The Senate

Standing Committee on Community Affairs

Health Insurance Amendment (Medicare Dental Services) Bill 2007 [Provisions]

September 2007

ISBN 978-0-642-71866-2

Senate Community Affairs Committee Secretariat:

Mr Elton Humphery (Secretary)

Ms Christine McDonald (Principal Research Officer)

Ms Leonie Peake (Research Officer)

Ms Ingrid Zappe (Executive Assistant)

The Senate
Parliament House
Canberra ACT 2600

Phone: 02 6277 3515
Fax: 02 6277 5829
E-mail: community.affairs.sen@aph.gov.au
Internet: http://www.aph.gov.au/senate_ca

This document was produced by the Senate Community Affairs Committee Secretariat and printed by the Senate Printing Unit, Parliament House, Canberra.

MEMBERSHIP OF THE COMMITTEE

Members

Senator Gary Humphries, Chairman	LP, Australian Capital Territory
Senator Claire Moore, Deputy Chair	ALP, Queensland
Senator Judith Adams	LP, Western Australia
Senator Lyn Allison	AD, Victoria
Senator Sue Boyce	LP, Queensland
Senator Carol Brown	ALP, Tasmania
Senator the Hon Kay Patterson	LP, Victoria
Senator Helen Polley	ALP, Tasmania

TABLE OF CONTENTS

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]

---

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.
>
> CHAIR—Because of that chronic condition?
>
> 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.
>
> 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.
>
> 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:

---

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.
>
> 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

---

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,

---

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…
>
> 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:
>
> - 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.
>
> 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

---

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

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]
>
> 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:
>
> • 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
>
> • 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.
>
> 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…
>
> 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.

---

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
ALP, Tasmania

APPENDIX 1

Submissions received by the Committee

1 Australian Dental Council (VIC)

2 Department of Health and Ageing (ACT)

3 Australian Medical Association (AMA) (ACT)

4 Spencer, Professor John (SA)

5 Australian Dental Association – Queensland Branch (QLD)

6 Australian Dental Association Inc (NSW)

7 Australian General Practice Network (AGPN) (ACT)

8 Oral Health Centre of Western Australia (OHCWA) (WA)

9 Dental Hygientists' Association of Australia (DHAA) - Victorian Branch (VIC)

APPENDIX 2

Public Hearing

Monday, 27 August 2007
Parliament House, Canberra

Committee Members in attendance

Senator Gary Humphries (Chair)
Senator Claire Moore (Deputy Chair)
Senator Sue Boyce

Witnesses

Australian Dental Association *(via teleconference)*

Dr Neil Hewson, Vice President

Department of Health and Ageing

Mr Richard Eccles, First Assistant Secretary, Primary and Ambulatory Care Division

Mr Lou Andretta, Assistant Secretary, Primary Care Financing Branch

Professor John Spencer, Social and Preventive Dentistry, University of Adelaide ***(via teleconference)***

APPENDIX 3
Comparison of existing and new MBS dental items

	Existing MBS dental items (10975-10977)	New MBS dental items (85011-87777)
Patient eligibility	Patients with a chronic condition and complex care needs whose dental condition is exacerbating their chronic medical condition, on referral from their GP under an EPC plan. That is, a patient must have in place: • a GP Management Plan (GPMP) – item 721 (or a GPMP review item 725) AND • a Team Care Arrangements (TCA) – item 723 (or a TCA review item 727) OR • for a resident of a residential aged care facility, the GP must have contributed to, or reviewed, a care plan prepared by an aged care facility (item 731).	Patients with a chronic condition and complex care needs whose oral health is impacting on, or is likely to impact on, their general health, on referral from their GP under an EPC plan. That is, a patient must have in place: • a GP Management Plan (GPMP) – item 721 (or a GPMP review item 725) AND • a Team Care Arrangements (TCA) – item 723 (or a TCA review item 727) OR • for a resident of a residential aged care facility, the GP must have contributed to, or reviewed, a care plan prepared by an aged care facility (item 731)
Eligible providers	Dentists and dental specialists	Dentists, dental specialists and dental prosthetists
Referral process	GP must refer the patient to a dentist. Patients cannot be referred directly to a dental specialist (referred on by the dentist). GP must use an *EPC Program Referral Form for Dental Care under Medicare* or a form that substantially complies with the form issued by the Department. Patients need a new referral form when they have had all 3 services available each calendar year (referrals may cross calendar years).	In most cases, GP must refer the patient to a dentist. However, where the patient has no natural teeth and requires dental prosthetic services only (eg full dentures), or requires repairs or maintenance to an existing denture/s the GP may refer the patient to either a dentist or dental prosthetist. Patients cannot be referred directly to a dental specialist (referred on by the dentist). GP must 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.
Medicare rebate	Currently $77.95 per service (to be indexed on 1 November 2007). Out-of-pocket costs for eligible services count towards Medicare Safety Nets.	There is no single rebate. The rebate will vary from item to item. Rebates for individual items to be set out in a new MBS dental schedule. Out-of-pocket costs for eligible services count towards Medicare Safety Nets up to the limit of $4,250 over two consecutive calendar years.
Limits on services	3 services per patient, per calendar year. Total annual benefits = $233.85 + Safety Net benefits (where applicable). Patients must have a dental assessment by a dentist (item 10975) as their first service, then a dental assessment every year they are referred by a GP.	Up to a maximum of $4,250 in dental benefits (including Medicare Safety Net benefits where applicable) per patient every two consecutive calendar years. No limit on total number of services. However, some limits on specific services will apply as per DVA arrangements (eg limit of 1 oral hygiene instruction service per 12 months). No mandatory requirement that a patient has a dental assessment. Access to services based on clinical needs.
Dental Prostheses (eg dentures)	The cost of supplying dental prostheses is not covered by Medicare. However, the cost of fitting prostheses can be included under 10976 or 10977.	The cost of supplying and fitting dental prostheses can be included under the relevant new dental items.

Source: Submission No.2, Attachment B (Department of Health and Ageing).