Shawnee Indian reservation and then had to pay $3.5 million to the subsequent students who were failed at a 92% fit up "exam". The relevance of this is two-fold: Australian prosthetists claim that we should legislate as other jurisdictions have done such as Washington State and secondly, they are an internationally organised lobby group holding Conferences on how to "lobby" your politician using a "war chest" of money.

Below is the Washington Denturist newsletter-advising members "to not let the patient out the door" and to run advertisements using a bogus or a non-declared identity. Interestingly the patient is referred to as "a prospect". They and the Perth prosthetists share an adviser of the same name "R. Adams" perhaps coincidence yet the point is that the dental technician movement is an international one, intent on overthrowing science trained dentists whilst ultimately their goal is to be permitted by gullible or greedy politicians to take radiographs, bleach teeth, employ dental hygienists and dentists - all for their own profit and certainly NOT for the benefit of the patient.

The egregious newsletter is also resplendent with fake qualifications again from Mills Gray, the non-existent university. Many denturists starting to place DMD behind their name to copy/confuse the dentist qualification DDM but remember Doctor of Medical Denturity is a concoction of 'smoke and mirrors' hoping to mislead the public.

Note the language – “sell, sold, prospect, money, marketing, lag in your income, don’t let them walk out the door, anonymous phone numbers in adverts ”.
Note “they often hate their denture”. Prosthetists always blamed dentists for the bad dentures, but now they are admitting that even they have “denture failures”?

WDA CELEBRATING 10 Years

Overdentures

continued from page 5

Be sure that you receive and keep certificates for each program that you do so you can easily establish your qualifications to do dentures on implants.

Now educate the patient

More and more of our clients are offering dentures with implants to their patients and, as in any service, we have found that there are right ways and wrong ways to meet this new challenge.

If you have working relationships with dentists, oral surgeons or periodontists, referrals from these individuals may well have already been sold dentures on implants. No brainer.

In the case of your own patient, new or old, who are candidates for dentures on implants, offer them this option along with the usual denture type you sell. Give them a full understanding of the benefits and downsides. Sell them what you believe in. Don't let them walk out of the practice without having made a choice.

The biggest downside is that the patient will have to undergo surgery, though relatively minor. Not all patients will want to proceed with that.

Then there is the cost. Present the value and benefits to overcome this. One prime factor in getting patients to go ahead with implants is that they often "hate" their existing denture.

In other words, there has to be a strong motivation on the part of the patient in order for them to proceed with implants. Your job is to educate the patient and create this motivation.

Business matters

Begin cautiously and selectively when first starting to offer implants on dentures. You need to build your team and gain experience and work out all the bugs before you get fully into them. Also, keep in mind that patients who decide to go ahead with implants will not be returning for some time for the denture, so there will be a lag on your income from delivering this service.

A separate ad or line of advertising can be set up which is designed specifically to attract patients who have some interest in dentures. This advertising should have a different phone number or something which clearly identifies the prospective patient as someone who is specifically interested in implants. One such ad which was run in the U.S. is: "Loose Dentures? Call 123-333-1234".

Another thing to watch out for is that prospects cool off over time. In other words, once they've decided to see the specialist for their implants, they must get in there and get serviced as quickly as possible. They won't wait three months to get a consultation with the specialists. Therefore, if necessary, work out special arrangements with your team members for fast service to your patients.

The political actions of the prosthetists in those Australian states where Parliament has determined a protective clause “under the prescription of a dentist” has been to immediately

recommence lobbying for the removal of that safeguard of the public welfare. “Know thyself” or “Know your limitations” are mottos that they have expunged. Yet, is that not the role of education? Certainly many prosthetists in WA have never proven their competency in literacy or numeracy by examination after having finished their 2-year apprenticeship. One prosthetist actually failed to pass his dental technician apprenticeship course. Additionally, there is no consumer representative on their Committee. They have refused overseas dentists registration. Their numbers and locations are unknown: it was registration by one fee only for a lifetime; ongoing administration costs being funded by the taxpayer.

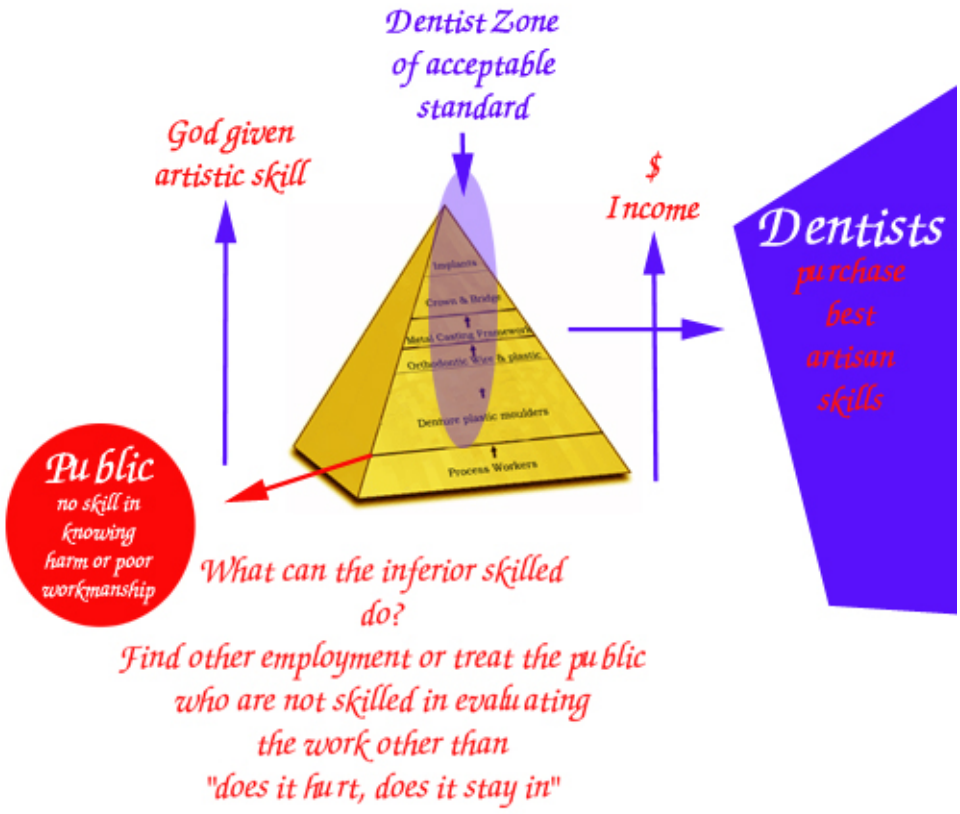
Double frustration for a dentist occurs when a new patient attends with toothache claiming to have seen a dentist 3 years ago… “Oh, I cannot remember his name” being a common but telling evasion. The embracing unhygienic partial denture is often found to be cast into a cavity of decay, the bite is high and the patient then say “oh, actually I had it made privately by a friend of a friend who is a technician/prosthetist”. Often when the matter is pressed as to how much they were rebated by their health insurer the reply is “oh, because it was a favour, I had to pay cash!” At this stage, a moment of mutual realisation, the patient can be expected to be never seen again. Certainly for an insured patient, a prosthetist’s main lever is a “cash deal” or dealing “direct with the manufacturer”. The actuality of this is often a falsehood for the big Perth Denture Barons employ up to 12 technicians, so they are not doing the construction themselves, rather acting as the dentists or architect and delegating the moulding to auxiliaries. In between times, they sip cappuccinos with their advertising agents or some of the underworld figures, planning their next campaign upon the gullible public.

The cash component of the whole dental technician industry explains why these millionaires can afford to spend so much money - far in excess of a dentist’s profit - on advertising and puffery. Traditionally, a tooth broken from a denture was repaired by a dentist who also inspected the mouth, discovering perhaps decay or pathology. The average Australian possesses 3 decaying teeth. This ***diagnostic opportunity*** saved the patient teeth, money and occasionally the patient’s life. It often commenced a program of rehabilitation for a delinquent mouth and the removal of hidden decay discovered on radiographs. The current model wherein the “emergency denture repair *specialists*” – prosthetists – this apparently *modus* of direct cutting out the middleman actually removes the dentist’s diagnosis and expertise from the treatment phase, thus increasing the nation’s liability for undiagnosed and delayed treatment. Insured patients who would **never** attend any health provider unless they were qualified for the task will pay through higher health premiums for those less cautious who **do attend** a prosthetist who has inadequate equipment and skill for diagnosis of impending problems i.e. No x-ray machine and criminally no autoclave.

The dental laboratory industry consists of many highly skilled workers who work exclusively for dentists providing dentures or crowns or orthodontic plates to move teeth. The highest skilled – ceramists - earn incomes far higher than dentists and they deserve such recognition for their rare artistic skill. Nationally, some laboratory owners employ up to 30 technicians providing work exclusively for dentists. This arrangement is “in the patient’s interest” because the dentist acts as the patient’s *agent*, purchasing those skills and

continually evaluating the quality and fit of the delegated work. Should the standard drop, the dentist merely uses another laboratory. These decisions are easily made by a dentist, just as a concert pianist can quickly evaluate a piano or its tuning. A consumer does not know a quality construction and under the conventional model, their decisions and outcomes were based on an assessment of the dentist's skill and integrity often by referral from friends or other dentists. Under the proposed new model, the patient will have no agent, no filter for quality and will most likely attend those street front prosthetists who could not "cut the mustard" at the high skill end of town. Parliament's registration of those less skilled technicians with another label with give an imprimatur of competency to a group who neither have the science skills nor the ability to advance up the 2 conventional income/skill ladders.

Most patients highly value their regular dentist's integrity. The infrequent attendees are often "hoppers" moving from one dentist to another, often a self-destructive strategy.



The industry worker layers of skill are:

Implant crowns and bridges
Crown and Bridge ceramists
Metal casting partial denture frameworks
Orthodontic wire and plastic
Denture plastic moulders
Process workers

The less skilled mix it with some “private” and some dentist work. The technician that cannot sell his skill to the discerning dentist market has only 2 options: find another job or sell to a less knowledgeable market – the public. Within that structure are casting labs who, like their jewellery counterparts, cast metal structures on a subcontracting basis to other labs. Similar to a CBD mall jeweller whose rings are actually made in Sydney *en mass* by a workshop exclusively casting metal and then the boutique jeweller’s shop customises the ring to fit the customers finger, dental casting laboratories fabricate castings for all the other laboratories who then add the prefabricated factory teeth (made in Chinese, German or the more expensive American factories) and cure the supporting pink plastic in a vat similar to a Christmas pudding. This processing technique is the *trade secret* shared with every first year apprentice.

So, a prosthetist working illegally providing partial dentures is cautious not to leave a paper trail. The patient is told that they can should a partial denture but “I cannot give you a receipt because it is not permitted under those silly State laws, but my fee will be far less than those horrid dentists”. So the patient pays cash, the casting lab, also keen not to leave a paper trail does the casting for cash and the patient receives a denture that may be supported by decayed fillings (the prosthetist cannot take or read x-rays), it may be high in the bite (the prosthetist does not have a dental high speed handpiece or if he does use a Demel type drill he will release mercury vapour from dry grinding the mercury amalgam).

Nevertheless, in WA, the whole prosthetist and casting lab sector is rife with cash transactions based on the consumer’s apparent thirst for a “good deal” (albeit 4 times the fee charged by a dentist) yet the subterfuge will continue along with the masterful disguise not to incriminate anything to paper. In SA the introduction of legislation and penalties will not stop this entrenched practice of making illegal “rabbits” for cash. How could it be stopped? All partial dentures under construction in a laboratory should be accompanied by a dentist’s prescription.

The net benefit to society when the prosthetist charges $6000 cash compared to my fee of $1500 when the quality is so appalling is hard to fathom. Many a stereotypical pensioner has sat in my chair saying he opted for the top $6000 model denture for his wife and whereupon I look at the troublesome denture and see something that should be at the bottom of a Kellogg’s cornflakes packet. Make any comment and the patient will not return!

It must be better than any alternative regulation or policy tool. It is not enough to compare a regulation to a counterfactual of no regulation, but to compare outcomes across all feasible policy alternatives.

The outcome for a Prosthetist denture is a gamble with a huge expensive down side for a patient that might have had a tooth diagnosed as decayed or high thus preventing its loss, infection or treatment. The cost leverage is basically: pay a dentist $40 for an examination and each tooth diagnosed with a cavity avoids a filling or root canal therapy followed by a crown. That's $2000 saved by that diagnostic opportunity for each of the 32 teeth or $ 64000. Thus for $ 40 out the saving could be $64,000 i.e. 1: 1800 odds so say 1:2,000. Said another way,

"For every dollar spent on *dentist* diagnosis,
A $2000 potential saving
or
For every dollar *not* spent on dentist diagnosis
The consumer or taxpayers or Health Funds could have to spend an additional $2000.

A prosthetist partial denture can NEVER be better than a dentist provided denture because a prosthetist will always be taking a gamble on the foundations, which cannot be assessed by the naked eye. Radiographs are required and an understanding of anatomy, pathology and teeth sciences. The best alternative is one type of provider – a dentist – one regulator, one system, one structure rather than two. Prosthetists do not want track with dentists and similarly dentists do not and should not associate with prosthetists. It is contrary to the patient interest that prosthetists are the first portal of entry to the dental delivery system. With advertising implant prosthetists, they are attempting to corner the market and some have aligned with the lesser dentists who have referral arrangements of a hidden nature. Multiple door referrals or in-house referrals are complexities with draconian outcomes of kickbacks, target figures and implicate expectations. The existing system operating in the dental profession is an honest method of determining the most appropriate specialist. Free from expectation and free from fee sharing, kickbacks, and hidden commissions or discount considerations. An in-house prosthetist or a cost sharing advertising arrangement between a prosthetist and dentist would necessarily be between greedy or hungry providers, the good dentists being sufficiently busy with appreciative patients and referring dentists.

The existing policy tool for the practice of dentistry is " display a knowledge and skill" to *this* level. Anybody can be a dentist – short people, blacks, whites, Jews, Muslims or even women! (Sic) Just display that you understand *this* about say HIV, or decay or medicine. The *this* standard is a minimum understanding for the

protection of the public. For a hypothetical situation of a dentist next to a prosthetist on Main Street, a patient with HIV would expect that both providers understand the condition, not that one of these providers only knows how to *spell* HIV. The standard, the expectation are the same, therefore, they must be trained and examined to the same level of competency and understanding.

Additionally, there is no point training someone for an occupation for which there is no demand. Health providers are initiators of treatment, so a saturated market will lead to overservicing such as highlighted in the 1982 Joint Committee of Public Accounts Report 203 “Medical Fraud and Overservicing” wherein it was revealed that NSW had 5 times the rate of hysterectomy than for other States. Similarly in a barren market, prosthetists and dentists *will* find work to do, either by replacing acceptable dentures or fillings or by extending the scope of practice which, for dentists, may be collagen injections, facelifts or nasal surgery and for prosthetists, as is happening right now, to sleep apnoea devices or headache splints and night guards – a field way out of their diagnostic league which constitutes quackery of a lethal nature.

The final proof of the stupidity of the experiment is that **NOT ONE** Perth DENTAL PROSTHETIST OWNS OR USES AN AUTOCLAVE TO CLEAN AND STERALISE THEIR MIRRORS AND PROBES. A dentist colleague has just voluntarily upgraded his autoclaves by writing a cheque for $60,000 yet prosthetists remain resilient in their archaic practice of soaking instruments rather than using high-steam high-pressure autoclaves. They have become an isolated Gulag ignoring community standards of practice, ignoring bacterial, viral and prion outbreaks as if it did not apply to them. We have already had one Health Minister die from CJD.. how many more must die before these dangerous transgressions are penalised or regulated ?

My complaint to the Health Department about the non-existence of prosthetist autoclaves was to be told that the infection examiners were told to “leave it alone – it is too political”. What if it was Ebola, not HIV or hepatitis that was my concern? Still political? Politics above the good and safety of the citizens?

This failure to comply, this failure to be held accountable for the irresponsible low quality of care is of national Public Health importance but alas, the regulators sit on their hands biding their political masters wishes to protect the millionaire cash packed electoral helpers. Yet, a Health Minister Marie Tehan has already died from CJD.

It must be robust to errors in the assumptions underlying it. While portrayed as a dull bureaucratic process, many regulations could be more aptly likened to risky experiments.

The Dental Board has perhaps 2 major faults: no policeman on the beat visiting laboratories and secondly, the funding of legal cases is not paid by the State, rather from registration fees paid by dentists. If corporate owners were allowed to provide dentistry in the future the

complexities of shareholder structures, inducements and influence could blowout the costs of any action by the Board. The existing system has been a simple *no-cost* excellent protective mechanism for the public. The new system, wherein cases are to be taken before State Administrative Tribunal not only emasculates the professions time honoured "policing of one's self" without *any evidence* that the Board had failed in its duty to protect the public but it gives a non-dentist the obligation of determining the significance of technical matters, and most importantly the relevance of those technical matters to the performance of skill and care compared to community standards amongst a practitioner's peers. Where will the pendulum swing? Perhaps more times towards the delinquent practitioner as a dentist is more likely to be *morally outraged* by a mouthful of filling overhangs than a lawyer.

The Prosthetist Committee has had no real income because of the one time registration fee and the history of few court actions taken against prosthetists would indicate a lack of Health Department funds or resolve to pursue.

My recent complaint to the WA Commissioner of Health about prosthetist advertising resulted in a response:

> *"I have considered the issues you have raised and made a decision in relation to the dental prosthetic services concerned.*
> *Thanks…*
> *Mike Daube Commissioner of Health*

A minimalist, no outcome, no revelation Teflon response with a vernacular equilivant.

Legislation to extend prosthetists to teeth or implants will go down as the dumbest legislative experiment in health care, globally showing proven graft, corruption, cronyism and legislator bribery and profound dental ignorance in utterances by legislators or drafters of reports. A tradesman acting as a first portal health provider has a faulty assumption and a proven faulty application. The last 20 years of WA's legislative experiment has shown advertising of a totally unfettered "free for all", with prosthetists failing to identify themselves in advertisements by using their reserved title, posturing as adviser about teeth – a defined act of dentistry- quick one stage mouthguards for school children plus blatant transgressions of scope of practice restrictions by thumbing their noses at the law. They also provide patients who brux with rubber sports guards – sacrilegious. *Why* would someone pose without their reserved title of "dental prosthetist" unless to be seen as someone else – to be seen as a dentist?

Such omissions and the incidence of advertisers calling themselves specialists would indicate a broad pathologic view of themselves as being *above* dentists. Dentists are *not*

busy exceeding their scope of practice or falsely advertising yet prosthetists are hell bent on increasing their public projection. Why? Money and self-aggrandisement I contend.

Dental implants are the *Olympics of the Mouth*. The modality is based on the radiographic assessment of bone height and width, density and complex restorative options involving the removal or preservation of teeth, possible crownings, infections or suitable or failing root canals, selection of implant surface type, bone densities and augmentation techniques and restorative options. The full challenges of dentist's skill is required from the beginning "Yes you can/No you cannot have implants" to the end maintenance and interception. A prosthetist wanting to make a denture "for the patient he found" is not skilled to either make those big picture decisions nor is he a desirable factor to be influential in his expectation of a denture as the desired outcome. The prosthetist should not be the entry door, or the director, or the catalyst for any treatment option. A prosthetist cannot provide informed consent to either proceed with implants NOR to not proceed. "I have sent you 3 patients for implant dentures Dr Surgeon, but you have advised them to have bridges on the implants, so this next one better be for an over-denture or I won't send you any more of my patients…. Got IT?" Perhaps that would not actually be said, but a prosthetist would eventually find a compliant dentist rather than the best surgeon who may institute a higher and more suitable treatment. The hospital gardener should not be touting for the neurosurgeon delivered lobotomy and nor should the dental technician be holding himself out at the fountain of implant knowledge.

The regulatory appraisal process should take explicit account of the likely outcomes if the regulator turns out to be wrong about aspects of the effects of the regulation.

"Old dentists never retire,
they just slowly fade away.
Their level of indebtedness and
their failure to seek a return on their capital invested
means that they break even at the age of 132.
Avrim King Dental Economist

Legislators may be sardonically pleased to take away some dentists' livelihood, but they will have to wait till the old prosthetists die out. Certainly the prosthetists have been "cherry picking" from young struggling dentists who have to spend about $200,000 per chair to "set-up". The dentures and repairs have dried up, so with that have been the diagnostic opportunities. Eventually the patient will return for pain relief so the complexity of the day has altered from simple to complex pain/infection/diagnosis and dramatic interventions.

Many politicians immediately assume that the universal dentist (and their chair-side nurses!) reaction *against* trade trained first portal health providers is because dentists think dentists will earn *less* money. Wrong. Dentists will be providing more reparative root canal therapies and crowns on last year's small cavity, which was undiagnosed and is now huge. Prosthetists will cause dentists to earn MORE money.

Dentists are “procedural” for 8 or 10 hours each day. Most young dentists having to work 5 days a week plus 2 nights and Saturday mornings tied to their chair just to pay their overheads. With 80% overheads, many dentists don’t commence profitability till Friday. Medical surgeons usually operate in the mornings, consult in the afternoon. The strain upon a dentist, day in and day out doing fillings is awesome for body and soul, somewhat like a battery hen or a pilot in the Battle of Brittan being scrambled every 40 minutes. Dentures were never profitable, more loss leaders or a service, but at least they allowed the dentist to stand up for 20 minutes.

Prosthetists are playing for big cash dollars by advertising for implant dentures. The taxation paid on these illegal structures is unknown, but it is highly probable that a prosthetist is NOT going to issue a receipt for an illegal denture on implants lest he incriminate himself.

My calculation for my profit for a $750 Rolls Royce denture compared to the $3000 cash payment for a Goggomobile denture was that for my $200 profit to match the cash payment, I would need to make 14 dentures to each 1 made by a prosthetist for “cash”. Not really a level playing field? Even if the prosthetist writes a receipt, still, I am disadvantage by a factor of 7.

Certain errors may completely overturn the gains from regulations and knowledge of these may make it sensible to re-design the regulation or, in some cases, not to proceed at all.

Dentists only want prosthetists to be educated to the same standard, as they had to prove as undergraduates or to the standard required by overseas graduates seeking competency recognition and registration. The reality of most dental courses is a high failure rate amongst the cream of the Secondary School system. How apprentice TAFE students would find basic sciences and biological disciplines to study without the necessary grounding sought in school subjects that they may not have done remains conjecture yet it is the same risk any student takes, but the same understanding of the human machine and science is necessary by written and practical examination. Dentists would be happy to see dental technicians study the existing course of dentistry under a state funded scholarship scheme. There have been a number of dental technicians who have returned to study and they have made excellent “full service” holistic dentists. Full service means multi-skilled, multiple income sources as contrasted against a prosthetist who can only deliver one product – a denture, whether it is necessary or not, only one source of income.
Partial dentures are oral time-bombs: at every point of contact with a tooth or gum, a biological environmental change occurs increasing the mouth to dramatic increases in gum disease and decay. Preventive education (a dentist invention) is necessary on an on-going regular basis – a second dentist invention – the recall program.

Most prosthetists work solo. They do not employ dental nurses nor do they provide chaperoned attendances. They administer, clean up and answer the phone without any staff. Can they operate and understand these preventive programs without clerical assistance and basic science education?

It should contain the seeds of its own destruction. Good regulations should not presume their own immortality, but allow for ongoing appraisal of their risks and continued effectiveness. If a regulation endures, that should be because it continues to pass stringent tests.

WA has had no assessment of the excellent dentist standard and the pitiful shameful standard of Prosthetists and the problems dentists observe weekly amongst patients who have had dentures full and illegal partials provided by prosthetists, usually for cash.

Dentists would welcome a stringent test of our quality and our fees, which could be easily profiled through insurance claims data and Vet Affair intra-oral examinations by "blind" examiners ie the Professors would not know who made the dentures.

If there is no politician with the stamina to protest about prosthetists not using autoclaves, it is implausible that one would exist who would "try to put the dental genie back in the bottle" by saying "no more fake trained mechanical dental providers".

My observation is that the standards of prosthetist dentures are as poor as they could possibly be whilst the fees are sometimes 400% greater ie my fee $1500; many prosthetists charge $6000. Generally, the prosthetists are 30% to 400% higher than dentists as evidenced by insurance receipts. For the uninsured patient paying cash? They may pay more?

WA dentist education standards have led the nation for the past 50 years. The local school has been most vigorous and excellent training for some of Australia's finest and most respected dentists. Its failure rate is testament to "how high the bar" has been applied. Perth's University of WA dentists are sought after in many other countries yet denigrated and shrugged off in their own parochial political society? Nevertheless, dentists consistently rate **highest** as the most credible professionals and the most credible ethical occupation. This will not be so in the future under NCCC changes when 'it's only a business lid' blows off.

It should state (ex ante) what it is going to do and, as far as possible, establish verifiable performance criteria.

Dentists would welcome an examination of the performance of prosthetists, their charges, the quality and the adherence to the law. WA dentists' fees are close to the lowest in the nation.

Prosthetists have not published a public document or argument for expansion of scope to partial dentures and structures on implants. Verifiable quality and fees could be easily assessed by an independent (real) specialist recalling some of the patients and reporting on a device quality. Easy.

This tests a regulation for precision and relevance, and provides a basis for assessment of ex post effectiveness.

The Hodge/Burke "for friends by friends" legislation of 1984 allowed a one time registration and just one fee for a lifetime licence. Government would not know how many

of the registered prosthetists are actually working… probably less than 50 but they certainly don't know because the sweetheart Bill didn't require annual registration, renewal or further funds to assist defraying administrative costs. Some registered prosthetists may have actually left the State or the mortal coil; such was the speed and recklessness of its passage through Parliament in 1985. They are a Lassiter's reef, lost in the hinterland.

Viewed upside down, the taxpayer receives 50% of a professional's profit as a "sole trader". Each dentist or medical practitioner is acutely aware that his or her total asset base underpins his or her every clinical action and advice. The family welfare, the house, the savings and the car are all vulnerable to actions for damages. With the introduction of incorporated practices and distant shareholders, tax payments can be reduced by perhaps an off-shore company in a low tax zone such as Hong Kong or Cyprus receiving royalty payments, licence fees and corporate charges for the companies added international structure and advertising expertise. The net benefit of incorporation for the service provider would be lower taxes, international tax minimisation, shifting of assets outside the jurisdiction of the courts in actions by consumers for alleged acts of negligence. The disadvantage to the consumer and the nation's coffers is that the tax paid by those corporations would be optional not mandatory, the funds available for consumer compensation would be less as the provider's assets could be held in international off-shore trusts with escape "duress clauses", allowing those assets to be moved ahead of any court interception. A large corporation owning many Australian dental surgeries could insist that all constructional processes involving crowns and dentures be airfreighted to the new facility in China. Something costing $200 now could be made in China for $20, the Australian subsidiaries charged $300 by the Hong Kong Branch and the profits repatriated to a 15% tax zone. The Australian consumer would be charged what the market would bear and new Australian dentist graduates and dental technicians could not compete. But at least we had our competition, which is small consolation but great ideology nevertheless until either the system imploded or just a few colluding corporate insurers controlled the field.

If a new safety standard is approved for … how many ..accidents is it expected to avoid?
Prosthetist patients are going to have many "accidents" because decay etc will be missed due to no radiographs, no training no diagnosticians "eye". Dentist work will dramatically increase for dentists will have to provide replacement dentures after root canal therapies and crowns on undiagnosed decayed teeth or implants.

If (speed cameras) are deployed for reducing accidents do they do so and by how much?

Prosthetists claim to be cheaper but often they are 30% to 400% more expensive. This data is held by Health insurance companies based on actual receipts. As much of the illegal work is cash with no receipt, many of the higher "come in spinner" charging patterns will be unknown because they were never documented.

It should be clear and concise. It should also be communicated effectively and be readily accessible to those affected by it. Not only should people be able to find out what regulations apply to them, the regulations themselves must be capable of being readily understood.

What layperson, politician or magistrate knows the difference between a hybrid bridge and an overdenture or a spark eroded Procera Bridge. If a patient has been charged a Rolls Royce fee for a denture and delivered a Goggomobile, would they know? Would the result be discernible? No. The legislation will be an open slather free for all by non-biological pretenders. The title “dental prosthetist” is confusing and inappropriate. “Denturist” is an American term, preferable because it accurately conveys the limitation to dentures and prosthetist is too close a term to the true 8 year trained dentist specialising as a Prosthodontist. Nevertheless, the Act states certain requirements, which the Minister has over-ridden without sanction by Parliament or perhaps he even wielded his stick without anybody else knowing that the Act is to be now considered irrelevant and secondary to His own highly inspired wish and desire? Eureka was supposed to prevent this kind of executive interference when miners won the right to elect their representatives onto what was previously a squatter controlled Board raising their registration fees.

It should be consistent with other laws, agreements and international obligations. Inconsistency can create division, confusion and waste.

In America there are 40,000 dental technicians and about 39,940 work for dentists. Denturism started in Tasmania a state with severe deficiencies in iodine, fluoride and perhaps other trace elements. The high decay rate of Tasmanians was legendary, yet even today, no dental school exists. The WA administration of prosthetists has been by Committee under the Health Commissioner. The Committee meets about twice per year. The inconsistencies of rule, the advertising by prosthetists yet not dentists had led to a greater market share due to intentional misleading and deceptive advertising practices, demonising of dentists such as a recent jingle “ We don’t give needles and we don’t cause pain”. Other unnecessary and unable to be substantiated terms with implicit denigration of other providers is the frequent use of “gentle treatments” somehow implying that others are not gentle so be careful not to go somewhere else.

It must be enforceable. But it should embody incentives or disciplines no greater than are needed for reasonable enforcement, and involve adequate resources for the purpose.

Police have been lobbied to discontinue co-operation with the Dental Board. They made their announcement some days prior to the defeat of the Bill Hassall Government. The technicalities of definitions are changing and neither patients nor the law nor the legislation can cover the restrictions, which they will break whatever is declared. They are above the law for their own behaviour; they only want the law changed so they can access HBF and Veterans Affairs or any intended national dental scheme.

Finally, it needs to be ***administered by accountable bodies*** in a fair and consistent manner. Governance arrangements for regulators are clearly a big topic in their own right and currently under review at the Commonwealth level. Apart from the nature of reporting responsibilities (to a Minister or the Parliament) and the scope for judicial or administrative review, important features of good governance include clear statutory guidance, transparency of both process and judgement, and public accessibility.

The WA Health Consumers annual report overlooked a prosthetist’s ill-fitting partial denture provided illegally, rather concentrating on refunding the fee because of its ill fit. If the Health regulators cannot detect the illegality, how will patients or magistrates?

There is no consumer representative on the state dental prosthetist advisory committee.

In WA Health Ministers have conveniently and undemocratically ignored the historical separation of powers between themselves and registration boards. They have leapt over the hurdles, the checks and balances. It is rumoured that Labor Health Minister in the 1980's directed the Chiropractic Board to register his unqualified friend. Also, it is rumoured that a Minister directed the Dental Board not to act against advertising by prosthetists or dentists in spite of the express wording of their Act. In 1980 the Liberal Minister Ray Young eliminated the election of members of the profession to the Dental Board, a democratic principle founded in the bloody sticky mud of the Eureka Stockade: "no registration fee/no tax without representation". Minister Young preferred to select "from a panel of names". Brothers? Comrade? Member of the Illuminate? Are these the new arbiters of suitability for citizens? The deletion of the historic clause could lead to cronyism and a stacked board, which for the Eureka miners was a Board stacked with squatters, for dentists, members of the Minister's party or the Politburo? Democracy is the sum of the composite parts. Dissolve the checks and balances and pave the way for entrenching hidden powers to distort legitimate thinking and promote their own puppets.

Our democratic structures must be erected and then defended to prevent the easy acquisition of power by conniving groups, not just for a Minister's convenience. Separation of registration Boards power from politician or bureaucratic influence plus the dentist communities right to directly elect representatives onto the Board are worthy checks and balances deserving reconsideration. Eureka has been conveniently forgotten 150 years later or has its true meaning been seen as a threat by Ministers intent on "giving gongs" to their mates or just wanting unbridled power unto themselves?

Consequently the regulator can be in the pocket of the Minister and the body of dentists, free from any ADA influence is emasculated from altering the course or lack of regulatory adherence. Those closest to the coalface are silenced. The workers are disenfranchised. Power blocks and influence rule. The Premier refuses an audience, the Health Commissioner writes 'with mirrors and smoke' and nothing happens.

As a result, the Dental Board cannot control the activities of prosthetists who are behoving to the Health Commissioner both under the protective wing and whim of the Health Minister and his power faction, nor can dentists protest at the prosthetist's criminal failure to autoclave their instruments as there is no stage or platform upon which to protest.

The prosthetists and their self-stacked Committee are
A Power of One.
No accountability.
No responsibility for the public welfare
No action taken to regulate hygiene standards.
Open slather advertising.
No future.
Reign of Terror

The NCCC review has unleashed a creeping tumour of doubt and uncertainty giving scent and encouragement to the purveyors of public health quackery, the seekers of quick fixes and the cowboys of the mouth seeking further millions.

Professional standards and ethics are not a conspiracy, nee, they are a necessity.

Dental ethics (Goggle reports 400,000 entries on the subject) is the oil that lubricates the dentist machinery in the patient's interest.

Standards of skill and behaviour may be "hidden" from the public or observers, but they exist through voluntary or honorary structures such as the ADA, the study Societies and hospital credential committees. They may be hidden from economists profiling the profession, yet their work is laboriously committed to the public welfare. If the profession's peer review committees' sympathy went too far one way, it would be to the patient's favour. Examination of the court/hearing testimonies by dentists (see many Dental Board websites) against sub-standard practitioners exhibit a resounding determination to reveal the actuality and consequence of treatment falling below those community standards. No conspiracy of silence or protection of a mate, just honest and tenacious defence of " the public interest". The hot new legal requirement of "informed consent" is a noble but contradictory matter when 2 providers operate in the marketplace, one with biological training and the other with a mechanical base. The latter cannot give "informed consent" or "informed refusal" for matters such as implants or even the presence of decay because they are ignorant of the necessary signs, symptoms and theories.

The public requires guidance as to a provider's *minimum* ability at least upon entry and then through continuing education. All of us are often limited one-time consumers of health, one-time consumers of a frontal lobotomy, 2 or 3 dentures, 3 or 4 head radiographs. How can a patient determine that an adverse outcome is due to patient factors or negligence? Dr Good certainly has failures but the marketplace in dentistry can be distorted to favour Dr Bad: he never hurts because he never removes all the decay, he charges less because he just patches, he never has patients with endodontic toothache problems because he extracts troublesome teeth. Many young news cadets "do a story on dentistry" travelling to 6 dentists for an examination. One dentists determines 6 fillings, the others none. Deduction: the dentist who found 6 fillings is Dr Bad. Perhaps wrong, as Dr Good might have greater diagnostic skills in locating the defects and acting according to his assessment of the patient's future risk. The point is that practicing dentistry is difficult for the Dr Goods and easier for the raconteurs and entrepreneurs who will eventually enter exclusive deals with nurses, teachers sporting clubs and health funds, tilting the competitive table to their advantage and against Dr Good or new entrants starting a new practice. Dental practice and the demands of honing ones skills is busy enough without meetings and conspiracies with corporate lawyers and advertising agencies.

Certainly a bad or good outcome does not indicate the level of competency applied, perhaps rather just the normal statistical scatter of any treatment's risk like throwing a coin. In such an asymmetrical marketplace other safeguards are required: high entry standards, peer review and severe penalties for malpractice, over-servicing and market leverage. Economists say that in an asymmetrical market place the consumers need an agent. These quality matters are the lessons of history and should be the focus of the NCCC, not the predictable fixation with "price" for it is an illusion. Dr Bad can generate more profit than Dr Good. A greedy provider *will* walk Parliament's corridors seeking an enhanced platform for his business. Quality regulations inhibit the entrepreneur who would gladly let his grandmother extract teeth or make dentures if there was a profit to be made. Often it is the *rate of application of a fee* rather than its magnitude, which is more important. Dr Good charges $100 for a particular type of filling. Dr Bad charges $80. A superficial observation might be that Dr Good is overcharging, but on examination of the charging pattern, Dr Good might charge only for the first 2 of those 8 small fillings, but Dr Bad charges his lower fee for each one. This was the key to dismal failure for the British National Dental Health scheme. Dr Bad behaviour was rewarded; Dr Good left England in order to maintain his/her integrity.

Dental fees reflect no valid information relative to selecting a dentist or prosthetist. Dr Good uses 87% gold 12% platinum for all his crowns, whilst Dr Bad uses a cheap alloy of beryllium. Dr Good charges more than Dr Bad, but many patients will leave Dr Good to attend Dr Bad because he is cheaper. Dr Bad's crowns don't last very long, that is why he is so busy. Unfortunately a consumer cannot apply the same technique for choosing a supplier of groceries to the selection of providers. Emphasis on price misses the whole point about time skill care and judgement being the foundations of professional fees.

Dental prosthetists want to do acts of dentistry? Yes.
Then do the existing course called "dentistry".

Partial dentures are oral explosives. Prosthetists are landmines of ignorance and merely a political pretence founded on quasi and quick courses and they were a faulty Tasmanian creation carried out with NO ASSESSMENT of quality, price or standards of knowledge.

There should be one standard for all *first portal* dental providers. Furthermore, dentistry should not be fragmented into independent archipelagos because those islands will become intellectually isolated and paranoid in their thinking, which will lead to grandeur in behaviour. Any attempt to allow dental hygienists, prosthetists or dental nurses to run their own business in Main Street will pick the cherries from the legitimate range of services a dentist offers plus it is illogically to assume they will detect the myriad of pathological events from the simplest decay to carcinomas. Well, taking the profit centre from dentists may have an ideological satisfaction for some, but the suddenly idle debt laden dentist could be a dangerous over-servicer either of his patient's **extent** of treatment or by not remaining within his/her own skill boundary i.e. a politically neutered dentist might start doing procedures that he would normally have referred to a specialist. It then worsens as the specialist becomes idle and then extends their frequency or range of services. An analogy

might be removing all the moles and sunspots from plastic surgeons practice by creating a competitive “auxiliary” with a quick course say for seamstresses skilled in stitching and cutting. What will the plastic surgeon do? More complex and expensive plastic surgery! And the consumer/taxpayer will pay.

Other occupations could be given direct access to the public and thus allowed to peddle their cures and balms:
“frontal lobotomies 2 for the price of one,
have your blood checked and a free x-ray by our 2 day trained expert,
ears washed with every prostate examination in our discrete tent,
get any antibiotic from our pharmacy without having to see any doctor”

Those touts are medieval echoes yet some economists not skilled in understanding the map of our historical path might have us back in that wonderfully free market? “*Abracadabra*” all the advances would be over so quickly!

Cute terminology, warming phrases and motherhood statements about consumer rights and choice could catapult us back 500 years into quackery with strutting infallible mountebanks.

Our 2004 Australian society is *chock block* full of quackery, witches and peddlers of scams, teas and pills. The modern claims make the Ray Barrett radio adverts for F..O..R..D pills of the 1950’s seem harmless, yet they too touted falsehoods, as did *Dr McKenzies Menthoids* for backache, lumbago and rheumatics. Two standards exist. One of rigid proving for the science based medical and dental practitioners, another vacant nod for anything herbal, diluted, vitamised or organically cultivated. If it grew, it is OK, if it was extracted with chemicals, well sorry, off to the TGA.

All goods claiming excellence or cures should be proven to the same scientific standard, but they are not. Why? Because it is not politically expedient to be viewing or testing alternative “medicine”.

Accordingly, there is an ideal number of *true science* health providers required in a community so that they are kept busy with real need rather than having to resort to drummed up (by advertising) demand for "aesthetic" procedures of dubious benefit. Much of the facings and smile make-overs are borderline malpractice where a slightly discoloured or chipped tooth is invaded by removing healthy hard tissue and condemning the tooth to a lifetime of maintenance and increased complexities.

First portal providers serve an important titration and screening selection to more expensive procedures provided by specialists. Also, they manage the patient's overall progress,

monitoring, advising and evaluating the specialist's standard of performance. Shopfront quasi-trained seamstresses, tooth cleaning boutiques and partial denture While U Wait "professionals" will only really be in their own eyes and those of their political creators just as Mary Shelley's scientist, Victor Frankenstein also relished his own creation.

Dental implantology would be an example of skill over-extension: were every dentist and prosthetist take that work without referring it on to a more appropriate operator, the work would be spread so thin that few would have the experience generated by an adequate history of cases. Fees might lower, but more likely they would rise due to the inefficient time required to diagnose difficult cases and the wear and tear on a less that skilled operator who, one could argue for the sake of this illustration, should really be doing less demanding procedures and certainly no implants. A skilled operator might do in 10 minutes what another less skilled may take 90 minutes in an operation akin to underwater watchmaking.

Dental over-servicing and quackery will be the result of the NCP profession = business = competition frenzy, which has ignored the history of dentistry in WA or even the global history back to the Reign of Terror in 1792 where anybody could practice medicine just by paying a licence fee. That was the terror.

Participating Provider Health Insurance: WA Hospital Benefit Fund Dental Scheme.

On Friday 3 December 2004 HBF (holds 74% of the WA health insurance market) met with the Australian Dental Association to unveil their new scheme to be commenced 27 days later on 1 January 2005. The scheme had been some 18 months in preparation without any consultation with the ADA or their appointed Consultant dentists – honorary ADA appointment to HBF. Some of the profession received a mailing the day before the meeting explaining the concept whilst some of the 6 dentists present had not even received the mailing of a very pretty glossy booklet. This was the first opportunity for dentist representatives to examine and discuss the proposal, which has apparently been funded by sink funds accumulated or held back from previous years' premiums. As the rebates had not been altered substantially for nearly a decade, in spite of increased premiums, many have wondered to where the dental insurance premium money was being sent.

The concept is

Managed care. The benefit change is actually an illusion for the limits remain the same, just that the member reaches it quicker. Example: prevention and major dentistry limits are not increased, only instead of 30% the *rate* of rebate is increase to 60%. The provider will provide *only* those services determined appropriate by the faceless men of the company. The agreement – there is no actual contract document – is "all or nothing". The dentists must accept all the plan or will not be able to just provide some of the services. This market dominance with the threat of 74% of patients stampeding could force dentists to accept the onerous contract with no overhead ratchet and no co-payment increment permitted. Dentists who elect to *not*

participate because they see it against their patients' long-term interest will simply not survive. The primary relationship of the Dentist to the patient is that of DIAGNOSIS AND TREATMENT. It is imperative that legislators maintain the right of the dentist to prescribe treatment regardless of any interfering third party.

1. Company dictates treatment provided. "No approval" based on no previous code profile means a professional will not be permitted to venture into unsanctioned or infrequent areas or new areas without the Star Chamber's permission.
2. There will be an open panel of participating dentist names advertised on a website and available from counter-staff. Presumably the claims clerk can then say to a patient complaining that the rebate is so small "here is a list of our dentists who charge our frozen fee and you will get 50% more back by attending one of them".
3. Rebates will remain the same (they have not altered for 10 years) for non-participating dentists. Patients of non-participating dentists will receive rebates of 15-30%
4. Dentists must charge their computer-profiled fees from 6 months prior ie 30 June 2004 fees determined by the computer. The fee must remain static until the company decides if and when it suits the company.
5. The patient cannot be charged more than that 'agreed fee'. No rising gap option.
6. The patient will receive a 80/70/60% rebate of the agreed fee
7. "HBF will undertake a review of the fee schedules.. under arrangement each year..take into account a number of factors including movement in dental practice costs (to be independently determined) and assessment of HBF's capacity to afford additional benefits". HBF's capacity to increase rebates is a right that should be supported by its capacity to pay, but it subjugates a dentists right to legitimately increase the co-payment amount to reflect his increase in overheads, a time bomb for bankruptcy or behaviour modification just to keep the company looking good. It is unjust, unfair and unconscionable for no business can survive without that essential flexibility to cover its legitimate overheads. It is intentional corporate slavery by creeping chains, link by link.
8. "To make an amendment to an agreed fee schedule, for example the inclusion of an additional item number, the dental practitioner must first contact HBF to agree the amendment".
9. No further contract conditions or documents tabled.

<u>Initial problems:</u>

1. **National Health ACT 1953 – SECT 73BDAA permits extension of hospital purchaser-provider agreements to cover rendering of some professional services in hospitals or day hospital facilities when a medicare benefit is payable. The Act upholds the right of the practitioner to a co-payment and**

the maintenance of professional freedom. The Act does not sanction agreements outside of hospitals nor when medicare benefits are not paid.

2. **Shifting of risk from the insurer to the dentist**: If a dentist operating at 90% overheads increased his fees 10% on July 1, he now has to return to his previous fee, which means he is not making a profit, merely breaking even. HBF insures an event that a patient requires a service. By denying the dentist to charge his customary fee, the dentist then takes the responsibility for the event, which he must subsidise or provide, in the above instant at break-even. Twelve months later he is still charging an 18-month-old fee having absorbed staff and material increases, thus the dentist is on the road to bankruptcy. The dentist should be registered as an insurer.
3. **The scheme's enforced discount is clawed back by increasing fees to uninsured patients**. By foregoing his profit the above dentist must increase his customary fee to other patients in order to make a profit. This is contrary to good social policy wherein the working class uninsured are being required to subsidise the middle class insured patients grasping a compulsory discount.
4. **The scheme's enforced discount will be probably *clawed back* by increasing services to HBF members and fees to other non-members**. The potential for the Dr Bad to over-service by advising more services is awesome. Dr Bad may also resort to the ultimate gimmick of the crazed entrepreneur "You pay nothing, leave it to me" He then does everything to the maximum permitted level. No fluoride to halt decay, no discussion about the uncertainties, just drill, fill and bill like the English "bash the Nat" scheme. Ethics and integrity are like virginity – once gone, it's nearly impossible to replace.
5. The scheme ignores a practitioner's **right to due process** in that there is no structure established for resolution of disputed codes available to a practitioner, challenges to the computer profile nor is their an established appeal mechanism for an aggrieved complainant.
6. **Multi-dentist practices operating multiple locations will have up to 16 different code schedules**. The tabled profiles permitted one dentist to make a denture at one location but not another. He was not allowed to extract a tooth at his other practice merely because he had not done so at that address in the recent past as he worked at the main practice.
7. The administration of such a **complex scheme of codes**, permissions and differing rebates to different dentists will create a plutocracy of empowered autocrats or disempowered slaves behoving to a *Star Chamber* administrative committee, which has no representation by dentists or consumers or members**.**
8. **The essence of the existing model is the doctor-patient relationship, which is now cleverly overturned by the imposition of a corporation ostensibly acting in its members' interests but by applying unconscionable pressure of *a sparkling gilded lilly* to either join or risk withdrawal of 74% of a practice's patients.** The issue of tortious interference relates to an outside party interfering with the existing contractual relationship between the doctor-patients. Patients are usually in phased treatment agreements extending over some years and each phase is re-initiated by a recall agreement where the practice posts a reminder letter at an agreed month. The existence

of in-coming patients constitutes a value or real property to the practice. An interloper attempting to overturn that arrangement affects the dentist's property and reduces his goodwill value, a quantum that can underpin mortgage borrowings used to fund equipment and expansion of facilities. HBF have a contract to rebate some costs to the patient. The amount rebated is determined by HBF based on what the members will accept. Their attempt to interpose themselves as the giver or taker of patients is without the authority of their members and to the financial and property detriment of the contracting dentist. It is an unsanctioned and undesirable interference.

9. By fixing a maximum fee which is less than his usual reasonable fee and then intensively computer monitoring the statistical profile, HBF is potentially creating an artificial and unnecessary pressure on a dentist to either maintain his maximum fee or to use additional codes to claw back the demanded discount. Formerly a dentist may not charge for many events or may have charged a token amount, but the new model requires a statistical monitoring and negative impact of such discount events, which will then downgrade the average fee charged and ultimately the rebate. By either forcing the elimination of discounts or up scaling the use of codes, HBF is potentially covertly altering provider behaviour to shift code use and fees higher. The net result is that Dr Naughty will be given a financial and competitive advantage over Dr Honest.

10. The scheme also disadvantages the 'out of network' Dr Good trying to compete with 'in network' Dr Maximum Treatment' merely because of the emphasis on price as the determinant for provider selection. This warping of the selection process is anti-competitive because the in network provider is sanctioned by association then referred patients by the HBF staff and website and advertised parallel or in tandem with HBF's corporate projection. The sanctioned association is implicate, falsely based and therefore anti-competitive.

11. The **simplicity of the existing model is the contract** that is made between the patient and the provider for the provision of a service. The new model is complexity personified abrogating the practitioner’s professional judgement of a patient’s care and permitted treatment to the whim of a clerk. Clinical scope of practice is limited to the existing profile: no history of a code equals cannot do without company approval.

Many a truck driver has attended a dentist saying

“How much to pull it out mate, it really hurts?”

“Are you insured,” asks the dentist.

“No, mate, but … yer like, the wife handles all that stuff”.

The dentist estimates an amount and the patient agrees. Three weeks later, his wife phones to say, “you overcharged my husband, he is a HBF member and I want the $20 refunded now, you inscrutable cad”. HBF then withdraws the dentists participating status because the patient was charged more than the agreed 8-year-old frozen fee.

When a child’s teeth are hit by a ball on a Saturday night at 11pm and I attend that child requiring a splinting of those loose teeth entombed in the parents handkerchief or jiggling a glass of milk, given that I have not got that code on my profile, can I phone HBF at midnight and gain the permission to use an infrequent code? How will

the relieved parents respond on Monday when the HBF clerk says “oh, you saw Dr O’Brien, he is not allowed to splint teeth so we will give you only 30% of his fee.. you should have seen our Dr Ruff N Ready and you would have got back 80%”. Is the dentist able to charge an additional loading on his agreed frozen fee for call out? No. So perhaps when the phone rings on a Saturday night a dentist might not respond? Are injured children going to be disadvantaged by any insurance companies’ Nazi corporation rules? Yes.

12. **New graduates entering an existing practice are to work under the Principal dentist’s agreed fee.** This is not reasonable given that the new graduate does not have the same skill and experience of a 30-year practitioner. Either way, many schedules will be covertly shuffled to attract the highest return. New graduates will naturally want to work in a practice where the profile is higher, so Dr Moral who attempts to restrain his fees will be disadvantage in his profiling and in his ability to attract an assistant dentist**.**

13. **HBF is discriminating *against* its members *merely* because of their choice of dentist.** This system overturns community-rating principles. HBF is classing its members based on which practitioner the patient attends. Dr Cheap’s patients may only receive $200 for the same procedure provided by Dr Good whose patients will receive $500 based on the % of the higher agreed fee. I question the legality of this inception as Section 73 specifically relates to services provided in hospital where a medicare benefit is payable. I also question the fairness and legislative sanction of such rebate quantum discrimination against loyal patients of a long standing family dentist and against non-complying independent practitioners**.**

NATIONAL HEALTH ACT 1953 - SECT 73AAJ

Community rating condition concerning quantum and payment of benefits It is a condition of registration of a registered organization **will not**, in determining, in relation to any contributor or to any contributor included in a class of contributor to the health benefits fund conducted by it:

(a) whether or not benefits are payable in accordance with an applicable benefits arrangement of the organization (whether or not modified by an election of the kind referred to in the condition set out in paragraph (ba) of Schedule 1); or

(b) if benefits are payable in accordance with an applicable benefits arrangement of the organization (whether or not modified by an election of the kind referred to in the condition set out in paragraph (ba) of Schedule 1)—the amount of the benefits so payable; or

(c) whether or not the contributor is entitled to make or revoke an election of the kind referred to in the condition set out in paragraph (ba) of Schedule 1; or

(d) the amount of the contributions payable in respect of an applicable benefits arrangement of the organization;

have regard to any matter that would cause the determination **to constitute improper discrimination in respect of any contributor**, or any contributor included in a class of contributor, to whom or to which the determination relates.

14. **The infallibility of the computer seems questionable given that every dentist seems to have bizarre amounts listed as their June fees**. With 1000 WA dentists in error, is seems with 15 working days prior to Christmas and each dentist requiring perhaps 1-2 hours to consult the HBF consultant, that 66 dentists appointments per day would be required, each consultant being able to see 3 or 4 per day, so 20 staff will be in the field compiling reports to submit to the Star Chamber for a decision. If 10% of those decisions are contested, will they be processed before Christmas, or, perhaps, could this unconscionable time line be intentionally designed over 18 months to soften a dentist over Christmas with a Pearl Harbour attack so that moral resolve weakens and he "participates" lest the chap down the road takes all his patients. Stalin could not have organised it better. A country practice in WA received a letter telling a dentist his fee profile was too high. Problem was that he had not practiced for 10 years. Perhaps the HBF computer might reincarnate some deceased dentists? If such faulty profiles are used now to exclude some as 'too high' what errors will occur when expelling a dentist. Will HBF allow access to its profiles for a dentist to argue that the data is incorrect or falsely weighted? The whole *schmazel* is full of complexities, errors and social engineering to improve the company's image at the expense and devastation of members. The rebate levels have not increase, merely the rate. The annual limits remain the same for all of the different categories of treatment so patients will not receive more rebate money, just reach their limit faster. The better alternative would have been to increase rebates following the existing non-contentious model rather than creating a flawed experiment model which has aggravated the dentist community because dentists know that a model based on the National Health Scheme of Land of the Old Dart will be contrary to the patient interest yet a gold mine for the unscrupulous.

15. **Patient loyalty** to a long-time family dentist will be catastrophically threatened by a scheme which has an undisclosed agenda – perhaps to alter its status to a *for profit* public company listed on the stock market? The stability of traditional practice, based on integrity and ethics is threatened by a predatory system, which emphasises *price* – or *what will I get back* - before every other complexity of dentistry.

16. **The predatory nature of the structure and its release**, its philosophical ignorance of the importance of enhancing the noble behaviours above avarice, will lead to a final *coup de gras* of what was Australia's finest dentist community. The worst dentists will prosper, the best will pray for relief as their longterm

patients haemorrhage from their practices and those Dr Good will eventually leave or become remote to the higher issues.

17. **Dentistry has operated *simply* using the 3 in line model**
Patient -> Dentist-> Patient->HBF

Patient pays premium to insurer for an event (needs treatment)
Patient seeks treatment from dentist and is issued with a code and cost.
Patient pays dentist
Patient presents evidence of the event and cost, insurer rebates.

The new model will be HBF->Dentist-HBF<-Patient

Patient pays premium to insurer
Insurer demands discount from dentist and freezes his fee
Dentist underwrites future cost increases of materials, gold and staff
Patient seeks rebate that will be high or low depending on dentists compliance with company wishes, whims, dictates, assessments, profiles, restricted scope of treatment.

18. **Stampeding and funnelling of existing patients**

I recently asked a HBF manager,

"Previously HBF had a financial relationship solely with HBF members. Now you have interposed HBF between the patient and myself. I am asked to reduce my fee to improve your company image tarnished by refusing to increase rebates for 8 years in spite of rising premiums, but what do I get from HBF for my discount of $100,000 to your clients?"

"Oh, we will give you the patients!"

Funny, they are my patients now; I won them by hard and excellent care. I don't need any more patients, but you are maliciously conspiring to rip them away from me **if I don't comply with your market power, dominance and bureaucratic whims**? My existing patients have a contractual relationship by being enrolled in a recall program. HBF are intending to commence a stampede of patients, they acting as the *caring and sensitive* drovers and shepherds. The doctor-patient relationship is sacrosanct. The cottage model is the cheapest and best way to deliver health services. Insurance companies are acting unfairly in tortiously interfering in a profession about which they only have *digit or numerical knowledge*. Their *expertise* is as valid as someone with a telescope on a distant high rise building watching the cricket scoreboard at the MCG – they cannot see the batsman, they cannot see the turf, they

cannot see the happy crowd or the satisfied patient, they aren't even sure if it is actually cricket, **but they can see the numbers which are meaningless unless related to the full details of cricket or a dental visit! Yes, a one surface filling can cost more than a 3-surface filling because it takes more time, skill, care and judgement. Not all cars cost the same, not all works of art demand the same fee, not all houses can be built for $100,000. *Stinking Thinking.* Thank you HBF.**

19. **Piecework fees** are convenient but less preferable to ***fees based on time***, which is really, the true indicator when adjusted by a difficulty factor. Cleaning someone's teeth for an hour is less demanding than removing wisdom teeth for an hour. The dentist professionals have used fees based on 'piecework' as a usual and convenient way but a one surface filling or an extraction could take 2 minutes or 90 minutes therefore the fee should vary. One method to eliminate fee codes and that method of charging would be for the ADA to dump its taxonomy scale of codes and just recommend a system of charging time multiplied by difficulty factor. Yet, the insurers like codes because it allows them to think they know something about how dentistry is delivered when clearly they don't! Numerous instances have occurred when HBF staff tells the patient that the fee was too high, the clerk little realising that the fee was totally accurate for the task. These moments of staff responses to the bewildered angry patient with threepence in their hand are denied by the company, yet the anecdotal reports continue.

I postulate that the most appropriate method is by time, just as lawyers (but not the 12 units of 6 minutes = 72 minutes per hour method), accountants and plumbers etc charge:

Scale and clean time: 40 minutes * difficulty 1* hourly rate = fee

Tooth removal: 40 minutes* difficulty 1.7 * hourly rate = fee

20. **The scheme will limit the healthcare options for patients**. Their wonderful dentist might be unable to provide some services due either to a computer glitch or withdrawal of permission because his use of that service may have exceeded the peer profile eg. Restorative pins, crowns or relines rather than new dentures. The presence of moral and ethical practitioners will be threatened either by forcing compliance or resignation or by maximising the code numbers.
21. **Bargaining position**. The scheme is destined to proceed in spite of any profession response. The leviathan's release of its secret plan 15 working days before Christmas deny dentists time for consideration or assistance. The election of an in or out option is a mirage for HBF know that it would be financial and ethical suicide to NOT participate and a slow death by strangulation by rising over-head if one joined. Dr Bad will be hoping that 90% of dentists take the high ground to protect standards of patient care: Dr Bad will then corner the market, employ enslaved new graduates and make a fortune with every patient receiving

their maximum 6 fillings, 3 crowns, full mouth radiographs. *The meek shall inherit the earth!*

22. **Those dentist members of the ADA will overwhelm the resources of the ADA with clinical and legal problems associated with the closed HBF mechanisms.**
23. **Discounts:** An honest dentist (yes, there are actually some, perhaps 99%) varies fees according to number and difficulty. If a family of 10 arrive for examinations, most dentists would perhaps charge for Mum and Dad and nothing for the 8 children. The receptionist then issues an account for say $80 with item codes 6 examinations. The watcher, the insurance computer then divides the fee by the number of services and profiles the dentist/s having an average fee of $14 for an exam! So discounts act against the provider's profile accuracy. Many procedures can be provided in a half hour appointment: clean 2 teeth, adjust a high spot, talk about diet for 2 minutes, apply some fluoride to one tooth and the dentist might charge just for an exam. Again the watcher unfairly distributes that discount as an average .A piece-work fee reimbursement, worked by a greedy dentist whose ilk often say, "You won't pay anything. Just submit the account to Medibank". The patient is elated at their wonderful dentist's generosity, but alas, Dr Bad can remove any suspect filling rather than fluoride to halt the slight softening, doing multiple teeth in short-time, no hesitation about taking a radiograph "is it <u>really</u> necessary?", providing most patients with their maximum permitted services. Dr Good may charge $100 for a 40 minute filling, but Dr Bad is the hero, only charging $45 as a Medibank Preferred Provider or now, a HBF Participating Provider, yet he can over-service doing 5 small fillings in that same time and double his income over Dr Good. Was it over-servicing? Who knows – the evidence has been removed down the aspirator. Co-payments keep fees low and dentists honest. *Carte blanche* piecework rebates make insurance watchers happy with Dr Bad and *very* cross with Dr Good who may take 1.5 hours to do a one surface filling - usually a smaller area and smaller fee - on a patient who won't go numb, won't keep still, salivates profusely, talks incessantly, has a small mouth housing a huge Jurassic purple tongue and always arrives late or cancels 10 minutes before every third appointment and maybe Dr Good charges for his time, skill, care and judgement plus a factor for stomach lining and heart muscle and the watcher on the insurance company says "what, $200 for a small filling – he is overcharging". Everything in dentistry seems to be pitted against the ethical operator, now even state and national politicians, economics and corporate ambitions. That all services or fillings be the same customary, reasonable, average, common, mean, mode or median fee is as illogical as saying all houses should be the same price! ADA codes should only be used to menu what was provided without any reference to a piecework fee.

24. **Alphabet soup: "**One of this, two of that, 3 of those and 4 of them, add it all up and you pay nothing or next to nothing" will be the success recipe for Dr Bad and the death knell for Dr Good whose practice will be gutted of patients at the claims counter "Oh, you went there, next time go and see Dr Bad, you will get more back". Dr Bad will be most pleased, Dr Good, foregoing the prospect of

immediate riches declines the HBF plan because he knows it is contrary to the good sense and practice of dentistry in an asymmetrical marketplace, watches his loyal patients reluctantly leave saying "Sorry, but my wife got $300 more back on a crown than I did, so I cannot really afford to stay with you". Dr Good will cry within, uttering platitudes to himself about "get what you pay for" or "this is all too hard to be correct and ethical – either I am leaving or I shall join the train to riches and happy patients". If he sells his goodwill, then who would buy it because the patients have left? Insurance companies, acting 'to restrain costs on behalf of our members- don't mention the old low rebates' will have destroyed Dr Good's retirement prospects, his life's work, his view of society's integrity and common sense and created a legacy for the unsuspecting public, which will resemble a Pol Pot *dental killing field*.

25. **A *fixed acceptable fee schedule* is anti-competitive, illogical and a factor to raise health costs** because often Dr Good will carry out services for which no charge would apply. Now, with a profile centred reimbursement scheme, a dentist will either charge for a tiny quick procedure lest his profile is altered and the patient co-payment is very small or necessary to fund the discounts or Dr Good will accurately list the item without a charge and find that his profile of "average" is downgraded.

Summation:

Dentists have been unsuccessfully lobbying HBF for many years to increase their rebates at least in line with their premium increases. We applaud the fact that they have finally done so, but the complexities of this new system, its potential to destroy established legitimate practitioners and enrich the unscrupulous Quislings is unconscionable. Their market share of 74% allows them extraordinary power to control dentists by *funnelling and stampeding* long term patients to competitors who may appear cheaper but may in fact be unworthy of such a breach of a practitioners long established relationship with the member/patient. That aspect alone means that it is contrary to the public benefit.

The system smacks of *social engineering* by the wealthy against the poor. The insured sector is only able to have its discount because the ordinary and customary fee to the uninsured must rise to fund the huge percentage of subsidised patients in the practices. As there is no ratchet to increase fees to cover real overhead rises. The dentist is required to act as an insurer by funding events from other areas of his practice. The scheme is blatant cost shifting putting the burden on the people least able to handle it. Should the dentist be registered as an insurer?

The administration of this scheme will require a huge Gestapo squad of investigators, computer profilers, PR *soothers* plus mechanisms to protect the legal rights of dentists – the code profiles, the legitimacy of treatment decisions – overseen by an independent

appeal mechanism. As there is no such mechanism, the committee of HBF faceless men could become a *Star Chamber*, a power unto itself, acting ultimately in the company's interest. Patient rights – more uncharted waters yet, the financial wreckage of managed care in the U.S. has resulted in the U.S. House recently passing legislation giving patients broader rights to sue their health plans in state courts under state malpractice laws. Other moves are for consumers and professionals to be represented on such committees, which should be accountable, open and subject to public scrutiny and legal appeal by providers and patients.

The HBF apparent failure to address these matters from its inception perhaps indicates its own assessment of itself as the Big Boy righting wrongs with a motto "Trust us – we have 74% of your patients". This abuse of market leverage is unfair, predatory and against the public benefit. It seems to be a smoke screen for a hidden agenda perhaps to transfer price rise risks to dentists or perhaps an ideological *reform of conscription* for the benefit of the corporation? The scheme is an abuse of market power and unfair to dentists and consumers. If the Commonwealth does not have the power to conscript dentists under Section 52, why does a corporation?

The additional accumulated funds should be used to increase rebates under the existing method. Funnelling will result in a nationalised profession by a corporate **leviathan that will cover one 3 out of 4 insured consumers and HBF could be a catalyst to downsize patient care to unreasonable and covert levels, creating unduly leverage on dentists and their on auxiliary nurses, dental technicians and ceramists – undermine competition by quality, skill and reputation and cause the potential for unfair business practices by collusion with the other insurers and by unseen pressures being applied to accept codes, agreed fees and rejection of legitimate fee increase both as co-payments or rebates. This "lets bolt everything at the front" scheme will open the gates for over-servicing and unperceived decreased quality in an asymmetrical market. The drop in standards will not be evident to the patient or the computer analysts, only dentists fully aware of the rorting implications of the similar and failed and shameful English National Health Dental Scheme.**

Dentists are a smart but constrained bunch. With the new NCP modus of '*profit is the King before all else'* like hungry wolves or prosthetists unleashed upon the unsuspecting public pursuing the dollar and expunging ethics and higher ideals, a capitalist dental killing field will occur with higher fees, higher usage and higher sales gimmicks involving *loss leading*, apparent discounts, braggadocio, superior claims and egotistical boasts. The insurance companies will concentrate the Dr Bad and his ilk into preferred providers or "one of our dentists" whereas the moral Dr Good will be watching the tumbleweeds roll across the empty waiting room.
Is this the type of marketplace we want for our children or even ourselves? Is this the type of market in which the best will be unable to surpass the least skilled or most entrepreneurial. *Competition by quality and expertise* and advertising are implicit

contradictions: advertising increases business turnover but who would want the least skilled and less ethical operators to be advantaged? Remember quacks need to "quack"!

The two end quotes from the past remind us that for many of the mistakes we intend unknowingly to make today, our forebears had made the same mistake and the survivors documented the lessons so to prevent us repeating the error.

Dental prosthetists providing partial dentures, implant structures, occlusal headache devices, apnoea or snoring devices or tooth bleaching is contrary to the public interest because it is illogical and dangerous.

Prosthetists should be prohibited from any mouth containing dental implants or any jaw containing teeth, as this will "hold traps for trusting pain".

WA's HBF should stop trying to apparently hijack dentistry and desist the perceived temptation of playing God and merely increase their rebates with the same untied funds. Less administration, less aggravation and more rebate dollars for their members.

Otherwise, with maraschino charlatans and greedy corporate harlequins, quality dentistry will crumble, as in the words of Francois Furet "The Passing of an Illusion":

"The inversion of canonical priorities has undone the dovetailing of epochs on the road to progress. Once again, history has become a tunnel that we enter in darkness, not knowing where our actions will lead us, uncertain of our destiny, stripped of the illusory security of a science of what we do. At the end of the twentieth century, deprived of God, we have seen the foundations of deified history crumble – a disaster that must somehow be averted".

"The Great Nation"
France from Louis XV to Napoleon
Dr Colin Jones
Professor of History Warwick

In the 1780's there was a powerful line of schism over the state in serving social utility. .. there was an impassioned debate about the role of professional competence in maximising social utility and how professional expertise could mesh effectively with the demands of a centralising state and on the other a grown and more self-conscious public. Broadly speaking, two discourses of professionalism and public service were emerging. On the one hand there was a desire for change within the corporative framework, in ways which respected social hierarchy and vertical ties of dependence.

… discourse drew upon both the equalising rhetoric of enlightened absolutism and the more democratic values of the public sphere and which stressed the horizontal and egalitarian bonds of mutual interdependence between citizens…

Advances in medical and surgical science helped foster a civil discourse of medical professionalism in which the dedicated medical man was viewed as a lay equivalent to the *bone petre*, a self-sacrificing super-patriot fraternally dispensing the gift of life and good health to ailing fellow citizens. Yet the capacity to practise was viewed as being endlessly circumscribed by selfish corporatist privilege. The superior privileges of physicians over surgeons, who were more empirically oriented and more closely associate with key curative therapies such as smallpox inoculation, cataract cutting and obstetrics were viewed as anti-social and anti-utilitarian. Similarly the Paris Medical Facility's insistence that only trained Paris graduates could practice with the capital was a selfish restrictive practice from which the health of all Parisians suffered. A free field of medical practice would allow the demand for improved medical services to be met by a burgeoning supply of 'citizen officers of health' (*officers de sante*). The state's repression of mesmerism led medical men who had championed the heterodox therapy to develop a full-scale attack on the academic and by extension the political hierarchy for it seemed only a short step from the 'academic aristocracy' to the aristocratic establishment.
The debate on professionalism was also found amongst… state servants.. magistrates.. civil engineers.. who were increasingly criticised for technological arrogance and remoteness from civic concerns.. from the outside it looked like selfishness and cronyism.
Professional groupings whose corporate lives were regulated by the state… they became responsive to the booming market for goods and services. Although members of the more market orientated professions had prided themselves as being above mere mercantile considerations, improved chances of enrichment as a result of growing demand for their services led many to embrace market values, which they regards as fully consonant with civic duty…

A discourse of corporative professionalism emerged which emphasised that the disciplined hierarchy of the society of orders offered an appropriate location for the development of different forms of expertise …
counter discourse on professionalism sought to transcend the corporative framework of the state and stressed that social utility was best served by professionals developing organic links with their fellow citizens within a more egalitarian and non-hierarchical polity. For civic professionals, one was a patriotic citizen first, a lawyer (say) second – whereas for the corporative professionals the order was reversed.

Those who dominated the Constituent Assembly exploded the pertinence of any version of corporatism.. and introduced a realm of patriotic freedom with all sectors of society and the economy. The notion of the 'career open to talents' endorsed by article sic of the Declaration of the Rights of Man was targeted at opening up professions to which privilege had restricted entry in the past and it proved a sturdy weapon against all corporative occupational groupings. Just as mercantilist regulation was remove from trade and industry, so bodies which has formerly regulated professional markets were viewed as anathematic. Colleges of surgeons and physicians for example were suppressed as corporative groupings under the provision of the Night of 4 August 1789 and universities which almost joined them cane under attack as 'Gothic' and elitist institutions. Some died out ……. Others finally suppressed in 1795.
Even before this, academies and other learned societies were put on the defensive. ' Free nations do not require the services of speculative savants' one speaker proclaimed, and in August 1793 all academies were closed down….
Extension of 'amateur' justices of the peace also struck against corporative legal professionalism. The Paris order of barristers disappeared o the grounds of its privileged status and the status of attorney, following a measure of reform was suppressed outright in October 1793.

Law and medicine were affected by this patriotic trend. The abolition of barristers and attorney opened the way for the .. ..patriotic 'unofficial defender' who acted as counsel in criminal cases. No training or prior legal experience was required for individuals to offer themselves ..

Surgeons and physicians found themselves operating alongside self –appointed 'health officers' whose highest recommendation was their own patriotic estimation of themselves.

By 1794, the Convention – at the very time, moreover that they were submitting the economy to the tightest controls it had ever experienced – were thus presiding over the development of a free field in professional practice. In the Terrorist public sphere, growing economic regulation accompanied professional deregulation. In a strange throw of fortune, however the late 1790/s ere to see an exact reversal of this trend: economic *laisser-faire* was conjoined with professional re-regulation as professionals in the legislature negotiated the perils as well as the pleasures of *laisser-faire*.
Problems with the free field in professional practice were first signalled in the Convention on 4 December 1794. The physician Fourcroy, while paying lip-service to 'laissez-faire(as) the great

secret and the only road to success' launched an attack on unqualified medical charlatans ruining the health of soldiers at the front. He dramatically evoked the way in which **'murderous empiricism and ignorant ambition everywhere now hold out traps for trusting pain**' going on to get the Convention to agree to the creating of three new health schools in Paris, Montpellier and Strasbourg. These medical faculties avant la tettre were soon certifying (and examining) the talents of the 'health officers'…Thibaudeau attacked the crooks and charlatans who had exploited… as if it were a branch of commerce.
In the bureaucracy there was a massive purge ….the educational level for recruits went up… expecting appointees to have prior experience not just patriotic opinions.

The following period… saw a re-engagement with the problems of ensuring quality services…. a full system of state approval for all medical practitioners was introduced in 1803.

A Thought to ponder….

"It is unwise to pay too much, but it is more unwise to pay too little.

When you pay too much, you lose a little money - that is all.

When you pay too little, you sometimes lose everything because the thing you bought was incapable of doing the thing it was bought to do.

***The Common Law of Business Balance** prohibits paying a little and getting a lot… because it cannot be done.*

If you deal with the lowest bidder

it is well to add something for the risk you run and
if you do that
you will have enough to pay for something better"

John Ruskin
1819-1900
British Author, Artist, Essayist and Critic

Dr Julian P. O'Brien
Dental Surgeon
President Australasian Osseointegration Society (WA) Inc – The Dental Implant Society

The above democratic submission and opinions are exclusively those of the author

<u>History shows us that the same mistakes have been tried before:</u>

Louis XV111 first controller, Turgot.. proposed the lessons of liberal economic theory, in particular that *of Physiocracy*, whose very name proclaimed it to be the "Law of Nature" and thus irrefutable.
The 'sect' of the physiocrats argued that it was corporatism, regulation and protection – the heavy hand of the State - that was stifling productivity and enterprise in France. Every….had to go so the economy could breathe the pure and heady air of market exchange….hence the urban and rural sectors would co-exist in charmed reciprocity and France would swarm with

contented, rational rustics all plowing, producing, saving and spending to the deep rhythm of the market.
That at any rate was the theory….removed all restrictions. The result was immediate dearth and riot. ..In 1770 Terray restored most of the restrictions obliging most of the merchants to be licensed.. Calm was restored.

Citizens *A Chronicle of the French Revolution* Simon Schama

3.1 Supplier Induced Demand

Most of the services provided by the physicians are "induced" in the sense that physicians are acting as agents to consumers who lack the proper knowledge of the product, which in this case is healthcare. Only the demand that exists beyond what the well-informed patient would have chosen is defined as supplier induced demand (SID).
The precise definition of SID is and has been open to debate over its existence for over two decades and there isn't a consensus over its precise definition. Below are two common definitions. (Donaldson and Gerard 1993)
"Supplier induced demand is the amount of demand created by doctors, which exists beyond what would have occurred in a market in which consumers are fully informed".
According to Donaldson and Gerard (1993) SID occurs because of the doctor moral hazard. Moral hazard arises first of all on the supply side of the 3rd party payment problem, since doctors don't have to bear the full cost of decision making, and secondly on the demand side because of the asymmetric information between the physician and the patient.
Another more cynical definition is given by (McGuire in the Handbook of Health Economics)
"Supplier induced demand exists when the physician influences a patient's demand for care against the physician's interpretation of the best interest of the patient".
Therefore under this definition the theory of SID says that health providers use their superior knowledge to influence demand for self-interests. Physicians therefore have the ability to generate demand in response to fee changes, declining market shares, or simply changes in the labour-leisure choices.
Studies into SID employ a variety of approaches to check for its existence, nature and extent and those that define it are divided over a normative or positive definition.
Firstly we look at the normative definition. Under this definition the physician does not act as a perfect agent for his or her patient because of financial incentives for providing 'extra' services. (Stano 1981) Self-interest on the physician's part coupled with asymmetry of information, resulting from the consumer ignorance begets market failure and inappropriate servicing. So the patient doesn't receive the service, which is appropriate.
The other definition is based on the positive definition. This is less disparaging regarding motive. It focuses on the physician's ability for better or worse to shift the patient's demand curve to the right (Richardson 1981). Hadley et al (1989) state 'demand inducement refers to the physicians' alleged ability to shift the patients' demand for medical care at a given price'. Therefore convince the patients to increase their use of medical care without lowering the price charged.
Supplier induced demand occurs when the supplier acts as an agent for the consumer. This causes a level of demand that is greater than one that would be chosen by the consumer that had been fully informed. Supplier induced demand is the amount of demand that exists beyond what would have occurred in a market where consumers have perfect knowledge. If consumers were fully informed, the demand for health care would therefore be less.
Supplier induced demand is a display of monopoly power. Health care providers have a monopoly in information about health and health care. Supplier induced demand is an example of exploitation by the health care sector, its one situation where the monopoly is used to its fullest potential in order to maximise the utility of health care providers as opposed to maximising the utility of the patient.
Figure 1 illustrates a commonly used model to explain the SID. Here D_1 and S_1 represents the initial

demand and short run supply of doctors with an equilibrium at Q_1. If there was an increrase to S_2, standard supply and demand anaylsis would predict the price to fall from P_1 to P_3 and the quantity demnded would increase from Q_1 to Q_3. Total spending would increase or decrease depending on the elasticity of demand. In this case its inelastic, therefore total spending would decrease. Since there are more doctors, the typical doctor's share of patients and earnings would decrease.

Quantity of services Price of Services

According to supplier induced demand, an increase in supply leads directly to an increase in demand. Doctors use their influence to shift demand i.e. demand is not independent and stable at D_1 but will be shifted out to a level such as D_2, the equilibrium price declines to P_2 with equilibrium quantity Q_2. In some cases the equilibrium may even rise above the initial level to P_2' with equilibrium Q_2'. As shown the equilibrium may be lower or higher under this view of SID.

Using the supply and demand implies that SID occurs in a competitive market, since the markets clear to reach a new equilibrium price. However this contradicts what is implied by SID. For example, following a shift in supply to S_2 and prices drop to P_3. At this price, by providing the quantity of services on the original demand curve to D_1, suppliers will be on their supply curves. When one is on their supply curve this means that they're are willing to produce and offer the quantities. Therefore there should be no reason to induce demand if prices clear to adjust the market.

Consumers make demands for goods and services on the basis of their needs, however when this is applied to health care it is important to make the distinction between demand and need as the existence of imperfect knowledge assumes that consumers are unable to act according to their needs, thus their needs would be unmet. The level of need of health required is difficult for the consumer to measure; therefore it will normally depend upon any clinical examination, which is carried out by the supplier. This leads to the problem of the consumer not being aware of any such illness and wouldn't seek medical advice in the first place. The fact that there is a considerable amount of difference in the number of people visiting a health care provider and the number of people that don't lead two issues known as the 'clinical iceberg' and the factors affecting illness behaviour.

The term clinical iceberg is used to describe the phenomenon of many unreported levels of illness, as it was thought that only a small proportion of the population actually reach the health care services, i.e. the tip of the iceberg. Wordsworth (1971 examined a sample of 2153 people from the London boroughs of Bermondsey and Southwark. He found that over a 14-day period only 5% reported no health problems and 60% resorted to self-medication. This could be due to the fact that only the serious complaints are taken to the GP, but various other studies have shown that serious and untreatable illnesses to go unreported. Williamson (1964) examined the elderly patient of one GP practice and he found that 25% of respondents with chronic bronchitis and 33% of respondents with heart disease hadn't contacted their GP.

As individuals don't state their needs, the provision of health care in the market will not reflect the needs of the consumers. Therefore the factors that influence an individual's decision to seek health care need to be looked in to. This is known as the study of illness behaviour. Illness behaviour was described by Mechanic (1968) as 'the way in which symptoms are perceived, evaluated and acted upon by a person who recognises some pain, discomfort, or other signs of organic malfunction.' There are many factors that affect the way individuals react to symptoms of ill health and Mechanic states that the 'visibility and recognisability of symptoms', 'the extent to which the symptoms are perceived as serious', 'the frequency and persistence of the appearance of symptoms', ' the monetary costs of taking action' and the 'needs competing with illness responses' all to some extent determine whether individuals will decide to visit a health care provider. Due to the patients' ignorance of health care, their demand for health will depend upon identification of need by examination carried out by providers.

The availability of such specialised knowledge is seen to reduce the ignorance on behalf of the consumers, however this in turn leads to the problem of asymmetry of information. This arises because the suppliers of health care know more about health than the consumers, thus the potential consumers of health are in a poor position to judge if they are ill. The existence of the medical profession can be explained by imperfect knowledge on the part of the consumer, but this in itself is not the problem. Patients often try to acquire some knowledge of health through the use of medical services but a detailed knowledge about health care is limited due to the huge illnesses to which we are prone. Information on health is also seen to be costly to acquire as its seen to be very difficult, time consuming and expensive, as can be see in the training of a nurse.

Many consumers go about acquiring such knowledge on health care by initiating what's known as an agency relationship with the supplier. The health care providers acting as agents for those consumers who lack the medical knowledge are is seen to be one way in which demand and need is being reconciled. The different type of information that a patient lacks will usually fall under three categories. These include information about health status, information about available treatments and information about the effectiveness of treatment. The introduction of such an agency is advantageous in the sense that it reduces any imperfect knowledge regarding the market for health care. However this relationship between healthcare providers and their patients may not be ideal, as the provider may act perfectly, i.e. in such a way as to maximise the utility of the consumer, or imperfectly which in turns leads to supplier induced demand as explained earlier. Even if the supplier acts perfectly there is another difficulty in developing a perfect agency relationship, as it is likely to vary according to individual consumers. Each consumer is likely to place a different amount of utility on receiving information and this utility will vary according to the individual healthcare provider and the particular health condition involved.

Problems arising from asymmetry of information and healthcare providers acting imperfectly are seen to be a problem in the NHS. Another problem seen to be in the NHS is that of the payment system. One such problem is that of the third party payment. As well as being a problem in the NHS it is also recognised as one of the main conditions for supplier induced demand existing. In the US there is a system known as the fee for service system, which is also associated with the third party payment problem, is seen to be prominent. Studies carried out by Fuchs (1978) have found there to be a large increase in inducement when there's a large increase in the number of doctors. Studies carried out by Cromwell and Mitchell (1986), and Rossiter and Wilensky (1983) have also found similar results though with less inducement effects. As well as fee for service systems, the fixed price system also showed evidence of supplier induced demand. Birch (1988) found there to be a large amount of support for the inducement in the UK when taking in to consideration dental surgeries. His study states that incomes are improved by the provision of services in excess of the requirement in order to fulfil the NHS objectives.

Evidence of Supplier induced demand is of two basic types. The first one being, 'evidence of a relationship between doctor/population ratios and health service utilisation rates per capita'. The study carried out by Cromwell and Mitchell (1986), which counted the number of surgeons per 1000 individuals, showed a significant demand inducement for surgical procedures with overall rates of surgery increase by about 0.08% for each 1% increase in surgeon supply. The second evidence is that of 'wide variation in healthcare utilisation rates between areas in the same country and between countries'. McPherson (1990) shows evidence on healthcare utilisation rates between areas in the state of Maine (USA). He found that there was a significant variation in the utilisation rates of particular hospitals for a number of medical procedures. E.g. the hospital with the highest admission rates for patients requiring a tonsillectomy had 850% more admissions than the hospital with the lowest. This is an example of such an incidence leading to supplier-induced demand.

Overall it is difficult to prove the existence of supplier-induced demand as its never clear as to the extent to which we have stated the relevant issues. We have discussed a few but other factors such as limited peer review and infrequent purchase of healthcare also need to be looked in to when deciding whether or not it exists. Whilst there is some supporting evidence, it is possible to dispute the existence of supplier-induced demand.

My Annual Address to the WA Implant Society:

"The poison chalice before us is the prosthetist issue regarding partial dentures and specifically implant supported dentures. This false *imprimatur* of competency given by Parliament will be a disaster for the unsuspecting public.

The double tragedy of this madness is that the superior ceramist, those here present, the skilled artisan at the top of his artistic, dexterity and intelligence pyramid, those good men have been pushed aside by their ex-apprentices who did not have the necessary artistic skill to cut the mustard as crown and bridge technicians. The ceramists should now claw back from the plastic gang, their respected position as the rightful leaders and role model and we dentists must empower them to regain their deserved recognition.

I have worked extensively with the ADA and politicians yet, at the same time there have been one or two Quislings – the Norwegian Nazi collaborator - Quislings amongst us who have been working to surreptitiously line their own pockets rather than seeing their higher obligation "to act in the public interest".

These couple of dentists, these latter day Gordon Geckoes abrogate the higher principles, casting asunder the historic principles, which were the foundations for the advancement of science, health and modern implantology. What's more, they are aiding and facilitating amateurs to break the law.

"Judge a man by the company he keeps"

seems a little old fashioned, yet, the dental economist Avrim King did predict that dentistry could eventually split into 2 groups or tiers, the first intoxicated with the money & hype , whilst the other committed to higher learning, excellence and their patient's welfare. Little did we know that misplaced government legislation and politician ignorance - no concept of what's actually happening at the coalface -would catalyse this dangerous and isolating split?

In spite of that politician remoteness, if we won't censor these self-interested renegades, perhaps we will be moulded by the Health consumer bureaucrats, lawyers and courts who will expensively underline the notions of duty of care and professional responsibility throughout our bank statements – these notions (are) essential legal considerations which are embedded in the term "professionalism" yet a couple of us seem to have placed these legal consumer notions second to our own egos and advantage?

I would recommend every scholar read historian Paul Johnstone's small book "Renaissance" in which he identifies the remarkable first spark of Western Enlightenment as the writings of Dante Alighieri, which commenced to throw off the veil of ignorance known as the Dark Ages during which was some 1200 years of total stasis.

This consciousness was later reinforced and dispersed to the masses by the invention of affordable printing. Dante's call was for a new excellence and aesthetic which was later given structure by Elizabeth 1's Lord Chancellor Francis Bacon's through his passion for the emerging scientific method and by his establishment of the Royal Society under Sir Isaac Newton, whereupon, slowly removed from medical education was magic, witchcraft, alchemy, astrology and quackery. Our hard won historical Health carer education standards must be defended ferociously lest we revert to the prancing quackery and mysticism, which were the hallmarks of the Dark Age.

Our present dental moral crisis is the entry of quasi-trained non-biological amateurs loading implants, a madness which will open a Pandora's box of legal and ethical issues plus endanger patients.

My intention is to resist this political push personally and/or as President of this Society and I call upon each member personally to discard his or her neutrality, apathy or covert hopelessness.

What could this have to do with us as implant practitioners tonight? Well, it was Dante who said, so long ago in the 13 centaury:

"The hottest places in hell are reserved for those who, in time of great moral crisis, maintain their neutrality." Dante Alighieri (1265-1321)

The moral crisis we collectively and individually face is the corruption of future standard of patient care and blatant corruption of the meaning of professional dentistry. The public will become carrion to the cloned Frankenstein mechanical vampires in their new white coats.

We cannot be neutral or bury our heads in the sand for this issue will not go away; it has the propensity to get worse if we sit and do nothing. In some American states denturists are lobbying for legislation to allow them to take – but not read - radiographs and to be able to employ dentists and and hygienists whilst, in their training school, they are teaching themselves how to do cavity preparations on teeth.

This dilution must be addressed and in addressing it, I am reminded of the words of Benjamin Franklin, words spoken to the infant American Congress when faced their first and greatest threat by King George 111

''Gentlemen we either all hang-in together or surely we will all hang separately'

The priority is protection of the public by highlighting our concerns to MP's.

The choice, fellow dentists is yours.

August 2004

Denturist Insight Editorial.... Some insight into money

Quotes from the world international Denturist Pontiff from his editorials:

- "We have raised scores of thousands of dollars of which are currently available in the ADAC war chest
- most technicians can probably double their wages
- Many technicians (not licensed denturists) are working out of their basements, garages and living rooms. Although this is not what we have in mind, by doing such, many have far exceeded their laboratory income. Thousands of technicians practice in this manner and many have built large underground practices solely by word of mouth.
- many of us have the tendency to resent the dental profession
- denturists hold the high ground both educationally and experientially
- Unless you are able to compete against the laboratory giants or are willing to work as a **serf** you would probably be wise to bail out of the industry that is being swiftly eroded by foreign trade
- It is a proven fact that denturists earn three times more than the average dental lab owner, and work fewer hours, have less stress
- The truth is, denturitry was never a part of dentistry and never will be.

- Some are worried about competition. The average denturist makes well over $100,000 annually. How many technicians make that kind of money? Don't worry, there will be plenty of business for everyone.

- Every denturist must take a program equivalent to the Mills Grae University, College of Denturity program.

- a means by which we can quadruple our income compared to that of lab work.

- Several months ago, we inherently missed removing information pertaining to Mills Grae University from this site. Some of the content was found to be erroneous. Currently, there is no information regarding the university hosted on this site. We extend our sincere apology.

Note: Mills Grae seems to run only one course. It does not exist as a recognised University. It is a sham doctorate.

October 1999

In the June and the July 1999 editor's columns, speaking about organization, we briefly touched on confidentiality. The importance of confidential data is all too often overlooked. Most dental technicians and denturists either depend on dentist accounts for their livelihood or they provide underground denture services. Of course, this varies from state to state and there are exceptions; but for the most part, is this assertion correct? If it is, we must take precaution. Some of the things that I am going to mention may sound almost paranoid. ..First, we must realize how vulnerable we are, as technicians and denturists. We need to work smarter in order to accomplish our goals without jeopardizing ourselves or our families. To a great extent, because of dentistry's illegal targeting of denturist leadership, most state denturist organizations will have no alternative but to organize their members in an under ground fashion. Some state coordinators have even elected to be anonymous, using alias names. Others are choosing a close friend, relative, neighbour (sic) or a zealous denture wearer to be the front person in their state organizations. This is not paranoia; how many of us want to put ourselves, our families, our profession, our livelihood and everything that we have, on the line? If you have nothing to lose or don't mind risking your neck, you may be a good candidate for coordinator in your state. However, keep in mind that many in the past have unnecessarily took risks for our profession that, today, wish they haven't. The ADAC State Coordinator Program assures you that if your state coordinator happens to be an alias, he or she is tactful, experienced, capable and has passed a background check. We also assure you that the treasurer of your state association will meet similar guidelines.

P hone numbers and addresses of many state coordinators are currently extended so as to put them out of harms way with the local dental community. One technician commented that he would not be a part of something of this nature. But stop and think a minute; isn't there a lot of technicians out there bushwhacking? Others have placed a dentist as a mere front, so that they, the technician, can do all the operative procedures of fitting the dentures. So what is unethical or degrading about a legal underground state association? Although underground, these state organizations are completely legal, legitimate and should be something to be proud of and if for nothing else, because we have found a vehicle that can out wit organized dentistry and its cruel monopoly. If this would have been done twenty years ago, along with the educational program that is now available to us, all the states would have been legal by now. These underground state organizations will only have to exist a little while because the denturist movement is making extremely rapid progress. Getting involved with our state association, now, will put each one of us in a lucrative position.

Our affiliated organizations, attorneys and strategists are about to achieve a major event that will rapidly usher independent denturist practice through out the entire country. Being a part of your state association will keep you actively informed and abreast of legal, legislative and other governmental decisions and updates that will probably allow denturists to openly practice early on; even before the law actually changes. How are we going to be ready? How are we going to know what action to take? We must keep informed so that we can be available for the local educational provisions to prepare us for our licensing examination. There is nothing for us to loose by joining our state association and everything to gain. Dues will be minimal. Our labs and denture practices will not be on the line. Our families will be secure. All we will have to worry

about is making money, taking care of our families and contributing a small portion toward our state association. We can not reveal any of the operations; but if you knew how close the grand finale is and how certain it is, you would already be involved.

The underground organizations will not have to be around long; but take advantage of them while they are in existence. To be ready, is the only way we will be able to **cash** in on our dream. ..Thank you for your visit.

http://www.google.com.au/search?q=cache:ALEdTX87ki0J:www.denturistinsight.com/archived%2520editorials/oct99.htm+denturists+cash&hl=en&client=firefox-a

Money in Politics Research Action Project

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$150,403 The Consumer Denture Care Act (a denturists front organisation
(Measure 24)
12 *OR State Denturist Association - $150,103

So US $300,000 war chest disclosed in Oregon.

Keith Allison, D.Dn. Denturist/Journalist turns whistleblower on international tactics
Yakima, Washington
Condor@nwinfo.net

our regulatory system is corrupt, and is one that elected officials apparently wield little, if any, control over.
Washington Denturist Association brought Initiative 607 (I-607) to the citizens of the state. Proponents of the licensing scheme demanded to “donate” at least $10,000.00 or denied future licensure.
those who complied with the extortionate demand were given the questions and answers to the National Indian Denturist Licensing Examination.
they were “tested” at the Northwest Denture Clinic, a denture clinic ..on the Nooksack Indian Reservation in Deming, Washington. After completing the fraudulent examination, the candidates were awarded the requisite National Indian Denturist License. As soon as I-607 was enacted into law and signed by the governor, they were to display their license to the newly established Washington State Board of Denture Technology, and they would in turn be awarded an official Washington State Denturist License through a reciprocity clause in I-607.
A discussion such as this is not complete unless one questions the authority of any government entity to destroy a legitimate business; particularly when government has licensed such entities to provide a service or product to the public. Is government truly interested in protecting the public? Or, is it their intent to whimsically dictate what government determines to be socially acceptable at any given time?

I also exposed the fraud, extortion, civil rights violations, conspiracy, restraint of trade and racketeering behind Initiative 607, the so-called Denturist Licensing Act.
I’ve also exposed how each of the above named public servants have refused to investigate or examine the evidence proving these allegations, and I will continue to raise this specter at every opportunity.

Under Color of Law and Appearance of Official Right - An Expose
by: Keith Allison, D.Dn. Denturist & Journalist
The practice of denturitry, or denturism as some refer to it, is the making, fitting, altering and/or repairing of full and partial dentures directly to the public. Evidence tells us that dental technicians routinely construct full and partial dentures without ever seeing the patient; and because many practitioners of this craft possess little more than a rudimentary education beyond on-the-job-training, constructing these appliances is, by its very nature, unscientific at best.. the risk comes from within via corrupt politicians, judges and bureaucrats that is wherein lies the crime.

As the following expose will document, the cover-up by federal, state, county and major news media officials, .., I believe that as the public comprehends the depth of the cover up, they will demand that public officials should be held accountable.

For the benefit of any person who believes our public servants always act above board and with the best interest of the public in mind, you are about to be introduced to the cold hard fact that many officials are as corrupt as any street-wise hoodlum. Where individual denturists named in this expose are concerned.. of their struggle for individual power and authority. ..It is only through the dedication of publications such as this one that the public will learn of the truth about the depth of the corruption to which our government has fallen.

During the early 1990's, several members of the Washington Denturist Association.. during an association meeting at my home in early 1994, Gary Fox, Don and Dorothy Jensen, and several other members announced their plan to run an initiative for the purpose of obtaining full licensure for denturists. In order to conceal their involvement in the initiative, they had formed and headed up an organization called *Citizens for Affordable Dentures.*

At the meeting, Dorothy Jensen, whose husband Don had been a dental supply salesman with no apparent training as a denturist, announced their initiative plans and told us, "If you ever expect to practice denturitry in this state, you're going to have to commit a minimum of $10,000.00 to our initiative. If you refuse to go along, you will not be allowed to obtain a denturist license in the future."

At that time, I made an effort to make everyone at the meeting understand that such a proposal was illegal. Not only did it defy the Washington State Health Professions Regulation Acts it also violates several aspects of constitutional law and numerous amendments to the U.S. Constitution. But, my efforts were to no avail, and the meeting broke up with two decidedly opposing factions going their separate ways.

Over the ensuing months, I had numerous telephone conversations .. about the illegalities of what they were doing, but they remained steadfast in their determination to proceed with their efforts to license denturists.. **These reports demonstrated there were no public or state interests to be protected by licensing denturists, but my efforts fell on deaf ears.**

In an attempt to fund their initiative, they sought "donations" from denturists across the nation, and telephoned me off and on, demanding that my wife and I "contribute a minimum of $10,000.00 each for a guaranteed Washington State Denturist License. Because this was done by telephone, the initiative proponents violated interstate commerce laws as well as laws contravening the buying or selling of official Washington State Licenses. My wife and I informed them that by making such demands, they were committing attempted extortion, but it made no difference. According to an affidavit from Gary Fox's receptionist, "All they could think of, was getting their hands on the money they needed to hire Sherry Bockwinkle's organization to obtain the signatures needed to place their initiative on the ballot." ..The initiative not only provided state licenses for denturists, there was a reciprocity clause that allowed for anyone who held a National Indian Denturist License to obtain a reciprocal Washington State Denturist License; there was also a provision for naming Indian Reservations "federal enclaves [this violated the states requirement that all initiatives be limited to one subject.] Also, state law required that any new professional board be of an advisory nature only, but the initiative called for members of the denturist association to be appointed to the soon to be formed Washington State Board of Denture Technology. This gave them the ability to control the licensure and all other aspects of the practice of denturitry in Washington State. During a telephone conversation with Kirby Putscher, an employee of the Washington State Department of Health about the make-up of the board, Ms. Putscher informed me that, "Only denturists who are members of the Washington Denturist Association may serve on the board."

It was readily apparent the initiative violated numerous aspects of the law.. they were going ahead with their initiative, no matter what. He again tried to persuade me to go along with their initiative and said, "If you and your wife continue to refuse to comply, Eric Hansen will see to it that neither of you will ever be licensed to practice in Washington State. And, if by some chance you are allowed to take the state exam, Eric has said that he will see to it that you never pass."

In talking with Gary Fox about what they were doing, I specifically asked him about the purpose of the National Indian Denturist Licensing scheme. At that time, he told me, "Anyone who contributes at least $10,000.00 to our campaign, will receive an Indian Denturist License in return. Then, after the initiative passes, all they'll have to do is take that license to the board, and with no further examinations, pay their licensing fees and receive a reciprocal Washington State Denturist License." I asked Gary, "If that National Indian License is legitimate, why can't I just use my pre-existing Indian License I received several years ago from the Nooksack Tribe, a license endorsed and promoted by Ron and Eric Hansen?" Gary told me, "Eric has said you can't use that one, you have to pay the National Indian Denturist Association for one of their licenses, give us $10,000.00 for the initiative, and then you will receive your reciprocal license." Gary also told me, "If you can't afford the $10,000.00 donation, Chet Charron has set it up so we can get a loan through his bank." I told Gary the entire thing was nothing but a scam, and that was the last time we spoke.

The National Indian Denturist Licensing scheme was ..simplicity at its best. Anyone who wanted to be licensed to practice denturitry in Washington State had to contribute a minimum of $10,000.00 to *Citizens for Affordable Dentures*, or the Washington Denturist Association. They would then meet at the Spokane area home of Gary Fox, where they would receive the questions and answers to the National Indian Denturist Licensing Examination. They would then be "examined by Eric Hansen and other proponents of I-607 at the Nooksack Indian Reservation in Deming, Washington.

After completing the examination, they were to receive a National Indian Denturist License, and then sit back and wait for I-607 to be voted on by the citizens of Washington State. After I-607 was codified into the Revised Code of Washington and signed into law by the governor, all anyone involved in the illicit scheme had to do was present their newly acquired National Indian Denturist License to the newly formed Denture Technology Board, and they would automatically receive their Washington State Denturist License. No matter how you look at it, every person involved in the scheme was guilty of buying/selling an official Washington State License. But where the Federal Enclave scheme was concerned, they had an additional agenda.

Their purpose here was twofold. First, they wanted to bypass the states regulatory system for healthcare workers. Second, they wanted to use National Indian Licensing Boards, which they would control, to be able to bring in healthcare practitioners from third world countries, and license them to practice on Federal Enclaves. This would have allowed them to do the same thing with heart doctors, brain surgeons, psychiatrists, and abortionists as they wanted to do with denturists. Regardless of their lack of experience or educational qualifications, all they would have to do is pay the price for licensure, and open their practices to an unsuspecting public.

They pressed forward with their campaign, and according to records from the archives of the Washington State Public Disclosure Commission, collected in excess of $300,000.00 and qualified I-607 for the November 1994 Ballot. The Washington State Dental Association ran an ineffective campaign opposing the initiative, and **the public swallowed the scam without giving it any thought.** ..Trying to curtail what my wife and I determined to be an illegal licensing scheme, we contacted Representative Jim Clements.. and numerous other legislators about the problem. Not one legislator responded to our letters, so we telephoned Representative Clements at his Olympia office. ..Shortly after being ushered into his inner office, my wife and I were introduced to Representative Mary Skinner. Representative Clements had requested Representative Skinner to sit in on the meeting, because she was a member of the House Health Committee, and would be the one to pursue the issue if she found our complaints to have merit. After explaining the situation to both representatives, we gave them part of the evidence showing the fraud, conspiracy, extortion, restraint of trade, civil rights violations and racketeering..Representative Clements had effectively removed himself from the loop.

Within a few weeks, I received a telephone call ..where I gave him additional information and evidence regarding the illegalities of I-607. I also gave him the names, telephone numbers and addresses of other registered denturists who would be willing to testify as to the validity of the information my wife and I had given to Representatives Clements and Skinner. No one ever bothered to verify the information with any of the other denturists; however, within just a few short weeks, the house and senate formulated and agreed on legislation to: [1] Remove the National Indian Denturist License from the reciprocity clause of the initiative; [2] Remove the title Federal Enclave from Indian Reservations; and [3] Remove the independent status of the Board of Denture Technology, changing it to advisory capacity only, as required by law [the return to advisory capacity was later **overturned by court action**.] However, despite Representative Dyer's assurances they would do so, the legislature failed to remove the unconstitutional licensing requirement from the statute.

Prior to the changes being voted on by the house and senate, I was asked to appear at a special meeting of the House Health Committee where Eric Hansen was questioned by several legislators. As one might expect, during the questioning, he denied being involved in any wrongdoing. Eventually, I was introduced to the committee, but no one bothered to ask me any questions and the meeting was adjourned. A couple of days later, I learned from John Welsh, that both houses, by all but one vote, had voted to enact the three provisions listed above into law. During this conversation with John, he told my wife and I, "The legislature wants to reward you for exposing the fraud in I-607 by giving you a Washington State Denturist License." I told John, "The only way I can accept that license, is if the state gives a license to all of the other denturists who had the integrity to refuse to be coerced into complying with the extortionate demands." Needless to say, no one was rewarded by the state. In hindsight, knowing as I do now how the state attorney generals office acts in collusion to promote an illegal political agenda, it is highly unlikely they would have allowed me to retain their "reward."

The governor, attorney general, secretary of the Department of Health and every legislator, knew precisely who was involved in the fraud, extortion, conspiracy, restraint of trade, civil rights violations and racketeering behind I-607. Even so, Bruce Miyahara, then Secretary of the Washington State Department of Health, appointed Gary Fox and Eric Hansen to be the first denturists to head up the newly formed Washington State Board of Denture Technology. I brought this up to numerous state officials and bureaucrats, but nothing was ever done about it, and I never received an explanation as to why they were appointed to these positions.

With their reciprocal licensure provision gone from the newly codified initiative [RCW 18.30,] Gary Fox, Eric Hansen, Val Charron, and the other proponents of I-607 came under intense fire from several of those who had contributed the required $10,000.00 to the initiative. It is my understanding that several of them began threatening Gary Fox, Eric Hansen, and the Denturist Association leadership with a lawsuit for breach of contract. In order to avoid having the facts of the case being brought out in open court, Secretary Miyahara instructed Gary and Eric to contract with Bates Technical College in Tacoma, and implement a "training program for those who contributed money to the I-607

campaign;" it was one more in their long line of illicit schemes. Bates Technical College is, by the way, an educational facility controlled by Washington State Government

The program purportedly covered such diverse courses as head and neck anatomy, nerves and blood supply to the head and neck, biology, chemistry, microbiology, oral pathology, histology, partial denture design and construction and dental juris-prudence. The classes were held one day a week, and the entire course was completed within twelve weeks. Having taught dental technology and denturist techniques in Southern California, and being a past director of the five campus Southland College's Dental Technology and Dental Assisting programs, I know that anyone who has taken even one of the courses listed above knows it is impossible to master any one of those classes in twelve days. But, according to Gary Fox, Eric Hansen and employees of the Washington State Department of Health, the original denturist licensee's managed to complete that remarkable feat. I find this particularly remarkable, since I have affidavits and first person testimony stating that some of the classmates did not make an attempt to attend class; however, they were still awarded Certificates of Completion from Bates College, signed by Joe Rosendahl.

One other thing that has denied all reason and log is the selection of Joe Rosendahl, as the Bates College instructor of the denturist-training program. According to his application for licensure as a denturist in Washington State, it shows that prior to and after taking a two-year course in dental technology at Bates College, Joe never took any of the science courses he was charged with teaching during the twelve-week denturist program. Without those courses, Joe should not have been allowed by the state to teach the courses, or apply for a Washington State Denturist License. And yet, official records show that Gary Fox and Eric Hansen awarded Joe Rosendahl a denturist license.

Upon completion of the twelve-day course, everyone who participated in the Bates Denturist Program passed the school's final exam. Each of the Bates graduates went on to take the Washington State Denturist Licensing Examination formulated by Gary Fox and Eric Hansen, and all but the few who refused to comply with their extortionate demands eventually received an official state denturist license. It was reliably reported to me that prior to taking the state examination, the examinees met at the denturist office of Laslo Bako, where they were given the questions and answer to the upcoming state denturist examination by Val Charron. Although Val had been a political science major in college, he too somehow qualified to become a licensed Washington State denturist.

Shortly after the donors to I-607 received their official Washington State Denturist License, the Board of Denture Technology withdrew its accreditation of the Bates Denturist Program, effectively leaving no educational program in the state through which state residents could obtain a denturist license. They did, however, leave one option open. That was for Washington State residents to move out of the country, and take a Washington State approved two-year denturist course in Canada.

In about 1990, I had been forced to cease working as a denturist …placed an injunction against my further practicing as a denturist. At one point during my battles with the state, Assistant Attorney General A. Craig McDonald wrote to my attorney [Greg Scott] and said, "If Mr. Allison will just move out of the state, we'll leave him alone." I refused to do that, but instead, turned my practice over to my wife; she practiced as a registered denturist for the next nine and one-half years without any problems or state interference. Also at about this time, Assistant Attorney General Margaret Bichel telephoned Greg Scott and said, "Greg, you've got a lot of years ahead of you practicing law, and you've got to make up your mind about something. Do you want to spend your years practicing law, or do you want to sit around watching as we audit your practice every other month?" Shortly afterward, Greg asked my wife and I, "Why don't you just give them the money they want, and get on with your lives?" I fired Greg Scott a few days later. Greg still makes an excellent living as a court appointed attorney for indigent criminals.

After blowing the whistle on the fraud involved in I-607, retribution from Gary Fox, Eric Hansen, and the other proponents and participants in the I-607 scheme was soon forthcoming.

..Due to her education as a Registered Nurse, Jackie was better educated in the health sciences than any of today's currently licensed Washington State denturists. But before long, the state began an intensive campaign to discredit her. State personnel began parking outside her office, jotting down the license plate numbers of her patients, and eventually contacted many of them at their homes. One patient informed Jackie of what was going on, and refused to assist the state in destroying Jackie's practice or her personal reputation. In order to make it appear that I had been practicing alongside Jackie, they eventually convinced a few of her patients to provide false testimony that I had been the one who made their dentures. By doing this, they were able to charge me along with Jackie, and attempted to tie her into the original complaint dentistry had filed against me years earlier. They therefore intended to file contempt of court charges against her too. Eventually, a reporter from KIMA Television telephoned Jackie and told her, "Assistant Attorney General Margaret Bichel has been calling various news outlets in Yakima, trying to get them to broadcast derogatory news about you and your practice as a denturist."

We hired Pasco criminal attorney Robert Thompson to defend Jackie ..and I wound up having to write the federal complaint as well as the Notice of Intent to the state that we intended to sue them. The Notice of Intent was filed with the state, but when it came time to file the complaint in Federal District Court, Mr. Thompson refused to do so. He told

us, "I don't have enough experience in federal court to file this case." Of course, his lack of experience hadn't slowed him down in relieving us of several thousand dollars in legal fees.

In the meantime, Jackie's gall bladder went into "critical mass," and had to be removed. About the time she was due in court, her father died and as you might imagine, she was an emotional wreck. Despite the fact that she was physically and emotionally unable to appear in court to defend herself, her case went on without her. Naturally, the state obtained an injunction against her from yet another corrupt Yakima County judge, another judge I refer to as one with questionable judicial ethics. The state wanted to confiscate all of the denture equipment from the office, and Jackie wanted to fight them. But because they were unable to determine the ownership of the equipment, the state was unable to confiscate it, and I told Jackie to close the office. I told her that through my own experience with the corrupt judicial system in Yakima County, I felt she had no chance of beating the state; she followed my advice and had the equipment removed for safekeeping.

The state's next step was to attack Jackie's license as a Registered Nurse; here, they were determined to destroy her ability to make a living, and probably force us to sell our land holdings and move from the state as they had done to another denturist earlier on. The Board of Denture Technology informed the Washington State Nursing Commission about Jackie having practiced as an "illegal denturist," and demanded they take action against her nursing license. It wasn't long before the commission concocted charges against Jackie that included "Moral Turpitude" as the centerpiece; this for supposedly practicing outside the nursing field. Jackie sent documentation showing she had been properly registered as a denturist with the state, and had obeyed all of the laws pertaining to practicing as a registered denturist; but it made no difference. Eventually, the commission dragged her out of Yakima and across the state to Pullman, a small town west of the Washington State Line for her "hearing." Their strategy was obviously to prevent her from bringing in local witnesses to testify in her defense, or to observe another corrupt state activity. Jackie had hired an ex-administrative law judge named Larry King to defend her. ..She stood before the commission and told them precisely what had been going on. She told them of her stand against the illicit demand for $10,000.00 for a guaranteed Washington State Denturist License, and how we had blown the whistle to the legislature about the fraudulent schemes behind I-607. She also told them that she knew the complaint against her nursing license was nothing more than retribution for her stance against the fraud, extortion, restraint of trade, conspiracy, civil rights violations, racketeering and for blowing the whistle on the proponents of I-607.

While the state was harassing Jackie and I, other prior registered denturists such as Claude and Cheryl Edlin and Alan and LaVerne McDonald, were allowed by the state to continue running their practices, unfettered by government interference. Alan had an injunction placed against him by a local judge, but that didn't matter, state and county government left them alone. Randy and Janet Vize originally opened their denturist practice in Pasco, but eventually fell in with Eric Hansen, Gary Fox, and the others associated with I-607. Randy told my wife and I they had "Borrowed around $20,000.00 from a close relative, and used it to pay the required $10,000.00 to the other denturists, and bought a new car with the remainder.

A few months into the year 2002, Randy died, but Janet has been allowed to keep his practice open using one of her sons to apparently represent himself as a licensed denturist. Federal officials, members of the board, the denturist association, the legislature, governor, attorney general and the Department of Health are aware of this arrangement, but refuse to do anything about closing down her office. Therefore, the state has engaged in selective prosecution where my wife and I are concerned, but not one federal, state, or county official has been willing to rectify this condition.

The commission appeared stunned by her revelations, and at the end of the hearing they informed her they would take her testimony into consideration. A few weeks later, she received their verdict of NOT GUILTY. Even though they found her not guilty, they still put her nursing license on probation, and required her to complete an expensive "nursing ethics" course. Her license was supposed to be returned to full status within a year, but as an apparent way of showing their authority over her, the commission refused to remove the probationary status for almost two years.

Even though they were unable to obtain a guilty verdict against Jackie, a member of the Office of The Attorney General telephoned her new employer, informed them of the punitive action taken against her and stated, "She's Of Great Moral Turpitude."

During the ensuing three years after the denture technology board withdrew the accreditation of the Bates College Denture Technology Course, the proponents of I-607 apparently came under increasing pressure to implement a new denturist-training program. Therefore, Gary Fox, Eric Hansen, the Board of Denture Technology, and members of the Department of Health set out to make that happen. At one meeting of the board, Bates College was reaccredited and Joe Rosendahl was re-instated as the instructor for the new two year-long denturist-training program.

For two years, a new denturist class toiled at learning what the initial denturists had purportedly learned in twelve days. Several weeks prior to completing two years in the course, the twenty students all passed the final denturist examination at Bates College, graduated and applied to take the state examination. After paying Bates College thousands of dollars for books and tuition, and then paying the Department of Health thousands of dollars to apply for and then take the state exam, only two of the twenty applicants passed the state licensing examination. Compared to the 100% success rate of those who paid the requisite $10,000.00 and took the state's twelve-day denturist course, this represents more than a **96% failure rate for the participants in the two-year program**.

After failing to pass the state denturist exam, most of the students in the Bates College Denturist Training program contacted a Tacoma law firm, and filed a lawsuit against Bates College and Joe Rosendahl. However, before the case could be adjudicated, Bates College officials settled the case out of court for a reported $1,250,000.00. Of course, no guilt was established in this case, and therefore, there was no decision made as to whether or not the students had failed because they had not contributed the required $10,000.00 or more to I-607. The plaintiff's in the case received but a pittance of the settlement with Bates College, but I'm sure you can ascertain where the majority of the money went.

A few months prior to the opening of the 2003 session of the Washington State Legislature, I spoke with Representative Jim Clements about the unconstitutionality of the Denturist Licensing Act. At the end of our conversation, he asked me to write up a synopsis of our conversation and submit it to him, which I did. I also gave him a copy of the legislation that would bring the licensing act into compliance with constitutional and state laws. After reading the material, he asked, "Since there is no potential for harm to the public, and there is no state interest to be protected, why are we regulating denturists?"

At one time or another, every Washington State legislator, including but not limited to Representative Mary Skinner; Representative James Clements; Senator Alex Deccio; Senator Harold Hochstatter; Senator Rosa Franklin; Governor Gary Locke; Attorney General Christine O. Gregoire; State Auditor Brian Sonntag; United States Senator Patty Murray; United States Representative Jay Inslee; United States Representative Richard [Doc] Hasting; United States Attorney General John Ashcroft; members of the Seattle office of the United States Attorney; Yakima County Superior Court Judge Francis James Gavin; Yakima County Superior Court Judge Michael Levitt; and ex-Yakima County Prosecutor Jeff Sullivan [now a U.S. Attorney in the Seattle office.] The current Sheriff of Yakima County, Ken Irwin, has been informed of this, but in a telephone conversation with me he claimed he "Is not responsible for protecting the civil rights of citizens of Yakima County, nor is he responsible for protecting the counties citizens from enforcement of unconstitutional laws."

Ladies and gentlemen, I have personally informed the governor, the attorney general, each and every legislator in the State of Washington of the unconstitutional acts that have occurred in relation to denturists in this state. I have selected 21 newspapers, among them the Yakima Herald-Republic, the Spokesman Review in Spokane, the Seattle Times and Seattle Post Intelligencer, and yet no one will do anything about this corrupt condition and the newspapers refuse to publish anything about the corruption.

I have also supplied legislators with evidence proving what has transpired, I have written legislation for them that would bring the Denturist Licensing Act into compliance with constitutional law and state statutes, but they refuse to act. I have notified the United States Department of Justice, the Federal Bureau of Investigation and numerous federal legislators of the injustices perpetrated upon citizens of this state, but everyone refuses to act. But if this nation is to continue to represent individual freedom to all the world's people, this double standard of to whom the law applies must cease. It is only through an enlightened, outraged citizenry, that such moral turpitude, corruption and degradation of the law can be brought to a halt, for knowledge is the key that unlocks the shackles of bondage.

With this in mind, one can only wonder whom the citizens of this state and nation can rely on. If we can't rely on our federal, state, or county officials to protect us from the proliferation and enforcement of unconstitutional statutes, whom do we rely on? And whom do we rely on to keep us informed, if the members of the Fourth Estate refuse to exercise their rights regarding freedom of the press?

Keith Allison, D.Dn. Denturist & Journalist

Ethical implications of competition policy in healthcare

Ethical implications of competition policy in healthcare

We need to debate the ethical and philosophical questions underlying the application of market economics to healthcare
Paul A Komesaroff MJA 1999; 170: 266-268

Patients come to doctors because they are experiencing pain, illness or fear. They offer access to their bodies and to the intimate recesses of their personal lives. They grant wide discretion and decision-making power to doctors, on the understanding that doctors will exercise their judgement in a disinterested and compassionate

manner. It is mutually agreed that the power of doctors is subject to rigorous ethical constraints arising from the long tradition of medicine, which have been upheld by the professional organisations for hundreds of years. These constraints, which constitute a complex, self-generated system of professional norms, limit the nature of personal relations between doctors and patients, the use and dissemination of information, licensing and credentialing of practitioners, and specific commercial practices such as fee splitting, advertising, self-referral, and ownership of pharmacies and hospitals by physicians. They primarily reflect altruistic concerns of doctors to separate personal and financial considerations from the paramount professional goal of doing what is best for their patients, even if, undeniably, they also have the effect of protecting doctors' financial interests. They do not prohibit competition, but rather channel it into non-economic forms, such as competition for reputation, recognition and status, and social influence.

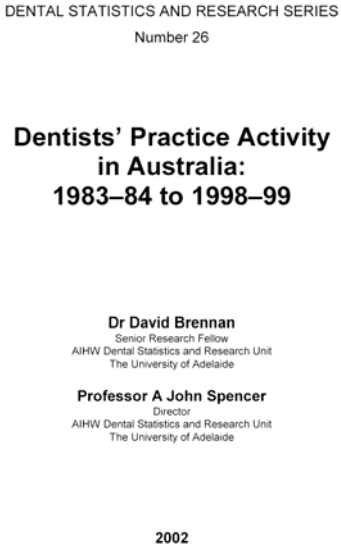
Emphasising economic values undermines the role and power of ethical values.16 This fundamental shift may in the longer run prove deeply significant for society as a whole, for it may lead to changes in the structure and dynamics of the clinical process itself.

A crucial aspect of the medical encounter is that it is not purely "instrumental" in character. It does not merely subserve technical functions, the solution of problems in biochemistry or physiology through the application of scientific modes of thought and analysis. It is also involved in setting goals, in identifying and scrutinising meanings, and in establishing the frameworks within which the technical problems are identified and given a value. These latter functions are "non-instrumental" in character, and become possible because of the peculiar nature of the contact between doctor and patient: its intimacy and openness, its reliance on vulnerability and trust, the moment of sanctuary it offers with respect to the utilitarian relationships of everyday life. It is through the contact that the doctor is granted with the life world of the patient that the healing process becomes possible. This contact, which occurs through a variety of mechanisms, including language and touch, stands at the irreducible core of clinical medicine.

It is an unavoidable consequence of the introduction of the unrestrained operation of market forces into healthcare that economic values penetrate to the heart of the medical relationship. Indeed, it is precisely the rationale of the policy that financial imperatives take over as the motivating principle of all medical decision making. To open up the clinical relationship to such forces, to subject it to criteria that are purely calculable and quantitative, risks undermining the dynamic structure on which the entire medical enterprise rests. The physician becomes the agent of the hospital or the system rather than of the patient. His or her primary obligation to act on behalf of the patient is displaced in favour of conformity to a complex system of economic incentives and

disincentives. The scope for disinterested, compassionate care is greatly contracted.17 The opportunities to respond to individual needs, to the specific details of the predicament of a particular patient, are severely contracted in the face of the overwhelming power of economic imperatives.18

Health-financing policies cannot be understood as exclusively technical, or "value free", mechanisms for regulating the healthcare system. Rather, they must be interpreted and evaluated in accordance with philosophical and ethical criteria and in relation to their social and cultural consequences.19 We need to ask not merely Is this a way to balance the books? but also Is this the kind of healthcare system we want to have? If this simple test is adopted it becomes immediately apparent



DENTAL STATISTICS AND RESEARCH SERIES
Number 26

Dentists' Practice Activity in Australia: 1983–84 to 1998–99

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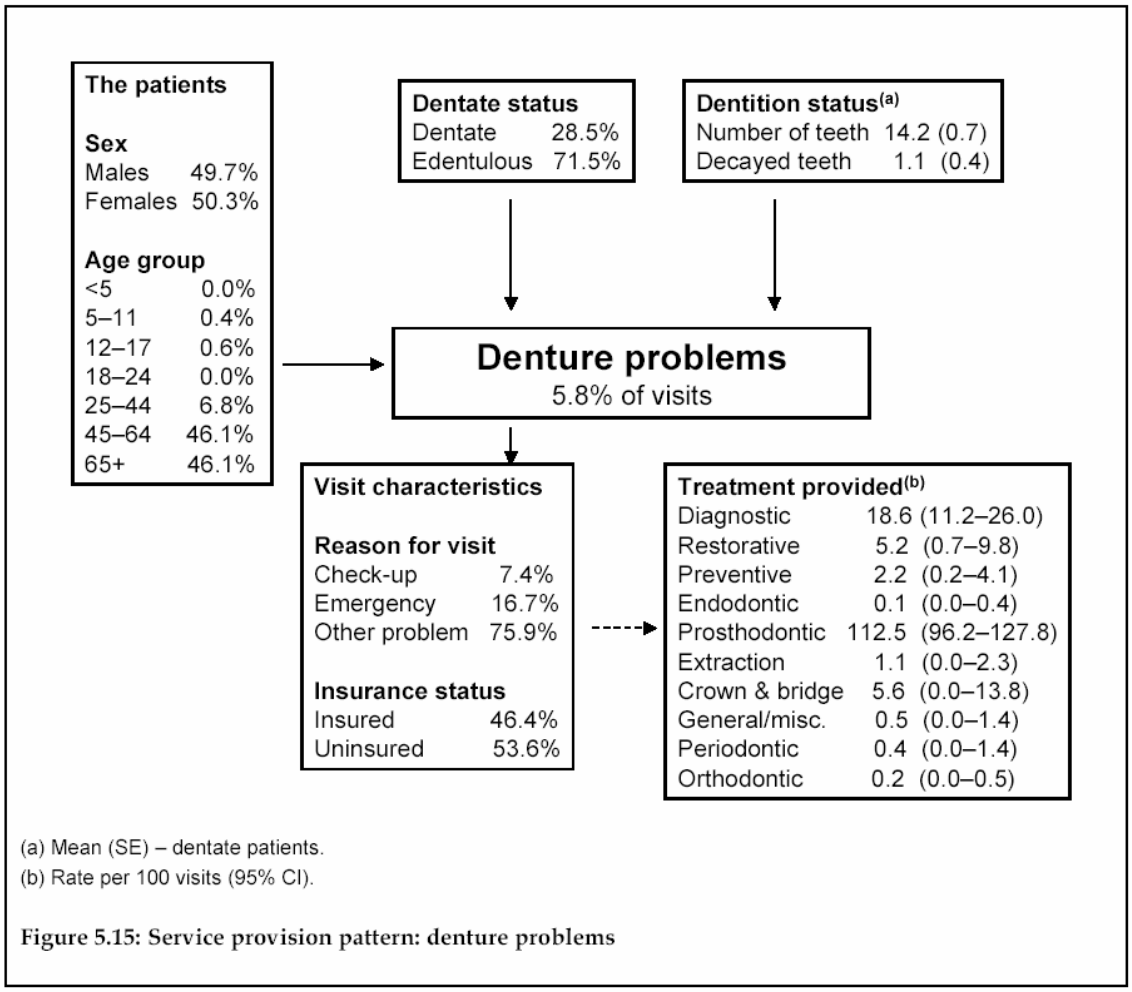
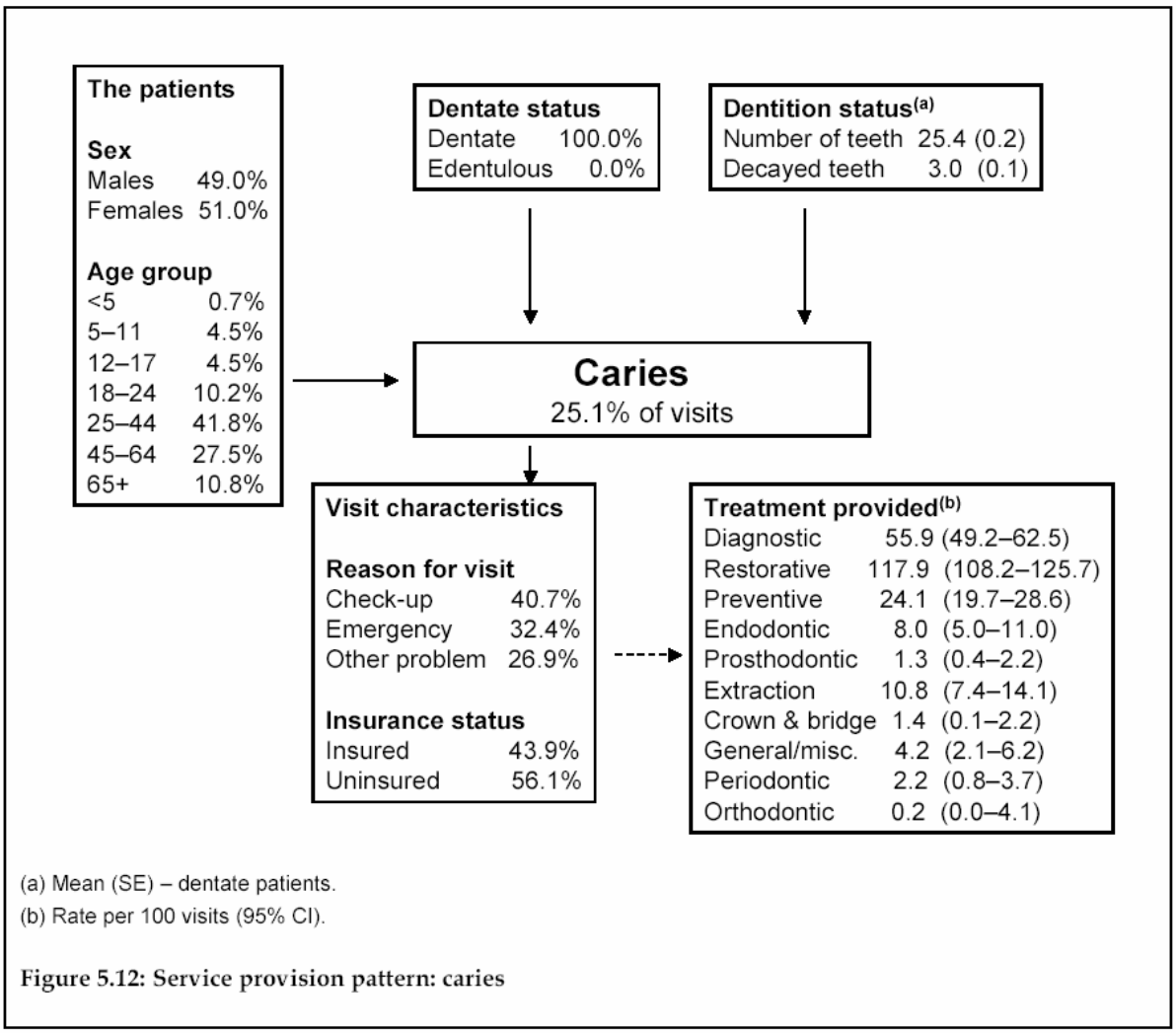


Figure 5.15: Service provision pattern: denture problems

Denture problems

The pattern of service provision is presented in Figure 5.15 for the main presenting condition of denture problems. Denture problems accounted for 5.8% of visits. There



(a) Mean (SE) – dentate patients.

(b) Rate per 100 visits (95% CI).

Figure 5.12: Service provision pattern: caries

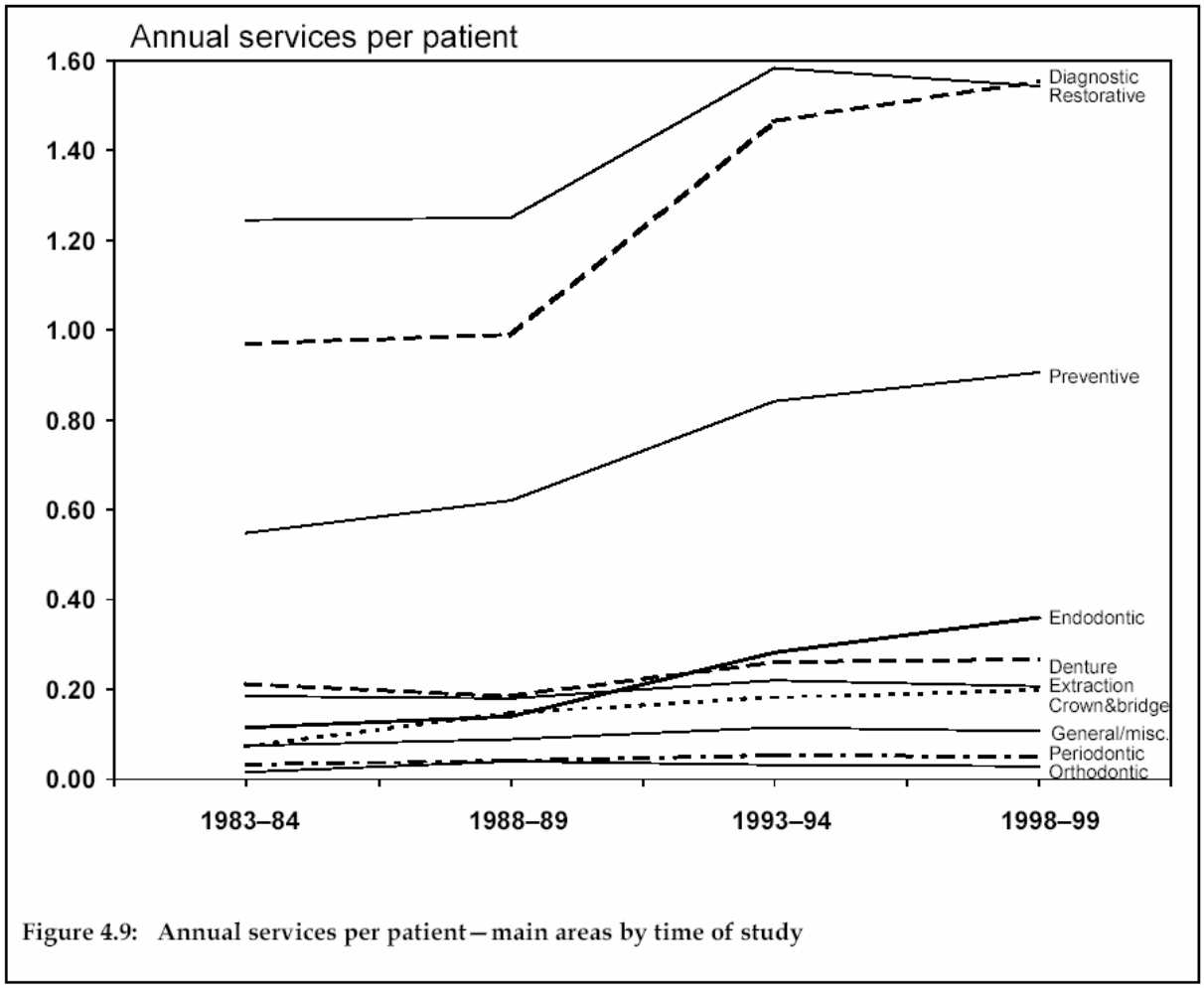


Figure 4.9: Annual services per patient—main areas by time of study

The above figures indicate that dentures comprise about 5% of a dentist's activity, the patient attending a dentist has 25 teeth and 3 or more are decayed. My estimation is that for those patients with teeth and a partial denture who do not attend a dentist will have a lot more than 3 decayed teeth. Nevertheless, these decaying teeth are ticking time bombs and a trip to a prosthetist for a repair or a new partial denture will deny the patient of a diagnostic opportunity, deny them an opportunity for preventive indoctrination (remember dentists invented prevention in the 1950's) and also deny the patient the cost saving interventions which will rebound on health insurers and government services in the following years as people lobby and queue for dentures, pain relief or higher rebates.

It seems strange that a denture having the low entry price of a TV and the possible huge negative outcome costing as much as a Holden car could now be reduced to eliminating the operator totally through a blatant mechanical market grab using Mail Order? All done in the name of efficiency and profit by elimination of the dentist, elimination of the denturists and elimination of the presence of the patient.