SENATE COMMUNITY AFFAIRS COMMITTEE

INQUIRY INTO:

HEALTH INSURANCE AMENDMENT (MEDICARE DENTAL SERVICES) BILL 2007

SUBMISSION BY THE AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING

23 AUGUST 2007

OVERVIEW

From 1 November 2007, new Medicare rebates for dental services will be available to people with chronic conditions and complex care needs under the Commonwealth Government's 2007-08 Budget measure: *Dental treatment – enhanced Medicare items for patients with chronic and complex conditions.*

This measure builds on the current Enhanced Primary Care (EPC) dental items (Medicare items 10975 to 10977) with a significant increase in funding. The new measure is estimated to cost $384.6 million over four years.

Approximately 200,000 patients are expected to access the new dental items over the first four years of the measure.

Eligible patients will be able to access up to $4,250 in Medicare dental benefits over two consecutive calendar years. This amount includes any Medicare Safety Net benefits payable to the patient.

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.

The new Medicare 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, his or her general health. To be eligible, a person needs to be managed by a general practitioner (GP) under specific care planning items. Patients will need to be referred by their GP to a dentist.

An example of how the new measure will work is provided at *Attachment A*.

BACKGROUND

Dental Services in Australia

In Australia, state and territory governments are responsible for the planning, funding and delivery of public dental services. This includes providing public dental services to concessional patients and children.

The Commonwealth Government supports individuals and families to access dental services through the 30% rebate for private health insurance. The Commonwealth also provides significant funds for dental care through a number of schemes including programs managed by DVA, the Department of Defence, and the Office of Aboriginal and Torres Strait Islander Health.

Additionally, the Commonwealth is helping people with chronic conditions and complex care needs to access private dental services through Medicare.

Patients with chronic conditions and complex care needs often have poor oral health which adversely affects their medical condition or general health. This 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.

The dental measure complements a range of other Commonwealth initiatives to support the management of chronic disease. For example, Medicare rebates are currently available for medical and health services to better manage and coordinate the care of patients with chronic conditions and complex care needs.

Existing Dental Items (10975-10977)

The current Enhanced Primary Care (EPC) dental care items for people with chronic conditions and complex care needs were introduced in July 2004.

To be eligible for these items, a patient needs to be referred to a dentist by a general practitioner (GP) because of a dental problem that is exacerbating the patient's chronic condition. The patient also needs to have a GP Management Plan and Team Care Arrangements in place. Residents of an aged care facility can also access these items where their GP has contributed to a multidisciplinary care plan prepared for them by the facility.

Eligible patients are able to receive three dental services (with a Medicare rebate of $77.95 per service) each calendar year. Out-of-pocket costs for eligible services count towards the Extended Medicare Safety Net.

Under the existing EPC dental items, Medicare benefits are not payable for the cost of making or supplying dentures (or other dental prostheses), only for their fitting.

Uptake of the EPC dental items over the first three years is 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**

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.

The new dental items address these problems and will better reflect the way that dentists practice. The items will cover a broader range of services, including the making and fitting of dentures. This, combined with a significant increase to Medicare benefits payable, will make the arrangements more attractive to dentists.

A comparison of the existing EPC dental items and the new dental items is provided at *Attachment B.*

Budget Announcement

In the 2007-08 Budget, the Government announced funding of $377.6 million over four years for eligible patients to receive an initial diagnostic consultation (at around $125 per year) and dental treatment services (up to $2,000 per year, including Medicare Safety Net benefits where applicable).

On 14 August 2007, the Minister for Health and Ageing announced some changes to the measure following consultation with stakeholders on the implementation arrangements:

- Eligible patients will now be able to access up to two years of Medicare benefits for dental services (a total of $4,250 including Medicare Safety Net benefits where applicable) anytime over two consecutive calendar years.

- Patients will also be able to access benefits for any combination of dental assessment and treatment services, based on the patient's clinical needs.

The change to a two-year monetary limit on benefits provides more flexibility for patients to receive dental services when they require them. This means that patients who require complex treatment, such as restorative dental work or dentures, will be able to receive Medicare services as part of a single course of treatment rather than having to split or defer treatment across different calendar years.

As a result of the changes, the revised allocation for the measure is $384.6 million over four years.

	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**

PROPOSED IMPLEMENTATION ARRANGEMENTS

Since the Budget, there have been extensive discussions with the dental profession on proposed implementation arrangements for the measure. GP groups have also been consulted.

The proposed arrangements are summarised below. Once finalised, the new Medicare arrangements will be widely communicated to GPs and dental practitioners. Pending legislative passage, the new arrangements will commence on 1 November 2007.

Eligible Patients

- To be eligible for dental services, a patient must have a chronic condition and complex care needs. This means that the person must have a GP Management Plan (Medicare item 721 or review item 725) and Team Care Arrangements (Medicare item 723 or review item 727) in place. Alternatively, for residents of an aged care facility, their GP must have contributed to a multidisciplinary care plan prepared for the resident by the facility (Medicare item 731).

- The patient's oral health must be impacting on, or likely to impact on, their general health.

- The patient must also be referred by their GP to a dental practitioner. In most cases, the patient will be referred to a dentist in the first instance. In some limited cases, the patient may be referred directly to a dental prosthetist.

Eligible Dental Practitioners

- A practitioner must be recognised as a dentist, dental specialist or dental prosthetist registered under relevant state or territory law and be registered with Medicare Australia.

Dental Services

- A broad range of dental services will be covered including dental assessments, preventative services, extractions, fillings and other restorative work, and dentures.

- The dental items and rebate levels will be set out in a new Medicare Benefits Schedule Dental Book (effective 1 November 2007).

Medicare Benefits

- Eligible patients can access up to $4,250 in Medicare rebates (including Medicare Safety Net benefits where applicable) for dental services provided over two consecutive calendar years.

- To assist patients to understand the potential cost, dental practitioners will be required to provide patients with a written quote or cost estimate prior to commencing a course of treatment.

- Patients (or dental practitioners) will also be able to call a Medicare Australia dental services helpline to obtain a progressive total of dental benefits paid to the patient. This will help inform patients whether they will exceed the limit of $4,250 in Medicare dental benefits over two consecutive calendar years.

- Like other providers under Medicare, dental practitioners are free to set their own fees for services.

- Where the dentist bulk bills, the patient will not be charged a co-payment.

- Where the dentist charges above the Medicare rebate, the Extended Medicare Safety Net will apply, up to the patient's limit of $4,250. This means that:

  - any out-of-pocket costs will count towards the patient's (or the family's) annual Medicare Safety Net threshold (currently $519.50 for concession cardholders and eligible families, and $1,039.00 for all other individuals and families);

  - once a patient / family reaches their annual threshold, the Government will meet 80% of the out-of-pocket costs incurred in that calendar year.

Repeal of EPC Dental Items 10975-10977

- The existing EPC dental items are likely to remain in place for a short time (eg until 31 December 2007) to enable patients to complete any treatment already commenced.

- There is no requirement for existing patients to use all of their current entitlement of three dental services per calendar year before they can access the new dental items. In practice, it is expected that most dentists will begin using the new dental items from 1 November 2007.

PURPOSE OF THE BILL

The *Health Insurance Amendment (Medicare Dental Services) Bill 2007* (the Bill) enables the above implementation arrangements in two ways.

First, it enables eligible patients to receive Medicare benefits up to a specified amount ($4,250 over two consecutive calendar years) for dental services.

Second, the Bill enables Medicare benefits to be payable for the supply of dental prostheses, including dentures. This will particularly help the elderly, many of whom have chronic and complex conditions and who need dentures to be able to eat a balanced, healthy diet.

After the Bill is passed and receives Royal Assent, a Ministerial Determination will be made under subsection 3C(1) of the *Health Insurance Act 1973* to set out the administrative arrangements for the measure, including:

- the specified amount and period of the monetary limit, being $4,250 over two consecutive calendar years;
- the Medicare dental items, including the schedule fees;
- the eligibility requirements for dental providers and patients; and
- other administrative requirements.

ATTACHMENT A

EXAMPLE OF HOW THE NEW MEDICARE DENTAL ITEMS WILL WORK

Mrs Jones is a concession cardholder who has cardiovascular disease and poorly controlled diabetes. In order to better manage her chronic conditions and complex care needs, Mrs Jones' GP prepares for her a GP Management Plan (GPMP) and coordinates Team Care Arrangements (TCA) in collaboration with her cardiologist, a diabetes educator and a dietitian.

Mrs Jones complains that she has pain in her jaw and her teeth hurt when she eats. Her GP notes that this is having an impact on her health and therefore decides to refer Mrs Jones to a dentist for investigation and treatment. As she is managed under a GPMP and TCA, Mrs Jones can receive up to $4,250 in Medicare benefits for dental services provided over two consecutive calendar years. The services must be provided in the dentist's consulting room, not a hospital.

Mrs Jones' first eligible dental service occurs on 21 February 2008. Therefore, she has from 21 February 2008 until 31 December 2009 to access up to $4,250 in Medicare dental benefits. At any time, Mrs Jones will be able to call Medicare Australia to obtain a progressive total of the dental benefits paid to her during this two-year period.

Mrs Jones will be able to access a broad range of dental services, including dental assessments, preventative services, extractions, fillings and other restorative work (eg crowns, bridges and implants) and dentures. However, dental services that are of a purely cosmetic nature will not be covered. If required, Mrs Jones' dentist may refer her onto a dental specialist or dental prosthetist for additional services.

To help Mrs Jones understand the potential costs involved, her dentist will provide a written quote or estimate prior to commencing a course of treatment. Mrs Jones' dentist will also provide a copy or summary of her treatment plan to the referring GP at the commencement of the course of treatment.

It will be up to the dentist to decide how s/he will charge Mrs Jones. If the dentist bulk bills, Mrs Jones will not be charged a co-payment. If the dentist charges above the Medicare rebate, the Extended Medicare Safety Net will apply (up to the $4,250 limit).

For example, if Mrs Jones has already reached her annual Medicare Safety Net threshold of $519.50 (on any out-of-hospital Medicare services), she will receive benefits as follows:

Service Provided	Dentist charge	MBS rebate	EMSN benefit (80% x out-of-pocket cost) once threshold is reached	Total benefit paid to patient	Total out-of-pocket cost to patient
Examination	$60	$40	$16	$56	$4
Extraction of tooth	$180	$100	$64	$164	$16
TOTAL	**$240**	**$140**	**$80**	**$220**	**$20**

If Mrs Jones' requires further relevant dental treatment within the same two-year period, she will be able to make an appointment with her dentist without the need to obtain a new referral.

ATTACHMENT B

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.