# Health Insurance Amendment (Medicare Dental Services) Bill 2007

## Minority report – Australian Labor Party

Introduction

Labor Senators consider that Australia is in the grips of a dental care crisis, caused in large part by insufficient Federal Government investment and lack of planning as to Australia's dental workforce.

The Government abolished the Commonwealth Dental Health Program (CDHP) in 1996, withdrawing $100 million from public dental services. Public dental waiting lists have now blown out to 650,000 people around the country, with many people waiting years for treatment.

As recognised by the majority report – "Statistics are regularly produced on the deteriorating oral health for many Australians and lengthy waiting time for treatment."[1]

Labor Senators consider that it is plainly inadequate to provide funding for acute dental services after the Government has removed its contribution to general and preventative dental care, as provided through the CDHP.

It is the view of Labor Senators that the Government has also failed to adequately plan for Australia's dental workforce. This lack of planning over the past decade is already severely limiting the public's access to both public and private dental services when and where they need them.

Labor Senators welcome the recent expansion of dentistry places and the Budget announcement of a new dental school at Charles Sturt University, however comprehensive and strategic national policies are required to ensure a long term solution to this crisis. Not enough has been done, in particular, to address regional and rural demand for dental professionals.

As acknowledged in the evidence / submission, this Bill will do little to tackle public dental waiting lists and does nothing to improve Australia's dental workforce problems.

> The proposed amendments, if introduced appropriately, will have the potential to improve oral health and general health conditions for eligible patients. A large number of noneligible Australians will still find dental services beyond their reach and will continue to languish on public sector

1 Para [1.36]

> waiting lists. This is a regrettable situation and one which it is hoped can be addressed in the near future.[2]
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> We are concerned that these arrangements will be inequitable and only benefit those in communities well served by dentists in private practice. There are only about 9000 practising dentists in Australia. The vast majority of these work in either central business districts or middle class residential suburbs of major population centres. AGPN strongly suggests that consideration be given to how existing schemes that support patient access such as the Medical Outreach Specialist Program (MSOAP) and the Patient Assisted Travel Scheme could accommodate access to dental treatment services.[3]

It is the view of Labor Senators that an investment of the magnitude proposed by the Government should be directed towards a broad based Commonwealth scheme that better addresses the priority oral health needs of those groups in the community most in need of assistance.

**1.1** Labor Senators do not support the majority report's finding that this Bill is "a fundamentally important step in improving access to dental services and care for many Australians."

This Bill - which will allow for the expansion of the Government's failing Enhanced Primary Care dental scheme - does not address many of the shortcomings of the current scheme and Labor Senators are not satisfied that it should be supported in its current form. As Professor John Spencer notes in his submission to the Committee, "many Australians who suffer with poor oral health will not obtain dental services through this Bill."[4]

The Government first introduced the Enhanced Primary Care dental scheme in July 2004. As was recognised in submissions to the Committee, the existing scheme has been plagued by low take up since its introduction. The Department provided figures on the uptake of the EPC dental items over the first three years as follows:

| | 2004-05 | 2005-06 | 2006-07 | **2004-2007 (3 years)** |
|---|---|---|---|---|
| Services | 3,157 | 5,532 | 7,754 | **16,443** |
| Benefits paid | $0.3m | $0.7m | $0.8m | **$1.8m** |
| Patients | 1,404 | 2,461 | 3,336 | **6,253** |
| Providers | 583 | 743 | 900 | **1,468** |

*Source*: Submission no2, p.3 (Department of Health and Ageing).

2 ADA Queensland, Submission no.2, p.2.

3 AGPN, Submission no.7, pp.1-2.

4 John Spencer, Submission no.4, p.1.

As the Department itself has acknowledged, stakeholders have identified a number of barriers to the uptake of the existing items.

> The main criticisms are that the items are too limited and inadequately funded. In particular:
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> • the current limit of three services per year (one of which must be a dental assessment) is a barrier to dentists initiating treatment for people with poor oral health. Dental treatment can be started but not finished in three services, and many patients do not have the capacity to pay for unfinished work; and
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> • the current rebate is not high enough to encourage most dentists to participate in Medicare or to bulk bill the service.[5]

While Labor Senators acknowledge that the Government has provided for a higher Medicare rebate to be paid under the new policy, it has failed to address other key problems with the scheme.

The Committee's attention has been drawn to a range of problems:

From the ADA:

> We believe there are negatives to the scheme. The first and most important is that it is not targeted to the financially disadvantaged, when it should be the case that limited funding is made available. Under this proposal, the very wealthy are still covered. It does not have the limitations on frequency of replacement of dentures, as is the case with the DVA program, and it does not utilise dental experts, as is also the case with the DVA program. The proposed rebate level of 85 per cent of DVA fees, a discount on already discounted fees, will make it extremely difficult for dentists to provide treatment on a rebate only basis. The development and inclusion into Medicare of more dental items outside the universal coding system, the Australian Schedule of Dental Services and Glossary, adds confusion and is not required.[6]

From the AMA:

> There is however some ongoing concern that GPs have difficulty locating a dentist who will accept the rebates as full payment when referring patients. It is anticipated that other initiatives announced in the last Federal Budget will go some way to addressing this issue.[7]

From John Spencer:

> Second, classifying those medical conditions which are adversely affected by poor oral health is a difficult task. Poor oral health may quite plausibly

5 Department of Health and Ageing, Submission no.2, p.3.

6 ADA, *Committee Hansard* 27.8.07, p.2.

7 AMA, Submission no.3, p.1.

> 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.
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> Third, 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. Past experience with much lower rebates was that few eligible patients received dental care. If the new arrangements are more attractive to patients, general medical practitioners and dentists, it is possible that most people under a GP Management Plan and Team Care Arrangements, estimated at approximately 400,000, could desire dental care. At the maximum Medicare benefit for dental services and the level of funding set out in the Financial Impact Statement only some 45,000 people will receive dental care in any year of full funding. How then will the one in eight eligible adults under a GP management Plan be chosen by their general medical practitioner? Will they be limited to people with particular chronic conditions, specific oral disease or dental treatment needs, financial circumstances, or none of these criteria.[8]

From the ADA Queensland:

> However this only addresses one of the limitations of the current scheme. The administration of the scheme is still an area that dentists have expressed concern about. Unfamiliarity with Medicare will continue to provide a barrier to practitioner involvement…
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> In summary, current Medicare Dental Services arrangements have failed to gain popular acceptance by dental practitioners because of financial and administrative difficulties. Increasing maximum patient rebates is only one part of the solution to these problems. The successful inclusion of dental services into Medicare must be done in such a way as to minimise the disruption to the practice routine of providers. This demands an alteration to the way in which Medicare is administered with regard to these services rather than a new layer of administration being imposed on an already highly regulated dental workforce. As the success of the scheme is reliant on uptake by practitioners, the administration must be tailored to their needs, which will in turn lead to outcomes tailored to the health needs of patients.[9]

In addition, Labor has been briefed by stakeholders that the poor take-up of this program to date has been due to the complex and restrictive eligibility criteria, limiting coverage to those whose oral health exacerbates their chronic disease.

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8 John Spencer, Submission no.4, p.1.

9 ADA Queensland, Submission no.2, pp.1-2.

Despite the fact that the three existing Medicare items are to be expanded to some 450 items, there is no detail available as to whether the narrow eligibility criteria of the original program will be expanded.

The Bill itself explains very little, instead leaving the detail of the Government's new program - including the eligibility requirements for dental providers and patients - to a Ministerial Determination.

In the absence of these details around eligibility it is impossible to be confident that this program will do anything to address the dental needs of the 650,000 Australians on public dental waiting lists around the country.

Further, Labor Senators are concerned that the 450 Medicare items proposed will only compound the complexity of this program, particularly for dentists who are not particularly familiar with Medicare.

**1.2** Labor Senators do not agree with the majority report's finding that the submissions made to the Committee provided broad support to the Bill. In fact, many of the submissions to, and witnesses before, the Committee highlighted that the Government's current Enhanced Primary Care dental scheme had significant shortcomings and that many of these flaws would be continued on to the expanded program.

While increased investment and slight modifications to the scheme were welcomed by some submissions / witnesses, a number noted the continuing limitations of the scheme. Most particularly the Committee explored the groups that would not be assisted by the Government's expanded scheme.

The access to the proposed scheme, by people with special needs, the aged and indigenous people, was questioned at the hearing. Medicare figures do not breakdown the usage of the current scheme, so it is difficult to predict the take up in the new scheme by people who are already identified by the sector, as having particular oral health needs. While any patient who is subject to a multidisciplinary care plan for a chronic illness may be eligible for the scheme, Labor Senators have real concerns that the complex, often entrenched, oral health issues experienced by older people, people with special needs, and indigenous Australians, will not be effectively addressed by this scheme. The current scheme has not been widely used across the community, and the gaps will not be met by the increased supplement.

**1.3** Labor Senators strongly argue against the majority report's recommendation that a formal information and education program targeting dentists be established, including information about the working of the new Medicare rebates relating to dentistry. Labor Senators are suspicious that this is a flimsy excuse for yet another Government pre-election advertising campaign.

It is the view of Labor Senators that providing resources to such an education program would be wasteful, and that such resources would be more efficiently and effectively utilised in a broad-based public health campaign highlighting preventative oral health

care. Such a campaign was in fact recommended by this Committee in its 1998 Inquiry: "That the Commonwealth, in consultation with the States and Territories and other key stakeholders in the public and private dental sectors, support the development of programs to improve the promotion of oral health throughout Australia."

Labor Senators consider that a broad based education campaign should be based on preventative oral health care, however we note that such a campaign can only be effective if the accompanying general and preventative services are available. Such services are not available under the Government's acute care program.

Senator Claire Moore
ALP, Queensland

Senator Carol Brown
ALP, Tasmania

Senator Helen Polley
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