Health Insurance Amendment (Medicare Dental Services) Bill 2007

Submission from the Australian Dental Association (Queensland Branch)

Many Australians suffer debilitating medical conditions that impact adversely on their oral health. Conversely, a poor state oral health has the potential to exacerbate underlying medical conditions. For some this becomes a vicious cycle of decline. At the same time, a percentage of the population is reported as being unable to access dental services because of financial restrictions. Publicly funded dental services delivered through state health departments have traditionally been the only avenue of dental care available to this group. This care is often delayed because of long waiting times brought about by chronic underfunding and low prioritisation of Oral Health Services. The private sector accounts for approximately 85% of registered dentists in Australia and has the capacity to absorb increased patient numbers particularly in the larger metropolitan centres. It is logical that those requiring treatment, often of a relatively urgent nature, would need to access private dentistry to see this treatment carried out in a timely fashion. For this reason, expansion of initiatives that seek to improve access to services and ultimately to achieve an improved oral condition for people with chronic medical conditions and complex care needs are welcomed.

In implementing such a program it is necessary to be aware of the differing nature of current Medicare services and the way in which dental services are provided and accounted for. Historically, dentists have applied *The Australian Schedule of Dental Services and Glossary*, currently in its 8th Edition. This schedule has been developed by the Australian Dental Association and is recognised by all third party benefit providers. It uses a three-digit number code to describe items of service provided to patients. Medicare, on the other hand, uses a five-digit number code more commonly related to occasions of service. In dentistry, one occasion of service may involve multiple items of service. This disparity between styles creates confusion in the minds of providers at the end point of the current scheme.

The Medicare system has had very little intersection with dentistry. One notable exception has been the cleft palate scheme. Even this has largely been associated with specialist Oral and Maxillofacial Surgeons. General dental practitioner's experience of Medicare systems on a daily basis is zero. As a consequence of this unfamiliarity and due to the low level of satisfaction with an ability to generate meaningful patient outcomes, dentists have consciously kept away from the current scheme, which has been limited to $200 annually provided over a maximum of three occasions of service. Participation rates have been well below expectations because of these difficulties.

The proposed expansion to the current scheme, allowing $4125 in Medicare funded rebates to be available over a two year period will enable the majority of patients to receive comprehensive treatment. 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.

Private general practice dentists have had a long and successful record of providing services under the Department of Veterans Affairs Local Dental Officer (LDO) Scheme. 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.

Many dentists believe that the Medicare Benefits Schedule (MBS) rebate, set at 85% of the DVA rate, is indeed the maximum allowable fee. Dentists should be clearly informed that they are entitled to apply their usual and customary fees for service when participating in this scheme. Any decision to 'bulk bill' would be at the discretion of the provider. Equally, medical practitioners whose primary role is to identify and refer suitable patients via their Enhanced Primary Care program must be aware of this. Too often patient expectations are of an entitlement to 'free dentistry' and this information has come from their general medical practitioner.

The way in which dentists can itemise claims should be similar to the DVA Scheme and consistent with *The Australian Schedule of Dental Services and Glossary*. This would allow a seamless introduction irrespective of whether the patient is claiming a benefit after settlement with the provider or the provider is choosing to 'bulk bill'.

Applicable services should also be consistent with the DVA Scheme. Certain cosmetic services may qualify for inclusion. Generally accepted definitions of oral health contain references to the emotional and psychological well being of the patient. For example, two missing front teeth may not impact on dental function but would cause most people to shy away from social contact which in turn may cause delay in seeking treatment for other conditions. Would the replacement of these teeth be categorised as cosmetic? This is obviously an extreme example but other areas may arise which may not be so clear cut. The appointment of a Dental Adviser to assist with transition into the scheme and with the authority to approve treatments in advance as per the DVA model is a means of alleviating difficulties and uncertainties while at the same time providing an opportunity to combat unintentional or deliberate fraud. It also provides ongoing dental expertise to advise on improvements to the scheme.

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.

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 non-eligible Australians will still find dental services beyond their reach and will continue to languish on public sector waiting lists. This is a regrettable situation and one which it is hoped can be addressed in the near future.