# HEALTH INSURANCE AMENDMENT (MEDICARE DENTAL SERVICES) BILL 2007

## THE INQUIRY

1.1 The Health Insurance Amendment (Medicare Dental Services) Bill 2007 (the Bill) was introduced into the House of Representatives on 16 August 2007. On 16 August 2007, the Senate, on the recommendation of the Selection of Bills Committee (Report No. 14 of 2007), referred the provisions of the Bill to the Community Affairs Committee (the Committee) for report on 5 September 2007.

1.2 The Committee received nine submissions relating to the Bill and these are listed at Appendix 1. The Committee considered the Bill at a public hearing in Canberra on Monday, 27 August 2007. Details of the public hearing are referred to in Appendix 2. The submissions and Hansard transcript of evidence may be accessed through the Committee's website at http://www.aph.gov.au/senate_ca .

## THE BILL

1.3 The purpose of this Bill is to amend the Health Insurance Act 1973 in order to increase access to dental treatment under Medicare for people with chronic conditions and complex care needs.

1.4 In the 2007-08 Budget, the Commonwealth Government announced an expansion of the current Enhanced Primary Care dental items (Medicare items 10975 to 10977) to provide higher Medicare rebates and more services to eligible patients. From 1 November 2007, eligible patients will be able to access Medicare benefits for dental services of up to $4,250 (including any Medicare Safety Net benefits where applicable) over two consecutive calendar years. This amount may be used for any combination of dental services covered by Medicare under this measure, depending on the clinical needs of the patient.

1.5 New Medicare items will be introduced for services such as dental assessments, preventative services, extractions, fillings and other restorative work, and dentures. These items will be based on the current Department of Veterans' Affairs (DVA) Schedule of Dental Services, with some modifications.

1.6 The Medicare dental items will be targeted at people with chronic conditions and complex care needs where the person's oral health is impacting on, or is likely to impact on, their general health. The new measure will make it easier for these people to access dental services in the private sector when they need treatment or to receive preventive care. To be eligible, a person needs to be managed under a GP Management Plan and Team Care Arrangements. Residents of aged care facilities can also access the dental items if they are managed by a general practitioner under a

multidisciplinary care plan. All patients will need to be referred to a dentist by their GP. It is expected that approximately 200 000 patients will access the new dental items over the first four years of the measure.[1] A comparison of the existing and new MBS dental items is at Appendix 3.

1.7 The estimated cost of the measure is $384.6 million over four years allocated as follows:

| | 2007-08 | 2008-09 | 2009-10 | 2010-11 | Total |
|---|---|---|---|---|---|
| Administered | $53.3m | $113.9m | $94.2m | $110.4m | $371.7m |
| Departmental - Health and Ageing | $0.6m | $0.2m | $0.1m | $0.1m | $1.0m |
| Departmental - Medicare Australia | $3.4m | $3.0m | $2.7m | $2.7m | $11.8m |
| **TOTAL** | **$57.2m** | **$117.1m** | **$97.1m** | **$113.2m** | **$384.6m** |

*Source*: Submission 2, p.4 (DoHA).

## ISSUES

1.8 The Bill was generally supported by those providing submissions and evidence to the Committee, though the need to expand on these initiatives was clearly expressed. The Australian Medical Association expressed 'its desire that further funding initiatives be rolled out to broaden access to dental care beyond those with chronic conditions and complex care needs'[2] and the Australian General Practice Network supported 'broader access to Medicare benefits for dental treatment for people on low income thresholds and health care card holders'.[3]

1.9 The Australian Dental Association (ADA) also welcomed the Federal Government's 'recognition of the greater role it must play in the improvement of the oral health of needy Australians' and hoped 'that this initiative is the first of many initiatives that will occur in relation to dental care delivery'.[4]

1.10 Professor John Spencer commented that:

> This is an important, albeit very constrained step in improving the oral health and access to dental care among the Australian population. Nonetheless, there are several issues [that] should be discussed with regard to this Bill and its rationale.[5]

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1 Explanatory memorandum, p.1 and *Submission* 2, pp.2-3 (DoHA).

2 *Submission* 3, p.1 (AMA).

3 *Submission* 7, p.1 (AGPN).

4 *Submission* 6, p.2 (ADA).

5 *Submission* 4, p.1 (Professor Spencer).

### *Chronic medical condition and impact on oral health*

1.11 The underlying premise of this Bill, that patients with chronic conditions and complex care needs often have poor oral health which adversely affects their medical condition or general health, attracted considerable discussion.

1.12 Professor Spencer made several points on this issue. Firstly, he referred to a quote from the US Surgeon General – 'You cannot be healthy without oral health' – that challenges the premise 'that poor oral health is only important in so far as it affects a chronic medical condition or its management' and argued that the quote 'acknowledges that oral health *per se* is important, even without an identifiable increase in the severity or complexity of the management of any medical condition'.[6]

1.13 Secondly, the Professor submitted that 'classifying those medical conditions which are adversely affected by poor oral health is a difficult task', and commented:

> Poor oral health may quite plausibly affect nearly all medical conditions through pathways involving reduced ability to chew, altered food choice and decreased nutritional value of foods consumed. Alternatively oral symptoms may adversely affect quality of life, reducing coping and self-efficacy. However, there is lack of research in these areas. There is difficulty in ruling a line between medical conditions which are affected or not by poor oral health. At present any decision about what conditions are included will seem quite arbitrary.[7]

1.14 The Department spoke to the issue of connection between chronic conditions and poor oral health, and how they expected the scheme to operate:

> Mr Eccles—Professor Horvath [Chief Medical Officer] alluded to this at Senate estimates. Our understanding of the impact of poor oral hygiene, poor dental health, on chronic conditions is growing all the time. In particular, there is a growing body of evidence about the link between heart disease and poor dental health. It is important to bear in mind that this is about people presenting with chronic conditions where, in the GP's view, they would benefit from dental treatment. That could be early-stage gum disease, acute infection or a whole range of things, but the focus is very much on people with chronic conditions who do need dental health care.
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> CHAIR—Because of that chronic condition?
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> Mr Andreatta—No. Under the enhanced measure that we are talking about now, people would be eligible to access these items where their oral health is either impacting on their medical condition, their chronic condition or their general health. So it is a broader eligibility criterion that we have adopted.
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> Mr Eccles—It is the same pathway into the general practice—it is people with team care plans or people who are under a GP management plan

6 *Submission* 4, p.1 (Professor Spencer).

7 *Submission* 4, p.1 and *Committee Hansard* 27.8.07, p.CA21 (Professor Spencer).

> where, in the doctor's view, their oral health is impacting on, or is likely to impact on, their health.[8]

1.15 With GPs now having to form a view on the impact of oral health and with the increased range of dental services being provided under the scheme, the issue arose as to whether GPs had the clinical capacity to assess eligibility against the new criteria included in the MBS dental schedule. The Department has given attention to this issue:

> On the fundamental point about the capacity of GPs to understand the item, that is why it is going to be very important that we get the information and the communication activities right.
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> We know that the professional associations that represent dentists and the GP groups are working together to try and work out how we can make sure that GPs, who are going to be the starting point for this, have a better and more comprehensive understanding of the link between how they care for someone and when dental treatment might be useful in managing someone's chronic condition. We are very aware of that, so that will be something we will be doing up front, and we are going to be pretty well ready to go as soon as or if the legislation is passed. From that point, it will be a matter of monitoring the uptake, monitoring the progress and continuing the dialogue with the GP groups and the dental groups, just to make sure that we have got this as right as we can.[9]

### *Targeted funding*

1.16 The ADA was concerned that Medicare was being used as the model of delivery for the dental care program because Medicare, by its very nature, does not discriminate on the basis of financial need. They remain dissatisfied that funding under this program 'remains universally available to Australians rather than being targeted to the financially disadvantaged and particularly those numerous Australians on dental waiting lists'. The provision of financial assistance for dental care to those that can afford such treatment is in the ADA's view an inappropriate use of the limited funds on offer. The ADA reaffirmed its view 'that any dental program should be selectively targeted for those most in need and that there should be other programs with regard to whole-of-life preventative initiatives'. The ADA has argued for the adoption of a DVA type scheme for a means tested identifiable group of Australians to receive the benefit from the limited available funds.[10]

1.17 While some aspects of the DVA scheme have been used as a model for this scheme, the Department commented on the issue of the Medicare model as opposed to the DVA model:

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8 *Committee Hansard* 27.8.07, p.CA10 (Senator Humphries and DoHA).

9 *Committee Hansard* 27.8.07, p.CA17 (DoHA).

10 *Submission* 6, p.3 (ADA) and *Committee Hansard* 27.8.07, p.CA1 (Dr Hewson).

> I think the Medicare model is considered to be the most appropriate means for, if you like, the mainstream population. One of the benefits of this is the focus on improving the links between general practice and dentistry. The approach of building on the Medicare schedule was by far the most efficient, effective and well-understood mechanism.[11]

### *Rebate levels and item numbers*

1.18 The ADA expressed concern at the possible rebate levels and the impact this would have for participating dentists:

> It seems likely now that the Scheme will apply a model where the DVA is seen as a "schedule" fee and provide a rebate of 85%. When the DVA fee is already at a significant discount to the average fee, we see no reason why a further discount ought to be applied. With statistics available to demonstrate that dentists already provide pro bono services of about $11,500 per dentist per year or, approximately 10% of their average income, no further discount over and above that provided in the DVA scale ought to be required.
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> It has been pointed out to the Department and to the Minister personally by representatives of the ADA that this proposed level of fee rebate will cause reluctance on the part of dentists to adopt the Scheme on a rebate only basis. The ADA has advised that quite often eligible patients cannot afford a gap payment and thus dentists would be providing these services at a significant discount and in some cases not covering costs.[12]

1.19 The ADA considered that the adoption of a DVA scale of fees would address these concerns and that an annual review of the rebate must be provided commensurate with dental cost indices.

1.20 The ADA also argued that the creation of new item numbers to describe a series of procedures that altered the Australian Schedule of Dental Services and Glossary could create confusion. This Schedule was a universal coding system, accepted by dental schools, the private health funds and all dentists.

1.21 The Department has indicated in its proposed implementation arrangements that the dental items and rebate levels will be set out in a new Medicare Benefits Schedule Dental Book. Because of the increased range of services that will be eligible under the new scheme, there will be 'around 450 new items' in the Schedule – a significant increase from the current three. However, the Department advised that the new Schedule:

> will be based quite largely on the DVA schedule, which is one of the things that resulted from the consultation that we had with the ADA…there is substantial mirroring of items even down to the numbering that they use to

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11 *Committee Hansard* 27.8.07, p.CA17 (DoHA).

12 *Submission* 6, p.4 (ADA).

> minimise the administrative burden on dentists. I think it is fair to stay that there is substantial mirroring of the item types and descriptions.[13]

1.22 With the schedule not yet being finalised, the Committee again raised as a matter of principle an issue of parliamentary process about which it has previously expressed concern. The Committee regards as undesirable having to consider legislation without access to the detail of how the scheme will operate (as outlined in subsequent delegated legislation). It notes that the ministerial determination providing detail of this scheme is a disallowable instrument, and it therefore foreshadows that it may undertake some formal scrutiny of that instrument when it is tabled in the Parliament.

### *Dental experts*

1.23 The ADA expressed concern that there was no expert dental supervision of the dental program similar to that provided under the DVA dental services scheme. The ADA contends that dental experts are best able to provide advice on the development of the program, monitor progress and provide feedback for the government, deal with special cases with a degree of flexibility enabling adequate and appropriate treatment, and detect aberrant practices.[14]

1.24 The Department commented on the issue of including a similar level of expert dental supervision to that provided under the DVA scheme:

> Logistically and financially, it would be another level. I do not think they are necessary to achieve the outcomes we are trying to achieve. There are a number of reasons cited by the ADA for dental assistants. Part of it was for the ongoing review to make sure that there is a legitimacy of care. I believe that we have mechanisms in place through Medicare audits, through complaints and through the role of the PSR in monitoring this activity to be able to give us the same level of comfort on that.[15]

### *Special needs patients*

1.25 The ADA noted that the treatment required by many special needs patients is beyond the capacity of the private surgery setting of many dental practitioners and sought clarification as to whether these patients are eligible to be treated in hospitals. According to the ADA, special needs patients are finding it increasingly difficult to receive the complexity of treatment that is needed.

1.26 The system should support these patients and deliver the best possible care available. The ADA argued that if the situation of special needs patients was jeopardised by divisions of responsibility between State and Federal governments,

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13 *Committee Hansard* 27.8.07, p.CA11 (DoHA).

14 *Submission* 6, p.3 (ADA) and *Committee Hansard* 27.8.07, p.CA5 (Dr Hewson)..

15 *Committee Hansard* 27.8.07, p.CA20 (DoHA).

then the Federal Government should take a leadership role and assist those in the community who are deserving of prompt treatment and ensure that State Governments also play a role and meet targets.[16]

1.27 In raising this issue with the Department, the Committee noted the situation where a treatment that could be performed in a dental surgery may, for special needs patients, produce a more satisfactory outcome if performed in a hospital under a general anaesthetic. The Department indicated that a dentist would not be covered treating in a hospital under the Medicare arrangements, but undertook to have discussions with the ADA concerning their issues with special needs patients.[17]

### *Referral by GP*

1.28 The AMA did note that there was 'some ongoing concern that GPs have difficulty locating a dentist who will accept the rebates as full payment when referring patients'. However, they anticipated that other initiatives announced in the Budget will go some way to addressing this issue.[18]

1.29 When a GP determines that their patient has a chronic condition that could be affected by their dental health, the referral process to a dentist requires the GP to use the referral form provided by the Department of Health and Ageing or a form that substantially complies with the form issued by the Department. The ADA commented that the paperwork required with the previous system was a bit cumbersome, but this had been addressed through discussions with the Department about conditions and the various relationships between dental health and chronic disease.[19] The Department advised that:

> We have spoken to both the dental and the GP professions and they have both said the referral form that they currently use under the EPC items is the most appropriate way of communicating between the two provider groups. So we have retained the referral form that is needed, though we may streamline it a little in terms of the content.[20]

### *Ceiling on eligibility for treatment*

1.30 Professor Spencer noted that the criteria for inclusion of dental services in a GP Management Plan are not defined. Uncertainty about specific medical conditions to be included could lead to either few or many eligible patients receiving dental care. However, if the new arrangements are more attractive to patients, GPs and dentists than is the current scheme, it is possible that most people under a GP Management

16 *Submission* 6, p.4 (ADA).

17 *Committee Hansard* 27.8.07, p.CA16 (DoHA).

18 *Submission* 3, p.1 (AMA).

19 *Committee Hansard* 27.8.07, p.CA4 (Dr Hewson).

20 *Committee Hansard* 27.8.07, p.CA20 (DoHA).

Plan and Team Care Arrangements, estimated at approximately 400,000, could be eligible for dental care. If this level of eligibility were to be realised, there was concern that, with the expenditure over four years expected to be $384.6 million, many eligible patients may not receive dental treatment under the scheme.[21]

1.31 The Department was able to allay this concern by advising that should the uptake be greater than estimated, outlays would be increased to cover the level of take-up 'much as is the case with any Medicare item'.[22]

***Communication/Education programs***

1.32 The AGPN noted that the uptake of items under the Enhanced Primary Care Scheme had been modest and recommended the need for 'a communication strategy to bring together local networks of GPs and dentists to raise awareness of the new items and provide an orientation to their use'.[23]

1.33 The ADA (Queensland Branch) noted that dentists were unfamiliar with working in the Medicare system. The ADAQ remarked that the administration of the Enhanced Primary Care Scheme was still an area that dentists were concerned about and that unfamiliarity with Medicare would continue to be a barrier to practitioner involvement. They suggested:

> The introduction of a scheme administered under a Medicare model requires a commitment to realistic and appropriate education and information for practitioners. Where the previous system has failed to gain acceptance is where this information has been provided in language and format familiar to existing Medicare providers but totally foreign to dentists. This includes not only the paperwork requirements (reporting and accounting) but also the allowable fee levels.[24]

1.34 The Department acknowledged the need for educating dentists:

> We certainly accept the need for information and education for dentists as well, particularly when it comes to the administrative aspects: the requirement to provide a quote, the role of Medicare Australia's hotline and all the things that were outlined in our submission about how we expect the process to work. There will need to be some education information provided…
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> It would be us and Medicare as one going to the ADA and using the ADA, if you like, as one means. I am sure that we will also be directly

21 *Submission* 4, p.1 (Professor Spencer).

22 *Committee Hansard* 27.8.07, p.CA 17

23 *Submission* 7, p.2 (AGPN).

24 *Submission* 5, p.2 (ADAQ).

> approaching dentists as part of information campaigns. Most likely, we will do it through the ADA.[25]

### *Monitoring and evaluation*

1.35 Professor Spencer noted that the expected costs over four years will make expenditure under this scheme the second highest outlay on dental services by the Federal Government and that such an outlay will need to be actively monitored and evaluated. It is likely that 'fine tuning' will be required to ensure satisfactory processes lie behind the provision of Medicare Dental Services and the best outcome is achieved for the expenditure. Professor Spencer proposed that:

> To inform these judgements, evaluation needs to be conducted at two levels: one among persons receiving Medicare Dental Services, and another at the population level. Among persons receiving Medicare Dental Services profiling of these patients and what services they receive would be an expected routine part of any administrative overview. However, a number of more specific questions might reasonably be asked about the persons receiving Medicare Dental Services:
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> - the reasons for seeking care,
> - the social, medical and other relevant characteristics of those who received care,
> - the oral problems they had,
> - the impact dental care had on their underlying medical condition and its management, and
> - the perceptions of the process from general medical practitioners dentists and persons involved.
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> At the population level it is important to understand the coverage achieved by Medicare Dental Services among those persons with chronic disease and complex needs and those who are under a GP Management Plan and Team Care Arrangement. Such questions can only be answered by planned evaluation activities. The implementation of such evaluation activities early in the program is of high importance if the management of the interface between oral and general health is to be improved in Australia.[26]

## CONCLUSION

1.36 In 1998 the Committee undertook an inquiry into dental services.[27] In the intervening years there has remained considerable debate over access to dental services in Australia. Statistics are regularly produced on the deteriorating oral health for many Australians and lengthy waiting time for treatment. The power to plan and

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25 *Committee Hansard* 27.8.07, p.CA18 (DoHA).

26 *Submission* 4, pp.1-2 (Professor Spencer).

27 Senate Community Affairs References Committee, *Report on Public Dental Services*, May 1998.

responsibility for the delivery of dental services and care between the Commonwealth, States and Territories has also been the subject of much debate.

1.37 The Committee considers that the significant expansion of the Enhanced Primary Care dental scheme proposed in this Bill is a fundamentally important step in improving access to dental services and care for many Australians. The Committee supports the measures being introduced in the Health Insurance Amendment (Medicare Dental Services) Bill 2007 and recognises the broad support that the Bill has received.

1.38 The Committee considers that it is most important that the provisions of this Bill are implemented efficiently and effectively. It is therefore recommending that an education program to ensure that dentists are fully informed of the changes be established and that monitoring and evaluation of the changes occur to ensure that all eligible people are able to access the benefits proposed by this scheme.

## RECOMMENDATIONS

**Recommendation 1**

**1.39 That, while noting the Department's acceptance of the need for information and education of dentists, a formal education program targeting dentists be established, including information about the working of the new Medicare rebates relating to dentistry.**

**Recommendation 2**

**1.40 That early monitoring and evaluation of the scheme be undertaken to ascertain who is accessing the rebates and for what conditions, and ascertain if the criterion that a 'patient's oral health must be impacting on, or likely to impact on, their general health' is well understood and consistently applied. Monitoring and evaluation should cover both the immediate recipients of Medicare dental services and the broader population level.**

**Recommendation 3**

**1.41 That the Senate pass the Health Insurance Amendment (Medicare Dental Services) Bill 2007.**

Senator Gary Humphries
Chair

September 2007