Braidwood Dental Practice

Dr Brad Horwood

**Submission to Senate CDDS Committee**

I am a dentist in with experience of the CDDS scheme and appreciate the opportunity to contribute toward possible changes to the CDDS.

- The CDDS *intends* to improve access to dental services for the community through Government financial assistance via Medicare.

  **My observations**:
  The CDDS leaves behind the battler and often pays for dental services on behalf of people who can easily afford it. This I have seen repeatedly. It bypasses the poor or low-income earner. It creates privilege from illness, which is strange.

- Just as a Health Fund reimburses a patient for part of their dental expenses, so the CDDS allows gap payments, which *should* see practitioners providing services in the usual way for their usual fee.

  **My observations**:
  The CDDS is being bulk-billed by the great majority of participating practitioners. This develops the tendency to treatment plan around the production of item numbers and skews clinical judgment away from "wait and see" to over-servicing.

  *Why do most bulk-bill?*
  The CDDS will pay the dentist directly when he bulk-bills. Dentists encounter resistance to up front payment from Medicare patients, and some judge dentists seeking co-payments to be taking advantage of a "Government" patient. Dentists must wait for the patient to bring in the cheque from Medicare if there is a gap payment.

  *Why don't I bulk-bill?*
  Very careful dentists doing work to a higher standard are oppressed by the commodification of the profession. Most people choose a dentist for personal reasons around trust and confidence. People with no need to pay devalue the service in their own minds. This has negative implications for community values and long-term health outcomes just as Noel Pearson suggests the welfare mentality is damaging indigenous Australians.

- The CDDS targets individuals whose chronic disease makes them eligible, and so should make them healthier to justify the money spent.

  **My observations**:
  In my clinical experience in most cases the link between their Chronic Disease and my dental treatment is tenuous. For example, a patient that presented with a loose bridge requiring a remake presents a few weeks later with the CDDS paperwork. The decay under his bridge has nothing to do with his diabetes and everything to do with a lack of hygiene.
  A lady with sensitive teeth has many shallow cavities on the gum line. All the bonded fillings paid for by the CDDS have more to do with her toothbrush abrasion than her osteoporosis. It's quite mad.

The vast majority of people I have treated under the CDDS have dental problems not caused by their chronic disease, with my work of no benefit to their chronic disease. At the same time, I have a single mother who owes me money, bringing me her child, unable to pay, unable to use her Medicare card for dentistry, and I treat her as a charity.

- Written Treatment Plan
  I have no objection, in principle, to the requirements of the scheme. Frankly I don't agree with the ADA's concern to defend large repayments from those who've shown chronic disregard for the CDDS rules.

  **My Observations**:

  It doesn't work in practice. During treatment you can find a cavity unexpectedly on an adjacent tooth, or a tooth turns out to be dead needing root-canal or extraction, or may need a crown due to an undetected cracked cusp. One may discover on the day of treatment you need to extend a bridge to include an extra tooth for strength.

  All these things have happened to me with Medicare patients and I despair to think I can't do it without a revised plan, and new letter to the doctor, time for the patient to get the new plan. Clinical processes grind to a halt. Instead of an open discussion with the intraoral camera explaining the unexpected, getting consent and continuing, you are stuck.

  There are also future dental occurrences. For example, how do I deal with a CDDS patient who presents after completion of their treatment plan with something unexpected like a broken tooth? They may still have credit with the CDDS scheme and expect you to respond, but one is afraid of breaching the rules by proceeding without a written treatment plan. This is unworkable for people at the coalface of dentistry.

  I have been abused when, after completion of her treatment plan, a patient presented wanting a clasp repaired on her acrylic denture under Medicare and I hesitated.

**Suggested Solutions:**

- The need for written treatment plans for routine work should be scrapped in favour of mandatory gap payments. What benefit does the CDDS derive from a written plan except that the patient knows in advance what will happen? This is **always** needed for informed consent anyway. The doctor is going to accept the dentist's recommendation as it is outside his area of expertise. *It serves no discernible purpose to the CDDS.*

- Bulk-billing should be disallowed (no really!) and the Medicare Schedule of Fees scrapped. The fees should be set for Medicare patients at each **State's average fee** as per the ADA publication each year with the CDDS benefit *unchanged* and gap payments compulsory. This incurs no extra expense for the CDDS scheme. It should be done in fairness to paying patients who keep our businesses viable. The fees would have some basic rationale, unlike the Medicare schedule.

Perceived expense is the main reason people do not seek treatment. If improved access is the goal, the CDDS can make treatment cheaper without fear of rampant expenditure by dentists, by removing the option of bulk billing. The patients' interest will prevent over-servicing and protect the public purse more effectively than a written Treatment Plan.

**Some examples based on NSW average fees are:**

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| Examination: | Fee $59 | CDDS Benefit $40.50 | Gap payment $18.50 |
| Scale and Prophylaxis: | Fee $102 | CDDS Benefit $68.85 | Gap payment $51.65 |

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| Extraction: | Fee $157 | CDDS Benefit $100.75 | Gap payment $56.25 |
| 3 surface filling: | Fee $237 | CDDS Benefit $161 | Gap payment $76 |
| Root canal therapy (2): | Fee $484 | CDDS Benefit $324.50 | Gap payment $159.50 |
| Xray: | Fee $41 | CDDS Benefit $26.50 | Gap payment $14.50 |
| F/F denture: | Fee $2008 | CDDS Benefit $1292.90 | Gap payment $715.10 |

*These are affordable sums of money*.

- Eligibility due to a chronic disease should be means tested.

The Chronic Disease justification is erroneous and blurs principles of fairness.
The financially secure can obtain dental care. They shouldn't use a chronic disease to justify Medicare assistance to go to the dentist more cheaply.

- Reduce the amount available.

The idea of one big sum of money producing one big "fix" is mistaken. Dental health is gained in small consistent steps developing good habits of attendance. The sum available under the CDDS is far too great, and the time frame too short.
*Better control and value for money will be achieved if the limiting factor is the rate at which patients are prepared to expend their co-contribution.*

**In summary, the CDDS can work better if:**

1. **It is made fair by means testing**
2. **Written treatment plans are removed as they are a barrier between Government's good intentions and the practitioners daily clinical reality**
3. **Gap payments with an end to bulk billing will put the required brakes on expenditure and strengthen community values**
4. **Change the paradigm to steady evolution and reduce the amount available by half whilst doubling the time frame**

**A large sum of money available for bulk-billing is causing excessive expenditure of Government funds as dentists try to meet high expectations from patients wanting work for free. When people have to put in a small sum of money they will say yes or no with more discrimination and save the scheme from misuse. Better access to dentistry at less public expense is possible with this suggested model of delivery.**

Yours sincerely,

Brad Horwood
BDSc GCClinDent