Submission to the Community Affairs Committee – Australian Senate on the Health Insurance Amendment (Medicare Dental Services) Bill 2007

24 August 2007

Authorised by
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AUSTRALIAN DENTAL ASSOCIATION INC.

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Submission in response to the Health Insurance Amendment (Medicare Dental Services) Bill 2007

The Australian Dental Association Inc (ADA) thanks you for the opportunity to comment on this Bill. We note that on the 16 August 2007 the Senate, on the recommendation of the Selection of Bills Committee, referred the provisions of the Health Insurance Amendment (Medicare Dental Services) Bill 2007 to the Community Affairs Committee for inquiry and report by 5 September 2007.

The Australian Dental Association (ADA) is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The primary objectives of the ADA are to promote the practice of evidence-based dentistry and encourage access for all Australians to affordable preventive oral care. Each State and Territory has its own Branch, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at www.ada.org.au

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

The ADA provides the following comments:

Revised EPC Program

The revision of the Enhanced Primary Care program to provide eligible patients with an increased rebate of $4,250 over two years (from $2,250 per annum) will enable a more comprehensive delivery of dental treatment to help those patients more effectively deal with the complications of their chronic illness. This will particularly assist those who need to receive a more extensive dental treatment plan which may not have been able to be conducted within the financial constraints of the initial draft of the scheme.

Dental prostheses

The ADA is pleased that the Bill will enable for the first time Medicare benefits to be payable for the supply of dental prostheses - an essential component of dental treatment for many patients. This marks a significant improvement, as it will provide a number of eligible patients with some considerable benefits by restoring their dental function.

Targeted funding

The ADA remains dissatisfied that this funding remains universally available to Australians rather than being targeted to the financially disadvantaged and particularly those numerous Australians on dental waiting lists. With the limited Federal funding available under the Scheme the money should firstly have been directed to those in financial need, which is consistent with ADA Policy Statement 1.5 – '*Principles of Government Funding of Oral Health Care*.' (Copy attached).

We do not depart from that stance. Medicare, by its very nature does not discriminate on the basis of financial need. Our Special Needs Dentistry specialists inform us that the proposed scheme would include chronic long term patients with diabetes, cardiovascular disease, cancer, asthma, HIV, Hepatitis C, dementia, multiple myeloma, osteoporosis, Paget's disease and any patient taking bisphosphonates or medication which causes salivary dysfunction (e.g. Psychotic drugs, blood pressure tablets). While this is a needy group, it will include people with the financial means to be able to receive treatment without government assistance. The ADA expects there will be considerable pressure from new patients to request that their doctors include them in the scheme, if it gives them access to over $4,000 of rebates towards dental treatment.

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 notes that the 'National Survey of Adult Oral Health 2004-2006' indicated just over 50% of Australians were receiving appropriate dental treatment. Models exist that can be adopted to achieve this such as the DVA type scheme for a means tested identifiable group of Australians. The ADA has advised the Government how this can be done. The political will to achieve this objective has to be created now. We are already seeing child decay rates increase and the same trend may inevitably arise across all age groups if immediate action is not taken. However, this practical and sensible advice seems to have been ignored.

Dental experts must be retained

The ADA is concerned that there is no level of dental expert supervision of the Program provided as is available under DVA. We maintain that dental experts are best able to provide advice on the development of the Scheme, monitor progress, deal with special cases with a degree of flexibility and detect aberrant practices.

Currently the DVA scheme places restrictions on the frequency of denture replacements. No replacements are allowed there until the expiration of 8 years from supply unless prior approval is obtained from the DVA dental supervisor. The absence of both this restriction and the intervention of the dental supervisor, in the scheme under consideration, will mean that patients will be able to claim payment for frequent replacement dentures-provided they stay within the monetary constraints of the system. This is fiscally irresponsible and both a limitation on such claims must be introduced together with the introduction of Scheme Dental Advisors as per the DVA scheme.

Rebate levels

We initially proposed the DVA scale as a benchmark at which dentists may be prepared to work with little or no co-payment. The DVA scale was last set as a percentage of the average fee for services as assessed in an ADA fees' survey that was completed more than 12 months prior to the calculation of the fees to be paid. It took no account of cost and fee increases in the intervening 12 months. 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.

Annual review of the rebate must be provided commensurate with dental cost indices.

While the Scheme permits a co-payment by the patient, we predict that many patients will expect to make no co-payment and this will inevitably lead to conflict.

We feel that the adoption of a DVA scale of fees will address the concerns expressed.

The ADA Schedule and Glossary

In attempting to create new item numbers to describe a series of step down procedures, mainly in the surgical section, you have altered The Australian Schedule of Dental Services and Glossary. This is a universal coding system, accepted by dental schools, the private health funds and all dentists. It is endorsed by the government's own National Coding Centre. We are strongly opposed to the creation of any numeric item numbers as this will ultimately lead to confusion between dentists and third party funding agencies.

Special Needs Patients

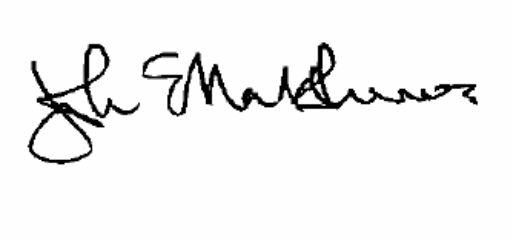
The treatment required by many special needs patients is beyond the capacity of the private surgery setting of many dental practitioners. We seek clarification as to whether these patients are eligible to be treated in hospitals.

Special needs patients find it increasingly difficult to receive the complexity of treatment that is needed. The system should support these patients and deliver the best possible care available. If this is perceived a barrier between State and Federal responsibility then the ADA believes 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.

General

The ADA has gone to considerable effort to assist the Minister and the Department to devise an appropriate dental plan[1] and improve the EPC scheme that will best target areas of greatest dental need and at the same time ensure the involvement of dentists to effectively deliver dental care to the deserving in the community. The ADA does not believe that what has been proposed meets this. We shall continue to remain committed to assisting and advising Government on the best way to improve dental health and dental delivery where possible.

Thank you for the opportunity to comment.



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[1] To view the ADA's Pre-Budget Submission go to: http://www.ada.org.au/App_CmsLib/Media/Lib/0703/M52929_v1_2007-2008%20ADA%20Federal%20Budget%20Submission.pdf