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Finance and Public Administration Legislation Committee

Health Insurance (Dental Services) Bill 2012 [No. 2]

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Senator David Bushby

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Introduction and Background

Introduction

1.1 On 22 March 2012, on the recommendation of the Selection of Bills Committee, the Senate referred the Health Insurance (Dental Services) Bill 2012 [No. 2] (the Bill) to the Finance and Public Administration Legislation Committee for inquiry and report by 8 May 2012. The reasons for referral and principal issues for consideration were to ensure the Bill addresses the wide concerns of the dental professions regarding the actions of Medicare.[1]

Conduct of the inquiry

1.2 The inquiry was advertised in *The Australian* and through the Internet. The committee invited submissions from peak organisations, interested parties, and the Commonwealth Government.

1.3 The committee received 432 submissions relating to the Bill and these are listed at appendix 1. The committee considered the Bill at a public hearing in Canberra on 1 May 2012. Details of the public hearing are referred to in appendix 2. The public submissions and transcript of evidence may be accessed through the committee's website at:

http://aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=fapa_ctte/index.htm.

Background to the Bill

1.4 The Chronic Disease Dental Scheme (CDDS) was introduced and implemented during the last few months of the Howard Government. A more limited scheme had been introduced in 2004. The scheme provided for capped dental benefits of $220 a year for the chronically ill whose dental problems were exacerbating their condition and who were being managed by a GP under an Enhanced Primary Care (EPC) plan.

1.5 This scheme had lower than expected uptake and the Government announced an expansion of the measure in the 2007–08 Budget, with funding of $378 million over four years.[2] The *Health Insurance Amendment (Medicare Dental Services) Act 2007* implemented the changes. It introduced a ministerial determination, the Health

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1 Senate Selection of Bills Committee, *Report No. 4 of 2012*, Appendix 11, 22 March 2012.

2 The Hon. Peter Costello MP, *Budget Speech 2007–08*, 8 May 2007, p. 9.

Insurance (Dental Services) Determination 2007 (the Determination) to allow eligible patients to access up to $4250 of Medicare-funded dental treatments over two years. Under the CDDS, Medicare benefits also became payable for dental prostheses, including dentures. The CDDS came in to operation on 1 November 2007.

1.6 The number of services provided under the expanded scheme subsequently rose dramatically, as did expenditure. In contrast to the 2007-08 budget funding of $378 million over four years, the CDDS has now cost in excess of $2.3 billion.[3]

Proposals to cancel the CDDS

1.7 In March 2008, the Rudd Government announced that it would introduce a new Commonwealth Dental Health Program (CDHP), to be established in agreement with the States and Territories. Funding for the new scheme was dependent on the cancellation of the CDDS. The then Minister for Health and Ageing, Hon. Nicola Roxon, MP, stated that:

> The Commonwealth Dental Health Program (CDHP) will replace the Howard Government's failed Medicare dental scheme for people with chronic and complex conditions. The discontinuation of that scheme, confirmed today, permits funding to be redirected to the new CDHP.
>
> The Howard Government's scheme helped only around 15,000 people in almost four years. The new CDHP will provide up to one million additional dental consultations and treatments.
>
> From 1 July 2008, following the cessation of the Howard Government's scheme, the Commonwealth will provide $290 million over three years to the states and territories to bring relief to the 650,000 people on public dental waiting lists around the country.[4]

1.8 The Minister stated that the CDDS would not be available to new patients after 30 March 2008, but existing patients would continue to receive benefits until 30 June 2008. The Department of Health and Ageing was advised medical and dental representative groups about cessation of the program to allow them to inform their members as soon as possible. In addition, letters were sent to existing patients, GPs and participating dental practitioners to inform them of the discontinuation arrangements.

1.9 In May 2008, the Health Insurance (Dental Services) Amendment and Repeal Determination 2008 attempted to cancel dental benefits available under the CDDS. As a disallowable instrument, a motion for disallowance was moved in the Senate by the Coalition on 18 June 2008. On 19 June 2008, the motion of disallowance was passed by the Senate, effectively repealing the ministerial determination. In addressing the

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3 Department of Human Services, *Submission 201*, p. 2.

4 The Hon. Nicola Roxon, Minister for Health and Ageing, 'First steps in implementing new Commonwealth Dental Health Program', *Media Release*, 2 March 2008.

motion of disallowance, the then Minister for Human Services, Senator the Hon. Joe Ludwig commented:

> The dental programs that we have announced will have a significant impact on Australia's dental crisis. The government is providing a total of $780 million over five years for additional dental services. This government is getting serious about these issues, unlike the opposition when they were in government.[5]

1.10 On 15 September 2008, the Government gave notice of a motion to rescind the successful disallowance motion. In speaking to the motion, Senator the Hon. Stephen Conroy, Minister for Broadband, Communications and the Digital Economy, provided the reasons for the need to close the CDDS:

> Today's motion will decide whether the government can implement the dental policies which the Australian public voted for or whether the government will have to suspend its investment in public dental services because of the economic vandalism of those in the opposition. The motion will decide whether the government can provide a million more dental consultations and treatments for needy Australians, especially pensioners and concession card holders, or whether these people will continue to languish on public dental waiting lists because of the opposition's irresponsible approach.[6]

1.11 The Minister went on to note that while the CDDS helped some people, many, often the most needy people in the community, were missing out on treatment. Further it was not targeted at the most disadvantaged, such as pensioners and concession card holders. This resulted in the take up being 'highly skewed, with many states receiving far less than a fair population share'. The Minister added:

> While one in five concession card holders live in Queensland, about 18.9 per cent, it has received only 4.4 per cent of benefits under the chronic disease dental scheme. While one in 11 concession card holders live in South Australia, about 8.9 per cent, it has received only 2.5 per cent of benefits. Again to my colleague from Western Australia, while one in 12 concession card holders live in Western Australia, about 8.5 per cent, it has received only 0.7 per cent—less than one per cent—of benefits for necessary care. While three per cent of concession card holders live in Tasmania, Senator Colbeck, it has received only 0.3 per cent— less than half of one per cent—of benefits.[7]

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5 Senator the Hon. Joe Ludwig, Minister for Human Services, *Senate Hansard*, 19 June 2008, p. 2817.

6 Senator the Hon. Stephen Conroy, Minister for Broadband, Communications and the Digital Economy, *Senate Hansard*, 16 September 2008, p. 47.

7 Senator the Hon. Stephen Conroy, Minister for Broadband, Communications and the Digital Economy, *Senate Hansard*, 16 September 2008, p. 47.

1.12 On 16 September 2008, the Senate negatived the motion to rescind its resolution of 19 June 2008 disallowing the Health Insurance (Dental Services) Amendment and Repeal Determination 2008.[8] As a result, services continued to be provided under the CDDS.

1.13 However, concerns continued about the provision of services under the CDDS, particularly the need to target the most disadvantaged members of the community. The National Rural Health Alliance, for example, stated:

> New evidence shows just how inequitable the Medicare funded dental health program is – and the critical need for the Government to introduce its planned Commonwealth Dental Health Program (CDHP).
>
> The existing Enhanced Primary Care (EPC) program which provides dental care under Medicare is a move in the right direction towards universally accessible dental care but it is heading towards a massive cost blow-out and failing to provide a service to many in need. If the use of the EPC dental scheme reaches the level spent in New South Wales in August 2008, the national cost will be almost $900 million a year compared with the Coalition Government's budget for it of $365 million over four years.
>
> There is mounting evidence to show that, on its own, the EPC program is resulting in massive inequities between jurisdictions. For instance the total dollar benefits paid from November 2007 to August 2008 per 100,000 head of population varies from $1,431,604 in NSW to $15,363 in the Northern Territory.[9]

Auditing of providers

1.14 Under the CDDS, where a GP forms the opinion that a patient is suffering from a chronic medical condition, has complex care needs and that their oral health is impacting (or likely to impact) their general health, their GP my refer the patient for dental services.

1.15 In order for these dental services to be provided under the CDDS, there is 'a requirement that there is appropriate communication between the referring general practitioner, the patient and the treating dental practitioner about the treatment plan'.[10] These requirements, as well as eligibility requirements and the services which may be billed, are set out in the Determination. Section 10 of the Determination states:

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8 *Journals of the Senate*, No. 30, 16 September 2008, p. 857.

9 Dr Jenny May, Chair, National Rural health Alliance, 'Dental health programs: equity hinges on introduction of the CDHP', *Medial Release*, 14 October 2008.

10 Department of Human Services, *Submission 201*, p. 1.

Section 10: Quotation for dental services and reporting

(1) This section applies if:

(a) an eligible dentist, an eligible dental specialist or an eligible dental prosthetist performs an initial examination and assessment of an eligible patient, including consideration of any diagnostic tests; and

(b) provides a course of treatment to the patient.

(2) An item in Schedule 1 applies to a dental service included in the course of treatment only if, before beginning the course of treatment, the eligible dentist, eligible dental specialist or eligible dental prosthetist:

(a) gave to the eligible patient, in writing:

(i) a plan of the course of treatment; and

(ii) a quotation for each dental service and each other service (if any) in the plan; and

(b) gave a copy or written summary of the plan to the general practitioner who referred the patient for dental services.

1.16 The Department of Human Services noted that compliance with section 10 of the Determination is fundamental to the effective operation of the Scheme.[11]

> The department has an obligation to ensure compliance with the legislative requirements of the Scheme. The department began receiving complaints about dental practitioners within the first 12 months of the Scheme and commenced compliance activities from November 2008. The department takes a risk based approach to managing compliance. Therefore, audits are not random in nature, and dental practitioners are generally selected for audit either as a result of complaints/tip-offs received from members of the public, and/or where high claiming patterns raise concerns.[12]

1.17 The Department of Human Services noted that a project was developed after initial compliance activity indicated that there were significant concerns about claiming under the Chronic Disease Dental Scheme. These concerns included non-compliance with section 10 of the Determination and claiming Medicare benefits prior to services being provided to the patient.[13]

1.18 In its submission to the committee, The Department of Human Services provided the following information[14]:

11 Department of Human Services, *Submission 201*, p. 2.

12 Department of Human Services, *Submission 201*, p. 2.

13 Mr Ben Rimmer, Department of Human Services, *Senate Community Affairs Legislation Committee, Supplementary Budget Estimates 2011–12 Hansard*, 20 October 2011, pp 171–173.

14 Department of Human Services, *Submission 201*, p. 2.

Number of complaints	1025
Relating to number of dental practitioners	745
Audits underway	94
Audits completed	29
Number found to be non-compliant	65
Amount identified for recovery	$21,618,721
Repayments received	$259,427

1.19 Of the 94 dentists audited as at 29 February 2012, a majority had delivered the services they billed to Medicare. On 16 February 2012, the Department of Human Services indicated that of the 63 practitioners deemed to be non-compliant for administrative breaches, such as not completing appropriate paperwork or providing patients with quotations at that time, 12 were found to be non-compliant due to a failure to actually provide a service.[15]

Response to audits

1.20 Concerns have been raised about 'inequities' arising when a dental practitioner who has provided a legitimate service is required to repay the Medicare benefit because of an administrative failure.[16]

1.21 On 19 March 2012, the Opposition health spokesman the Hon. Peter Dutton, introduced the Health Insurance (Dental Services) Bill 2012 in the House of Representatives. The Bill was also introduced in the Senate on 21 March by Senator David Bushby.

1.22 The Bill proposes to redress past and future inequities that have arisen from the operation of subsection 10(2) of the Determination.

Overview of the Bill

Purpose of the Bill

1.23 The Bill requires the Minister for Health, in conjunction with such other Ministers as may be necessary, to redress past and future inequities that have arisen from the operation of subsection 10(2) of the *Health Insurance (Dental Services) Determination 2007*.[17]

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15 Mr Jeff Popple, Deputy Secretary, Department of Human Services, Senate Community Affairs Legislation Committee, Additional Estimates, *Committee Hansard,* 16 February 2012, p. 127.

16 Parliamentary Library, *Flagpost: Calls to waive dentists' debt to Medicare,* 19 April 2012.

17 Explanatory Memorandum, p. 1.

Provisions of the Bill

1.24 The Bill describes the inequities imposed on dental practitioners by the operation of subsection 10(2) of the Determination. The Bill specifies that the Minister must take one or more of five courses of action to redress those inequities. It establishes a timeframe in which action is to be taken and requires a report to be tabled in both Houses of Parliament detailing the actions taken.[18]

Financial impact

1.25 The explanatory memorandum does not include a financial impact statement.

Statement of compatibility with human rights

1.26 The explanatory memorandum states that the Bill is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.[19]

Related inquiries

1.27 The following related Senate committee reports have been tabled:

- Senate Community Affairs References Committee, *Review of the Professional Services Review (PSR) Scheme*, October 2011; and
- Senate Standing Committee on Community Affairs, *Health Insurance Amendment (Medicare Dental Services) Bill 2007 [Provisions]*, September 2007.

18 Explanatory Memorandum, p. 1.

19 Explanatory Memorandum, p. 4.

Chapter 2

Issues

Introduction

2.1 The Health Insurance (Dental Services) Bill [No 2] (the Bill) seeks 'to redress past and future inequities that have arisen from the operation of subsection 10(2) of the Health Insurance (Dental Services) Determination 2007' (the Determination).[1] The inequity is described in the Bill in clause 5: that a dental practitioner who has legitimately provided a dental service and claimed a Medicare benefit as payment, is required to repay the benefit where they did not provide a patient before commencing treatment with a written plan of their course of treatment and a written quotation, or failed to give copies of these documents to the referring doctor.[2]

2.2 As outlined in chapter 1, the repayments have arisen as a result of compliance audits by Medicare Australia. Those providers who have been found to be non-compliant are required to repay the total benefit received. The Department of Human Services indicated that the amount, as at 29 February 2012, identified for recovery is $21,618,721 with $259,427 received.[3]

2.3 The Australian Dental Association (ADA) commented that the auditing and recovery of payments through non-compliance with subsection 10(2) was 'unjust'. Dr Shane Fryer, President, ADA, stated:

> We are here though to address what the ADA sees as unjust treatment of dentists that have provided appropriate services to deserving patients yet are being chased by Medicare Australia to refund moneys due to noncompliance with regulatory requirements. That is under section 10—that is, it is administrative noncompliance.[4]

2.4 Dr Fryer went on to state that there were a range of causes for the non-compliance with the causes put forward by the ADA and other submitters including:

- lack of appropriate consultation occurred during the establishment of the scheme;
- problems with the operation of the scheme in relation dental practice and procedure;

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1 Senator David Bushby, *Senate Hansard,* 21 March 2012, p. 60.

2 Explanatory Memorandum, pp 1–2.

3 Department of Human Services, *Submission 201*, p. 2.

4 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 1.

- insufficient education on compliance arrangements for the scheme, both at the commencement of the scheme and when non-compliance issues were identified; and
- provision of inconsistent advice to participants of the scheme.

2.5 Other issues raised by submitters included how the audits have been undertaken and the effects of audits on practitioners, patients and families; and the full recovery of benefits paid to the practitioner by Medicare, which the ADA described as 'grossly out of proportion to the offence'.[5]

2.6 The Department of Human Services (DHS) also noted the level of concern that has arisen for dental practitioners. However, Mr Ben Rimmer, Associate Secretary, DHS, stated:

> There is no doubt from the submissions that are in front of this committee that the compliance arrangements regarding the scheme have caused concerns for dental practitioners...It is also quite clear that some practitioners have not complied with the requirements of the scheme as set out in the law.[6]

Establishment of the scheme

2.7 Submitters pointed to three main concerns with the establishment of the scheme which, it was argued, contributed to non-compliance issues. First, it was argued that there had been a lack of consultation with the profession before the CDDS was implemented. Secondly, no comprehensive education program was put in place. Thirdly, the compliance arrangements for the scheme were seen as being more rigorous than other schemes administered by Medicare.

Consultation

2.8 The ADA and other submitters commented that there had been very little consultation with the profession when the CDDS was implemented. The ADA Queensland Branch stated that 'had the profession been consulted and engaged by Medicare to assist, many of the non compliance issues that have resulted in this Bill could have been avoided'.[7] Dr Mark Sinclair, President, ADA (NSW) Branch, concurred and stated:

> In addition, there was little or no consultation with the dental profession regarding the construct of the scheme or its ongoing operation. This has been a significant factor contributing to high levels of noncompliance by

5 Australian Dental Association, *Submission 231*, p. 2.

6 Mr Ben Rimmer, Department of Human Services, *Committee Hansard*, 1 May 2012, p. 26.

7 Australian Dental Association Queensland Branch, *Submission 208*, p. 4.

> dentists. As a result, many of the requirements of the scheme are illogical or impractical and often fly in the face of standard dental treatment protocols.[8]

2.9 Dr Sinclair went on to conclude:

> I think that it is an extraordinary oversight for a professional body that is going to be responsible for the implementation of this scheme for there to be virtually no discussion.[9]

2.10 The Australian Dental Prosthetists Association (ADPA) also indicated that if consultation with the profession had taken place prior to the CDDS legislation being introduced, it would have been likely that some of the problems would not have arisen.[10]

2.11 In addition, it was noted that until the CDDS was implemented, dentists had very limited experience dealing with claims involving government rebates or Medicare and its rules. Most dentists had experience with Department of Veterans' Affairs (DVA) programs, but the 'complexity and importance of meeting the administrative requirements under the CDDS – as a health provider – were therefore new'.[11]

2.12 The Department of Health and Ageing (DoHA) did not agree with the above assertions regarding the level of consultation. Ms Kerry Flanagan, DoHA, stated:

> A number of discussions were held with the Australia Dental Association. In fact, as far back as 2006 we met with the ADA at national and state branch levels to receive feedback on the existing EPC dental items. There had not been a great take-up, so the government of the day was interested in talking to dentists about that and to better understand some of the barriers to that uptake. Following the budget in 2007 we held extensive discussions with the ADA and the ADPA on the implementation arrangements for the measure, including the content for the new dental items. There was also a joint meeting involving the ADA, ADPA and the GP groups—because, of course, we needed to understand how this process was going to work from GPs through to dental practitioners. Certainly our take of those consultations was that they were positive and cooperative. That is certainly the record that I have of those discussions.[12]

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8 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 10.

9 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 15.

10 Ms Sara Harrup, Australian Dental Prosthetists Association (NSW), *Committee Hansard,* 1 May 2012, p. 24.

11 Australian Dental Association, *Submission 231*, p. 3.

12 Ms Kerry Flanagan, Department of Health and Ageing, *Committee Hansard,* 1 May 2012, p. 32.

Compliance arrangements

2.13 A key issue for dentists has been the difference in the level of rigour required by the CDDS compliance arrangements. The ADA submitted that:

> We have been informed that the compliance regimes with this scheme are the most onerous of any scheme that Medicare is administering and controlling. Again, as I intimated in my introductory remarks, if the ADA had been approached and consulted and our advice heeded we would have argued—and still do—that these sort of compliance regimes are not necessary for the efficient delivery of dental services to the Australian community. That is not withstanding that it is appropriate and acceptable that Medicare conduct audits, because they must make sure there is responsible expenditure of public moneys.[13]

2.14 However not all dentists agreed with the ADA's position with one dentist submitting that the Medicare requirements are consistent with expectations of the Dental Board of Australia:

> One rule in particular – namely the provision of an itemised treatment plan and written quotation before treatment begins – is a fundamental safeguard that must be upheld rigorously to ensure the provision of (1) good medicine, (2) patient acceptance, (3) provider compliance, and (4) transparency for audit and complaint resolution purposes. This is no different from the underlying expectation the Dental Board of Australia places on dental practitioners to provide services to privately paying patients in this country.[14]

2.15 Some submitters have drawn comparisons with the way the Veterans' Affairs scheme operates and have generally viewed that scheme more favourably.[15]

2.16 DHS acknowledged that the requirements in the CDDS determination are more specific and greater in number than in many other Medicare arrangements, and in particular, have greater time specificity. Mr Rimmer stated:

> So they require the provision of documents before the treatment has started. 'It is kind of a binary switch: was the document handed over before the treatment or not? There is not much grey in that matter.' So the detail of this determination sets up compliance arrangements that are different in that respect from other parts of MBS compliance arrangements.[16]

2.17 DoHA explained the reasoning behind some of the compliance arrangements. Ms Flanagan stated:

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13 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 6.

14 Dr Kia Pajouhesh, *Submission 429,* p. 3.

15 Dr Bella Kolber, *Submission 1,* p. 1.

16 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 29.

> I might just talk about the policy intent of the particular clause that appears to be causing so much concern. This was done on the basis that it underpins two very important principles. The first principle is that this is treating chronic disease patients, so for the first time the former government made available dental treatment for chronic disease patients. So it was seen as very important and necessary for the GP who was managing the overall totality of a chronic disease patient to know what dental treatment was being provided in that context. The second part of this is the fact that it was important for informed financial consent to be given by the patient before treatment was started. That is a principle that we believe should follow right through the health system in terms of letting people know in case there might be a cost that they incur as a patient. So that was the policy intent. We believe that the policy intent of both those things stands.[17]

Education of the dental sector

2.18 The committee heard some quite divergent views on whether sufficient education had been provided to dental practitioners regarding the CDDS and in particular its compliance arrangements. Concerns were raised about:

- whether the avenues used by Medicare to inform practitioners were adequate;
- whether the information provided was adequate;
- whether the potentially imminent closure of the scheme impacted on the level of education provided.

Provision of information to practitioners

2.19 When the scheme commenced in 2007, DoHA undertook a mailout of the Medicare Benefits Schedule Dental Services Book to dentists, dental specialists and dental prosthetists. A Fact Sheet was also distributed at that time. Following this initial mailout, DoHA contacted dentists, dental prosthetists and their professional bodies on a number of other occasions to provide information about the CDDS. Details of these communications were provided in response to the Senate order for the production of CDDS documents.[18] The index of documents is at appendix 3 of this report.

2.20 Concern was expressed about the adequacy of the approach undertaken to provide dentists with information about the scheme. The ADA advised the committee that its membership mailing list was used by DoHA, but that there are a significant number of dentists who are not members of the ADA:

> The first notice was in October 2007, I think, from the then health minister, telling the profession about the new scheme that was to be introduced. But none of the correspondence, as far as we can ascertain, has been provided to

17 Ms Kerry Flanagan, Department of Health and Ageing, *Committee Hansard*, 1 May 2012, p. 30.

18 *Journals of the Senate*, No. 53, 19 September 2011, p. 1504.

> all practitioners; even the numbers that have been going out. I think 10,000 booklets were sent out, and there would probably have been 13,000 registered dental practitioners in the country at that time.[19]

2.21 The ADA undertook a survey to identify how many of its members had received information about the scheme. Mr Boyd-Boland, Chief Executive Office, ADA, provided the following results:

> Slightly less than 18 per cent—17.8 per cent—of members said they received it in November 2007; 21.6 per cent said sometime in 2008; 16.2 per cent said 2009; 14.6 per cent said 2010; 10 per cent said 2011; and 31.5 per cent said they have never received it.[20]

2.22 The committee sought evidence on whether there were alternatives to the ADA mailings for contacting dentists. The ADA (NSW) stated:

> As you would understand, national regulation consolidated a database, but even prior to that there was the ability for the dental boards who hold the register of practitioners to exchange information, even in the absence of the national scheme.[21]

2.23 DoHA explained to the committee why the ADA lists were used:

> When the scheme was introduced in November 2007, we did not have the national registration and accreditation scheme so we worked with the ADA. We recognised that there was an issue because not all dentists were members of the ADA, but it was the best source, I suppose, that we had to try and get to individual dentists.[22]

2.24 In addition, the ADA drew to the committee's attention the consultation and education undertaken by DoHA, Medicare and stakeholders in relation to nurse practitioners access to Medicare. The ADA noted that nurse practitioners were fully informed of the new arrangements including compliance requirements.[23]

2.25 The ADPA also pointed to the lack of education for its members, noting that they had received less education opportunities than dentists:

> For dental prosthetists, because of the lack of engagement with the ADPA from Medicare, the only education that they have really received is documents that were sent to them on their initial provider number request

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19 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 5.

20 Mr Robert Boyd-Boland, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 5.

21 Dr Matthew Fisher, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 16.

22 Ms Kerry Flanagan, Department of Health and Ageing, *Committee Hansard,* 1 May 2012, p. 33; see also Department of Health and Ageing, Answer to question on notice, No. 1.

23 Australian Dental Association, *Submission 201*, p. 3.

> and two letters that were sent to them—one in June 2010 and one in April 2011.[24]

2.26 Ms Harrup went on to state:

> If we have a look at the statistics at the back end of the Medicare website we will see that they demonstrate that in the provision of dental services to patients dental prosthetists provided approximately 46 per cent of those services since inception of the scheme. At a meeting that we had with the Department of Human Services on 2 September this year they advised us that 990 dental prosthetists had registered with the scheme and 879 had made at least one claim at that time.
>
> For dental prosthetists, because of the lack of engagement with the ADPA from Medicare, the only education that they have really received is documents that were sent to them on their initial provider number request and two letters that were sent to them—one in June 2010 and one in April 2011.[25]

Adequacy of information

2.27 The committee received evidence that the written information provided by Medicare was inadequate, that practitioners who sought assistance from Medicare were often provided with confusing and/or conflicting advice and little or no education was provided to those providing services under the scheme.

2.28 The ADA commented that while the section 10 of the Determination clearly imposes steps that need to occur before a dental service can be considered a valid Medicare service, these were not clearly set out in either the book or fact sheet provided to dentists.[26] Dr Jane Pinchback, ADA (NSW), noted that the references to section 10 were confined to one paragraph in the 65 page book.[27] Many other submitters mentioned that the section 10 requirements were inadequately detailed in the book.[28]

2.29 Of particular concern, was that even when compliance issues had been identified as being significant, Medicare did not implement an adequate education program. The ADA stated that:

> The ADA's position has been that there was exceedingly bad communication of the details and requirements of the scheme to dental

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24 Ms Sara Harrup, Australian Dental Prosthetists Association, *Committee Hansard*, 1 May 2012, pp 18, 19.

25 Ms Sara Harrup, Australian Dental Prosthetists Association, *Committee Hansard*, 1 May 2012, pp 18, 19.

26 Australian Dental Association, *Submission 201*, p. 4.

27 Dr Jane Pinchback, ADA (NSW), *Committee Hansard*, 1 May 2012, p. 13.

28 See for example Dr Paul Werner, *Submission 156*, p. 1; Mrs Jeanette Culic, *Submission 117*, p. 2.

> practitioners when it was introduced. The identification of a level of noncompliance with the administrative requirements was something that Medicare Australia seemed to have been aware of from mid-2009, if not earlier, and it was not until 2010 that the issue was brought to the attention of the ADA.[29]

2.30 The ADA (NSW) also commented that the first detailed letter from Medicare advising of increased audits of the CDDS was sent in April 2011. This letter specified the explicit purpose underpinning section 10 requirements.[30] Mr Rupasinghe for the ADA (NSW) went on to comment

> ...it was only 2½ pages. It was sent 42 months after the scheme commenced and it was what we would call a very short letter. It was the most comprehensive that had been sent but it was still a very short letter sent to dentists.[31]

2.31 As a result, the ADA described the education process as 'scant, inconsistent and confusing'. The ADA argued that its survey bore this out:

> ...our average member: in 2008–09, 95 per cent were unaware of the administrative compliance and the penalties. In 2010, 80 per cent were unaware—but that was at the end of 2009, when the ADA were notified that Medicare Australia had determined that there was administrative noncompliance; in 2011 it had dropped to 40 per cent being unaware—so the dentists and our members were starting to get the message. I would like to say that every ADA member is now aware—it is not quite that high, but it is certainly down to single figures who are not yet aware.[32]

2.32 In addition, evidence was received that the information provided by Medicare staff was often confusing, incorrect and inconsistent.[33] For example, submitters stated:

> When we received our first referral we had to call our local Medicare office for advice. They were not sure exactly what to do procedurally and we received differing advice from different officers on different days. This differed markedly with our experience in dealing with Dept. Veteran Affairs. They had a claim form which we had to fill out that satisfied their needs. It is easy and consistent.[34]

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29 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, pp 1–2; see also Mr Bernard, Rupasinghe, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 13.

30 Australian Dental Association (NSW), *Submission 343*, p. 9.

31 Mr Bernard Rupasinghe, Australian Dental Association NSW, *Committee Hansard*, 1 May 2012, p. 13.

32 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 5.

33 Australian Dental Association (NSW), *Submission 343,* p. 11.

34 Dr Kim Stock, *Submission 26*, p. 1.

> Medicare assistance has been a bit perplexing and contradictory over time. There seems to be an enormous number of people one gets to talk to and they can give you misleading or incorrect information. The people are always friendly but don't seem to know much about dentistry.[35]

2.33 Some allegations were made that the proposed imminent closure of the scheme influenced how well communication to dentists was undertaken.[36] For example:

> The department seemed content to do as little as possible to educate members, perhaps thinking that, as the scheme was to close, education expenditure could be saved. Indeed, if you look at the material allegedly distributed to dentists before this time, as identified by the department in the material it presented to the Senate, you will see that almost as many letters were sent advising of closure of the scheme as were sent with details of compliance requirements with the scheme.[37]

> The ADA New South Wales strongly suspects both the Department of Human Services and the Department of Health and Ageing assumed the Chronic Disease Dental Scheme would close relatively early in its existence, which helps explain the initial failure to consult with and then educate dentists about the CDDS requirements.[38]

2.34 The ADA and other witnesses concluded that the inadequacy of the information and education provided by Medicare contributed to the high rates of non-compliance. Dr Fryer, ADA, commented:

> ...the completed audits show that 70 per cent of dental practitioners have been deemed to have failed to comply with the administrative compliance requirements of the scheme.
>
> In any arena, if a teacher had 70 per cent of their students fail an exam, a significant amount of the blame for that occurrence could be attributed to the educator rather than to the student. So although Medicare or the department are saying that they have supplied a significant list of documents and information to us, the emphasis within those documents has not had the same significance which Medicare applied to it when they were auditing the profession.[39]

2.35 In response to the evidence received concerning the provision of information and education to providers, DHS noted information had been provided from the inception of scheme. Mr Rimmer, DHS, commented:

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35 Dr Damir Culic, *Submission 160,* p. 4.

36 Australian Dental Association, *Submission 231,* p. 6.

37 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 2.

38 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 10.

39 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 2.

> The department has used its best endeavours through a whole variety of different media to communicate about the scheme and its requirements, going well back to its establishment under the previous government. That is probably the best that can be said on that one.[40]

2.36 Mr Rimmer also added that he did not accept that insufficient information was provided, and noted that there had been a 'very extensive effort from both departments and from the Minister for Health to communicate about this matter and to ensure that the dental profession understand their obligations under the scheme'.[41] Mr Rimmer went on to comment:

> I think respectfully we might disagree with the views put forward on some of these matters by the ADA and various branches of the ADA. The evidence that we have put before the Senate about what matters were covered in different letters was, I think, very transparent in the Senate...[42]

2.37 DHS pointed the committee to some examples of documents where the requirements were clear and noted that dentists had met some requirements of the checklist, but not others:

> I would just highlight the checklist for dental practitioners. I know that has been the subject of some comment in some of the submissions, which was really very clear about some things that dentists had to do before claiming. Some of those things, which are quite specific, dentists did do; for example, call in relation to a particular patient and check that item 713 had been claimed in relation to that patient in a particular time period. In other words, check their eligibility for the scheme. To check that the amounts that they had not already reached their cap of $4,250. Some of the things in the checklist were being done and were being done very effectively. Some other things in the checklist that are frankly very clear in the checklist were clearly not being done in at least some cases.[43]

2.38 When asked whether DHS and Medicare assessed if dental professionals had understood the literature provided to them, Mr Rimmer, DHS, stated:

> There have been a range of conversations with dental stakeholder groups such as the ADA and others, going back for some years now. In addition, we obviously hear from individual practitioners through our Medicare providers phone line. We aim to be as responsive as possible to what we hear in those conversations and what we find out in those phone calls.[44]

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40 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 29.

41 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 30.

42 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 32.

43 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 33.

44 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 31.

Responsibility for public money

2.39 The ADA and ADA (NSW) acknowledged that individuals had a responsibility if they were accessing public money available under legislated requirements:

> The law is the law and even though this is bad law it is still the law. We as individuals and the community have to take responsibility.[45]

2.40 The ADA (NSW) stated:

> I think that is an entirely reasonable proposition, but the nature of the compliance and the ramifications of noncompliance were such that I do not think that has been clearly educated at all in the processes that have been delivered.[46]
>
> As to the question about whether the profession bears some responsibility, we would say no. We bear no responsibility for this. This is a situation that has been made by Medicare Australia and the Department of Health and Ageing.[47]

Operation of the CDDS

2.41 A number of issues in relation to the operation of the scheme were raised in evidence. These ranged from problems with the requirements of the scheme which do not reflect dental practices and procedures to administrative problems when dealing with Medicare.

2.42 Many submitters commented on the restriction on treatment available when the patient first consulted the dental practitioner. The ADA (NSW) noted that section 10 requirements 'severely limits' the services which can be provided to a patients at the initial consultation. Failure to comply with these requirements resulted in all subsequent services being non-compliant making the dentist liable to repay all Medicare benefits.[48] However, many dentists indicated that they would treat patients at their initial consultation. Dr Pinchback, ADA (NSW), stated:

> If we access our member survey where we asked practitioners what they would routinely do at an initial consultation, 86 per cent of them indicated that they would attend to the patient's presenting complaint, and that would automatically render them non-compliant in an audit situation.[49]

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45 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 8.

46 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 17.

47 Dr Bernard Rupasinghe, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 17.

48 Australian Dental Association (NSW), *Submission 343,* p. 13.

49 Dr Jane Pinchback, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 14.

2.43 The need to be compliant with section 10 has resulted in some distressing outcomes for patients with Dr Sinclair reporting cases where ambulatory patients in pain have been transported 300 kilometres for treatment and been advised that, because of paperwork requirements, their pain cannot be treated on that day.[50] Dr Sinclair went on to acknowledge that this could be solved by immediately faxing or emailing the plan to the GP.[51]

2.44 A further requirement of section 10 is the provision of the treatment plan to a general practitioner. Many dentists submitted that GPs appeared to have little interest in the treatment plans and few dentists indicated that GPs had contacted them regarding a treatment plan.[52]

2.45 Another area of concern was the poorly defined linkages between chronic disease and dental health.[53] Some submitters commented that patients were referred with conditions were it was unclear that there was, or was likely to be, an impact on dental health.[54] There was a general view that the lack of rigour around the basis of referral meant that the most needy members of the community were not receiving care. Dr Fryer argued that a government dental scheme:

> ...should be targeted and means tested, should provide long-term effective care to those that are not able to access it and should focus funding and care delivery on that 30 per cent of the population that is not accessing care now.[55]

2.46 The ADA did not support the universal nature of the CDDS and supported the closure of the scheme but argued 'it should not be closed down until an adequate scheme is put in place to address the dental needs of that disadvantaged group, that 30 per cent of the population who are not getting to the dentist now'.[56]

2.47 Other matters of an administrative nature were raised with the committee. These included:

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50 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 11.

51 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 11.

52 Dr Susan Wise, *Submission 88*, pp 1–2*;* Dr Bradley Harwood, *Submission 121*, pp 1–2; Name withheld, *Submission 167*, p. 1.

53 Dr Susan Wise, *Submission 88*, p. 1; and Name withheld, *Submission 167*, p. 1.

54 Dr M. Mustafa, *Submissions 87*, pp 1–2*;* Name withheld, *Submission 123*, p. 2*;* Name withheld, *Submission 218*, p. 1.

55 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 1.

56 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 7.

- whether the nature of the CDDS contract is clear, i.e. whether it is between Medicare and the dentist or Medicare and the patient;[57]
- problems with reimbursement to dentists not occurring in a timely way or correctly;[58] and
- lack of accurate advice concerning status of a patient, leading so some work not being eligible for reimbursement.[59]

Over-servicing

2.48 The committee heard of some concerns about over-servicing occurring in the dental sector, but did not pursue these in detail during the inquiry. For example, Dr Sinclair commented:

> I think that, if you drill down hard enough into these figures with any publicly funded scheme, it would be naive of us to say there has been, without question, no over-servicing. I think that is a naive proposition, but what I can say is that on balance I think the treatment needs of this group that previously had not had any access to care have been well met.[60]

Audits

2.49 DHS indicated that, as with all Medicare claiming, compliance activities commence on the day the scheme takes effect. The first targeted compliance activity for the CDDS commenced in September 2009. In June 2010, the former Minister for Health announced the establishment of a task force to look into compliance arrangements associated with the scheme.[61]

2.50 In the earliest audits dental practitioners were selected randomly. As complaints were received about the operation of the scheme, the circumstances of providers who had individual complaints were also considered.[62] The ADA (NSW) described the nature of the audits as they saw them evolve:

> The dentists were sent a letter which indicated a two-year period. They were provided with a schedule of 20 patients that they had seen during the two-year period and were asked a series of questions which related to section 10 compliance. The questions included: was a valid referral from a provider provided prior to the beginning of treatment? Was a written quote

57 Mr Iain Indian, *Submission 239,* p. 2.

58 Dr Linda Steinberg, *Submission 148,* p. 2.

59 See for example, Dr Medhat Ramzy, *Submission 222,* p. 2; Dr Gregory Morris, *Submission 234,* p. 2.

60 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 16.

61 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 31.

62 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 27.

> provided to the patient prior to the course of treatment? Was a written treatment plan provided to the patient prior to the course of treatment? Was a treatment plan or summary provided to the referring GP prior to the course of treatment?
>
> The practitioners could answer the schedule by putting a yes or no in a box, signing it, sending it off and providing supporting documentation.[63]

2.51 The ADA informed the committee that in December 2009, it was advised by Medicare of its concerns that dentists were not complying with the requirements of the CDDS. Following this advice, the ADA issued information to members that non-compliant practitioners could be required to repay benefits received.[64] Mr Boyd-Boland added:

> ...we then embarked upon an education program for our members seeking to educate them in relation to the compliance requirements of the scheme. That was done through both our written publication and an educational CD that we provide to all of our members...indicated in that discussion that the audits had been conducted over a period of time and had revealed some noncompliance for a period of about 12 months prior to that date, but that was the first time we became aware of compliance issues within the association—or on the part of dentists within the association.[65]

2.52 The committee heard a range of concerns about the audits of the CDDS, including the methods used to audit dentists, such as asking family members of deceased patients for audit information or seeking information from patients who have a poor understanding of English;[66] delays in finalisation of audits;[67] and difficulties of accessing information required by the auditors.[68] The committee also heard about poor communication during the audit process. Ms Harrup, ADPA, stated:

> The audit process in itself has caused a lot of stress for members. There are members whose audits have not been finalised despite its seeming that the actual audit activity has been complete for some months. So those members are in limbo with the fear of possible financial ruin. They have had no closure on that. It also appears that there is a contravention of Medicare's own compliance philosophy where in their compliance brochure they talk about cases of accidental noncompliance being treated with the recognition

63 Dr Jane Pinchback, Australian Dental Association (NSW), *Committee Hansard*, 1 May 2012, p. 13.

64 Australian Dental Association, *Submission 231*, p. 7.

65 Mr Robert Boyd-Boland, Australian Dental Association, *Committee Hansard*, 1 May 2012, p. 3.

66 See for example, Dr Dragan Flajnik, *Submission 147*, p. 3; Dr Tony Andrianopoulos, *Submission 132*, p. 1; Mr Iain Indian, *Submission 239*, p. 4.

67 See for example, Dr Richard Minc, *Submission 3*, p. 1.

68 See for example, Dr Heba Ibrahim, *Submission 260*, pp, 1–2.

> that people make honest mistakes and that the response is that they provide counselling and feedback.[69]

2.53 The DHS responded to some of the above concerns, noting that:

> On the information that is available to us, the overwhelming majority of practitioners, their stakeholder groups and, for that matter, the department have approached the task of compliance and education in this area in good faith.[70]

2.54 The committee received many comments that the action taken for non-compliance was extreme. Submitters noted the administrative oversights had not had an adverse impact on the care provided with patients happy with the work done and many accessing dental care for the first time in many years. In these circumstances, the repayment of the full benefit was seen as being unfair and harsh. The ADPA, for example, commented that 'for those dental prosthetists who have committed accidental noncompliance we believe that repayment of the entire Medicare benefit is inappropriate'.[71]

2.55 The ADA, while acknowledging that 70 per cent of audited dental practitioners have been deemed to have failed to comply with the administrative compliance requirements of the scheme,[72] indicated that in its view, Medicare had not followed its compliance framework.[73] The ADA stated that where non-compliance is accidental, Medicare will counsel and provide feedback. The level and seriousness of action by Medicare then escalates matching the level of non-compliance. However, the ADA argued that the compliance program model articulated by Medicare has not been followed with respect to its audits of dentists.[74]

2.56 In response DHS stated that:

> The diagram that the Australian Dental Association has in their submission reflects the broad strategic approach we take to our compliance activities and, in particular, that we use every opportunity available to us within the law to educate, to provide early intervention and to work with the professions in a collaborative way to ensure that any issues are identified early and that there is an opportunity to address those matters early in the proceedings. What guides us more...is the legal framework that surrounds our compliance activities and, in this context in particular, the operation of

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69 Ms Sara Harrup, Australian Dental Prosthetists Association, *Committee Hansard*, 1 May 2012, p. 18.

70 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 29.

71 Ms Sara Harrup, Australian Dental Prosthetists Association, *Committee Hansard*, 1 May 2012, p. 18.

72 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 2.

73 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 9.

74 Australian Dental Association, *Submission 231*, p. 8.

> the Health Insurance Act, the Health Insurance (Dental Services) Determination 2007 and obviously the Financial Management and Accountability Act.[75]

Recovery and re-education

2.57 The ADA (NSW) summarised the concerns of its members on the inflexible nature of the financial recovery process that was triggered once non-compliance had been identified. Dr Sinclair stated:

> Despite repeated assertions by Medicare that auditors were prepared to be flexible in individual cases, our experience suggests quite markedly otherwise. No flexibility or leniency has been shown where section 10 requirements of the Health Insurance (Dental Services) Determination 2007 are not met.[76]

2.58 Submitters indicated that the recovery of benefits where there had been non-compliance with section 10, would result in financial difficulties. It was noted that dental treatment incurred significant costs to the dentist including laboratory fees and staff costs and the repayment of the full benefit did not acknowledge that the dentist had not received the full benefit. This is exacerbated in the case of employee dentists who only receive a percentage of the fee charged, generally 35 to 45 per cent.[77] Dr Fryer, ADA, noted:

> The expenses of running a dental practice are at about 70 per cent. It can be a little higher and it can be a little lower. For every dollar that has been received from a member, shall we say, from Medicare, the dentist has kept only 30 per cent and the rest has gone on expenses to provide that dental service. Medicare is requesting the whole dollar back so it is a significant financial imposition.[78]

2.59 The committee was advised that recovery of benefit funds from non-compliant dentists is undertaken where it is economical to do so and the debt is legally recoverable. In instances where only a small proportion of the total claims made are non-compliant, recovery is not sought on the basis that it would be uneconomical to do so.[79] DHS explained the basis for the financial recovery process:

> Under the Financial Management and Accountability Act when a debt to the Commonwealth becomes ascertainable and certain then the secretary of the department is obliged under that act to pursue recovery of that debt in

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75 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 25.

76 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 10.

77 Dr Mehrdad Abolghassemi, *Submission 70,* p. 1. Dr Wilma Johnson, *Submission 97,* p. 1.

78 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 5.

79 Response to 24 November 2011 Senate Motion on *Health – Medicare – Chronic Disease Dental Scheme – Audits – Report – Order for production of document*, Item 87, *Journals of the Senate*, No. 73, 7 February 2012, p. 2035.

> full. In particular, the chief executive—the secretary, in our case—has to satisfy themselves that the debt is legally recoverable or, to put it the other way, if the debt is not legally recoverable then clearly there is no obligation to pursue it...
>
> In addition, the chief executive or the secretary needs to ensure that it is economical to pursue recovery of that debt...Effectively the secretary is obliged to take into that litigation process a view about whether the debt is legally recoverable and whether it is economical to pursue. As you would know, in some circumstances the question of legal recoverability is actually relatively open. We do not believe that to be the case in this circumstance.[80]

2.60 Mr Rimmer concluded:

> Once noncompliance has been found in relation to an MBS claim, by operation of statute—not by operation of official decision but by operation of the dental services determination and the Financial Management Act—the department is obliged to pursue recovery.[81]

2.61 DHS informed the committee of the strong emphasis it places on re-education where possible and noted that it may have been more lenient in the past than it should have been. Mr Rimmer stated:

> The compliance arrangements established by Medicare Australia, and now carried on by the Department of Human Services, place a heavy emphasis on an educative approach. Officers of the department, in good faith, have tried to apply that to this scheme to try to respond to the facts and circumstances that are in front of them and the facts and circumstances of the individual audits. More recent legal advice says to us that, in the course of that decision making, officers exercised a discretion that was not available to them under the determination. That is a matter that is obviously of concern to us, because we are very focused on making sure that we act precisely within the legal framework that applies to us. And it is obviously a concern in relation to the individual cases of the 17 who we have written to, and that is one of the factors that has led the minister to ask us to inform the committee that he believes that some of the matters that are under discussion today do require further consideration.[82]

80 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, pp 25–26.

81 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 28.

82 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 28.

The Bill

2.62 As can been seen from the issues discussed above, there were many submitters who supported the Bill, including relevant dental associations[83] and the ADPA.[84]

2.63 There were also other submitters, such as the AMA, who did not support the Bill because, in their view, it would create inequities between different types of health professionals. The AMA stated:

> The AMA does not support the Bill because it seeks to exonerate one class of health practitioner from the legal requirements applying to a particular set of Medicare items. If passed the Bill would create an inequity between dentists and other health practitioners (whose services attract Medicare benefits) to meet the legal requirements when billing Medicare items.
>
> We do not consider it appropriate that dentists can use "I did not know" as a defence against future non-compliance with the Determination. Nor do we consider it appropriate for Parliament to provide this defence by passing the Bill, particularly as we are not aware that this defence exists in any other Commonwealth law.[85]

2.64 Another submitter opposed the Bill on the grounds that the CDDS administrative processes were not a problem and that in his view there is a need for ongoing audits:

> As a matter of principle, I oppose any legislation or regulation that would serve to reduce the compliance parameters currently required for dental practitioners to seek Medicare funding under the Chronic Disease Dental Scheme (CDDS).
>
> I refute any assertions that the current administrative processes are cumbersome and unnecessary, and that Medicare did not provide dental practitioners with adequate information about the scheme.
>
> The importance of maintaining the current protocols and rules set for the CDDS, and the need for ongoing expansive audits of high-billing CDDS dentists in order to ensure that over-servicing has not taken place at the cost of public health or the public purse.[86]

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83 Australian Dental Association (Victorian Branch), *Submission 164*, p. 1; Australian Dental Association (Queensland Branch), *Submission 208*, p. 2; Australian Dental Association, *Submission 231*, p. 1; Australian Dental Association (NSW Branch), *Submission 343*, p. 20.

84 Ms Sara Harrup, Australian Dental Prosthetists Association, *Committee Hansard*, 1 May 2012, p. 18.

85 Australian Medical Association, *Submission 209*, pp 1–2.

86 Dr Kia, Pajouhesh, *Submission 429*, pp 1, 3.

2.65 DHS advised the committee that the first and most fundamental premise is that there is a requirement on all health professionals to ensure that they are complying with the requirements for the payment of Medicare benefits.[87]

2.66 DoHA indicated that the Government's stated intention is that it would like to close this particular scheme, so there is a reluctance to change the determination.[88] The department also raised concerns about whether the Bill would have unintended consequences in other areas. Ms Flanagan explained:

> One of the concerns that certainly we would have in a policy sense about the legislation is the duty of care changing quite significantly. The thing that I suppose would give us concern is the test that is applied.
>
> That, to us, would be a very worrying development across the expectations that we would apply to health professionals...This actually changes the burden of responsibility very clearly, and that would be a worrying development.[89]

2.67 The committee was informed that the government has accepted that some of the concerns raised may need to be addressed fairly across different professions. Mr Rimmer stated:

> The minister has asked us to advise the committee that, notwithstanding the government's intention to close the scheme completely, he accepts that some but not all of the concerns that have been raised do require further consideration and that is a matter that is now underway within normal departmental processes.
>
> As a matter of administrative practice, if there is a changed approach, as a hypothetical, then obviously we would need to apply that changed approach fairly across particular cohorts. But as I stress, no decision has been made about that.[90]

Conclusion

2.68 The committee acknowledges that the CDDS scheme has assisted many in the community. However, it considers that the scheme is not adequately targeted at those most in need of dental services particularly pensioners and people on concession cards. The committee notes the Government's commitment to closing the scheme.

2.69 During the inquiry a range of issues in relation the CDDS scheme were identified by a large number of dentists. These issues included the conduct of audits

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87 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 29.

88 Ms Kerry Flanagan, Department of Health and Ageing, *Committee Hansard,* 1 May 2012, p. 30.

89 Ms Kerry Flanagan, Department of Health and Ageing, *Committee Hansard,* 1 May 2012, p. 30.

90 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 26.

and the impact on practitioners and patients. However, of particular concern were matters related the adequacy of consultation before the scheme commenced, the information and education about the scheme provided by Medicare and the Department of Health and Ageing and the lack of consideration of the practice and procedures of dentistry. Submitters argued that these had contributed to the high level of non-compliance in relation to the requirements of section 10 of the Health Insurance (Dental Services) Determination 2007. Further, it was argued that the requirement to repay all the benefits received from non-compliant claims was 'unjust'. The Bill before the committee is seeking to address perceived 'inequities' that have arisen because of the operation of subsection 10(2) of the Determination. The committee observes that the Determination has been in place since the CDDS was introduced by the Howard Government in 2007.

2.70 The committee notes that not all dentists shared these views. In addition, the committee acknowledges that submitters were strongly supportive of measures to address opportunistic non-compliance, inappropriate claim behaviour or fraudulent behaviour of any kind.

2.71 The committee notes that evidence received from the Department of Human Services indicates that information was provided to dentists and dental prosthetists at the commencement of the scheme and since that time. Further, Medicare is required to enforce requirements, including compliance provision, contained in legislation. The committee notes that the Department of Human Services stated that it had tried to, during compliance activity, place more emphasis on an educative approach. However, legal advice indicated that officers did not have a discretion under the Determination.

2.72 However, the committee notes that the Minister accepts that some but not all of the concerns that have been raised do require further consideration and that is a matter that is now underway within normal departmental processes. The committee therefore considers that the Bill may not be the best way to deal with the problems that have arisen, as the proposed actions would create further inequities.

Recommendation 1

2.73 The committee recommends that the Health Insurance (Dental Services) Bill 2012 not be passed.

Senator Helen Polley
Chair

Dissenting Report

Coalition Senators

Introduction

1.1 The Chronic Disease Dental Scheme (CDDS) was introduced by the Howard Government to fill a gap in the provision of health services in Australia. Since its inception in 2007, many thousands of people suffering persistent and complex dental conditions associated with chronic disease have benefited from access to the CDDS.

1.2 When the Rudd Government came to power, it sought to dismantle the CDDS and replace it with its own scheme. Its first attempt at bringing a halt to the scheme was through the introduction of a repeal Determination in May 2008. This failed as the Senate voted for disallowance of the Determination. Again, in September 2008, the Senate rejected the Government's attempt to have the disallowance rescinded. The decision by the Coalition to block the cessation of the CDDS was not taken lightly. As Senator Richard Colbeck stated at the time:

> The opposition has considered this question very carefully before taking the serious action of moving this disallowance. We did not move this motion capriciously, but we are strongly of the view that the enhanced primary care dental access scheme, colloquially called Medicare dental, has, since its establishment last year, been of immense benefit to many Australians suffering chronic and complex dental conditions.[1]

1.3 After these defeats, it appears that the Government changed tack and Medicare Australia began a wide-ranging program of compliance audits aimed at discrediting the scheme. These audits were not only aimed at fraudulent activity but also at non-compliance with administrative requirements under section 10 of the Health Insurance (Dental Services) Determination 2007.

1.4 The Health Insurance (Dental Services) Bill 2012 [No. 2] was introduced in the House of Representatives by Shadow Minister for Health, the Hon. Peter Dutton, and by Senator David Bushby in the Senate. It aims to redress past and future inequities regarding Medicare's auditing of dental practitioners participating in the CDDS. The inequities addressed arise from the pursuit by Medicare of dentists and dental prosthetists who have provided desperately needed services to those who have suffered from chronic dental conditions but who have failed to comply with administrative requirements.

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1 Senator Richard Colbeck, *Senate Hansard*, 19 June 2008, p. 2814.

1.5 The undertaking of these audits has resulted in adverse outcomes for dentists, dental prosthetists, their employees, their patients and the reputations of highly regarded health professionals. The Australia Dental Association made clear how dentists have been treated by the Government:

> The comments published in the press by ministers have painted the dental profession in a bad light by the use of the words 'rorting' and 'overservicing', when in fact what has occurred is some administrative paperwork noncompliance and expenditure incurred that has exceeded government expectations. If dentists are going to participate in ongoing schemes to help deliver care to the needy, some significant bridge-building needs to be done.[2]

1.6 The Australian Dental Association (NSW) (ADANSW) informed the committee that:

> The ADA New South Wales endorses this bill because it seeks to redress an injustice. Dentists should not be penalised if they have provided appropriate dental treatment in a timely fashion to patients with chronic disease simply because they failed to comply with paperwork requirements they misunderstood or even were unaware of. This profession would never assert it is immune from scrutiny, audit or review, nor will it ever condone fraudulent activities against the crown or defective and inappropriate delivery of care.[3]

Issues

1.7 This Government has done nothing but try to denigrate a scheme which has delivered around 11 million treatments to more than a million Australians. Of great concern has been the way in which audits have been conducted. There were many reports of delays in communication of outcomes, the distress caused to patients and families and the undermining of reputations. The Australian Dental Prosthetists Association reported:

> The audit process in itself has caused a lot of stress for members. There are members whose audits have not been finalised despite its seeming that the actual audit activity has been complete for some months. So those members are in limbo with the fear of possible financial ruin. They have had no closure on that. It also appears that there is a contravention of Medicare's own compliance philosophy where in their compliance brochure they talk about cases of accidental noncompliance being treated with the recognition that people make honest mistakes and that the response is that they provide counselling and feedback.[4]

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2 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 1.

3 Dr Mark Sinclair, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 10.

4 Ms Sara Harrup, Chief Executive Officer, Australian Dental Prosthetists Association, *Committee Hansard,* 1 May 2012, p. 18.

1.8 One submitter indicated that family members of deceased patients were contacted as part of an audit:

> I have unfortunately had a couple of patients pass away during treatment but I was very disappointed to see from my Audit outcome that family members have indicated that NO services were conducted. This isn't fair and isn't true.[5]

1.9 The Committee has received more than 400 written submissions in three weeks, the vast majority of them supporting the Bill and many containing personal accounts of the stress caused by audits.

1.10 Coalition senators note the completed audits show that 70 per cent of dental practitioners have been deemed to have failed to comply with the administrative compliance requirements of the scheme. The Department of Human Services has suggested that dentists simply failed to properly read and understand educational material on the scheme. It provided the Senate with documents which it argued made it clear that adequate information was provided.[6]

1.11 Coalition Senators dismiss this assertion. It is highly unlikely that a large number of highly educated professionals would not understand these requirements, if sufficient information had, indeed, been provided. In addition, closer examination of the documents reveal that some have only passing reference to the CDDS and do not in any way provide targeted information on the compliance requirements of the CDDS. The ADA NSW commented:

> ...those six documents that we outline in our submission were specifically referred to on numerous occasions in various previous Senate committee hearings by both the Department of Health and Ageing and the Department of Human Services, where they have been asked a question about what education was provided—what correspondence was sent to dentists or dental practitioners to alert them to the requirements of the scheme? There is constant reference to six documents.
>
> If these are the best that they can come up with, two of them really only say, 'We're going to close this scheme.' One of them talks more about the Medicare Teen Dental Plan. Really the only one that we have identified as being of any substance was very early on, the second occasion, on 17 October, when the Medicare Benefits Schedule was sent to dentists. We note the fact that at the time there were probably 13,000 registered dentists in Australia but according to Medicare they only sent it to 9,000 people.[7]

5 Dr Dragan Flajnik, *Submission 147*, p. 3.

6 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 35.

7 Mr Bernard Rupasinghe, Australian Dental Association (NSW), *Committee Hansard,* 1 May 2012, p. 12.

1.12 Coalition senators do not believe that the education process undertaken to ensure that dentists and dental prosthetists understood the requirements of the CDDS, in particular, section 10 requirements, was adequate. Some witnesses considered that because of the supposed imminent closure of the CDDS, the Government may have failed to devote sufficient effort to educate dentists. The ADA submitted:

> The department seemed content to do as little as possible to educate members, perhaps thinking that, as the scheme was to close, education expenditure could be saved. Indeed, if you look at the material allegedly distributed to dentists before this time, as identified by the department in the material it presented to the Senate, you will see that almost as many letters were sent advising of closure of the scheme as were sent with details of compliance requirements with the scheme.[8]

Admission by the Government

1.13 Representatives from the Departments of Health and Ageing and Human Services acknowledged mistakes have been made throughout the Federal Labor Government's aggressive pursuit of dentists. The Department of Human Services stated that 'with the benefit of hindsight there are always opportunities to improve in most things that we do in government'.[9]While this may be true, it is dentists and dental prosthetists who are feeling the brunt of inadequate provision of information. The Government is demanding the repayment of some $21.6 million of benefits paid to dental practitioners who have provided services but who failed to comply with administrative requirements and this is likely to grow as the results of further audits become apparent.

1.14 Under questioning from Senator Concetta Fierravanti-Wells, the Shadow Minister for Ageing and Mental Health, and Senator for Tasmania, David Bushby, officials confirmed that Minister Kim Carr has identified a need to examine the audit process and its impacts:

> The minister has asked us to advise the committee that, notwithstanding the government's intention to close the scheme completely, he accepts that some but not all of the concerns that have been raised do require further consideration and that is a matter that is now underway within normal departmental processes.[10]

8 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 2.

9 Dr Shane Fryer, Australian Dental Association, *Committee Hansard,* 1 May 2012, p. 2.

10 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 26.

1.15 Furthermore, it was revealed that the Government has sought legal advice to determine what level of discretion can be exercised when seeking repayments from dentists.[11] It is not surprising that Minister Carr has needed to obtain legal advice. Further Coalition senators call on the Government to ensure that any reconsideration of the audit process includes all those who have already been audited.

Conclusion

1.16 The evidence received by the committee has thrown light on an injustice inflicted on a highly professional and dedicated group of health practitioners. While it is acknowledged that there was non-compliance, the non-compliance was of an administrative nature. It was not because of fraud or rorting and it arose primarily because of inadequate information and education about compliance requirements.

1.17 Finally, Coalition senators note that there has been an acknowledgment from the Government that they've mishandled this witch-hunt. It is up to Minister Carr to immediately halt the Medicare Audit Taskforce and waiver any demands for repayments.

Recommendation 1

1.18 That the Health Insurance (Dental Services) Bill 2012 be passed.

Senator Concetta Fierravanti-Wells
Senator for NSW

Senator David Bushby
Senator for Tasmania

11 Mr Ben Rimmer, Department of Human Services, *Committee Hansard,* 1 May 2012, p. 28.

Australian Greens Additional Comments

Australian Greens Comments

1.1 The Greens note the purpose of the Bill is to remedy a particular injustice – the high financial burden placed on dentists and other practitioners who took part in the Chronic Disease Dental Scheme, were found to be non-compliant with all the requirements of the scheme, and have been ordered to make full repayment of all benefits thereby received. After considering the evidence presented to the committee the Greens remain of the opinion that this injustice is real and should be remedied as soon as possible.

Causes of non-compliance

1.2 After examining the evidence and speaking to practitioners who took part in the CDDS, the Greens are satisfied that the majority of practitioners provided services in good faith to patients eligible for service, and that most cases of non-compliance do not represent fraudulent intent on behalf of dental practitioners.

1.3 The Greens note the high rate of non-compliance with the requirements of the scheme is indicative of fundamental problems with the design of the scheme and engagement with the profession, rather than negligence by individual practitioners.

Education process

1.4 The committee heard differing views on whether sufficient information was provided to dentists and dental prosthetists to properly educate them on the details of compliance requirements. Based on submissions received and the testimony given to the committee, the Greens remain convinced that education measures were not sufficient and that the planning undertaken in the design of the scheme did not take into account the challenge inherent in bringing dental care into Medicare. Many or most dental practitioners had no previous interaction with Medicare and so the burden was on government to make training especially clear and explicit, including the penalties that could result from non-compliance whether accidental or otherwise.

1.5 The Greens also note that because of the Government's stated intention to close the CDDS, there appears to have been little effort to further develop comprehensive materials nor to sufficiently educate the Medicare service staff who dealt with inquires from dental practitioners.

Remedies

1.6 The Greens note that there has been significant confusion about the remedies available to the Department in cases where non-compliance was detected. According to the of the evidence Department, it appears that it is incorrect to state that compliance officers had the discretion to recommend further education when non-compliance with Section 10 requirements was identified, and that the Department had

no choice under the Act other than to seek repayment of benefits except where pursuing the debt would be uneconomical.

1.7 If this is the case, the Greens maintain that there is a need for other remedies in the cases where full repayment would lead to an unjust outcome. This bill represents one potential remedy.

1.8 The Greens note that closure of the CDDS remains stated government policy. In the event that the CDDS is closed as part of wider reforms, the Greens feel that this provides an opportunity to redress this issue with the profession. The Greens encourage the Government to take this opportunity.

1.9 The Greens note that in the current climate in which dental care is undergoing significant reforms it is crucial that good relations are maintained with the profession and that both sides must act in good faith.

Senator Richard Di Natale
Senator for Victoria

APPENDIX 1

Submissions and Additional Information received by the Committee

Submissions

1 Bella Kolber
2 Roger Sharpe
3 Richard Minc
4 Confidential
5 Confidential
6 Ved Berani
7 Graham Parry
8 Kiran Nayak,
9 Confidential
10 Name Withheld
11 Carol Szekfy
12 Scott Jenkins
13 Lesley Antolos
14 Steven Serebnitski
15 Dragan Antolos
16 Vadim Rogelberg
17 Damien Jones
18 Beverley-Anne Rodan
19 Larry Benge
20 Confidential
21 Clare Straker
22 N F Oscar McInvor
23 Name Withheld
24 Jim Yannopoulos
25 Warren Antonoff
26 Kym Stock
27 Avron Lapidus
28 Raymond Montag
29 Ravi Pather
30 Lisa Chong
31 Mark Russell
32 Agim Hymer
33 Grant Keogh
34 Joseph Da Cruz
35 Con Lakoumentas

Sonia Sumer
Amanda Hales
Ahmed Bagdadi
Tania Nixon
Michael Kalas
Janet Neal
Brendan Moore
Bronwyn Davies
Sigal Jacobson
Tracey Yannopoulos
John Kovarik
Bruce Bowden
Alan Kwong
John Wilkins
Darren Donnellan
Jonathan Skilton
Malcolm Duff
Phillip Ly
David Ayton
Confidential
Jaipal Reddy
Stephen Nordstrom
John Wilson
Debbie McAllister
Anil Kontham
Lew Steinberg
Marina Donnellan
Angy Yoannidis
Santosh Joy
Jim Bossinakas
Gregory Jaunay
Mick Lyons
Omid Allan
Roland Komzak
Mehrdad Abolghassemi
Husam Al-Dujuaili
Confidential
Confidential
Confidential
Gino Florio
Confidential
Graeme Morris
Kristina Gorgievski

79 Alizabeth Magoulias
80 Mary Choo
81 David Raine
82 Zoe Klein
83 Confidential
84 Geoff Lambert
85 Maurice Wolecki
86 Caroline Brown
87 M Mustafa
88 Susan Wise
89 Elsa Fischer
90 Susan Ravida
91 Vincent Leung
92 John Hatzis
93 Name Withheld
94 Chris Jacobs
95 Ahmed Bagdadi
96 Stanley Cheung
97 Wilma Johnson
98 Confidential
99 Alan Rosenberg
100 Arthur Batzios
101 Confidential
102 Confidential
103 Rosemary Watts
104 Ian Charles
105 Ernst Kroon
106 Hercules Constantinou
107 Confidential
108 Antje Vogelsang-Sharman
109 Dragan Grubor
110 Victor Manton
111 Imran Ali
112 Saima Rizvi
113 Name Withheld
114 Ann Starkey
115 Craig Swift
116 Don Alexander
117 Jeanette Culic
118 Joseph Cordima
119 Daniela Yoannidis
120 Confidential
121 Bradley Horwood

122 Michael Piras
123 Name Withheld
124 Drs Imad Eltenn, Michelle Romanos, Yvonne El-Zoghbi
125 Annette Varley
126 Val and Jo Cirvydas
127 Department of Health and Ageing
128 Confidential
129 Carla Vescio
130 Brett Stewart
131 Dimos Andrianopoulos
132 Tony Andrianopoulos
133 Ria Zergiotis
134 Confidential
135 Confidential
136 Veronica Roller
137 Geoffrey Thomas
138 Confidential
139 Ewa Walczak
140 Confidential
141 Ronald Vincent Ravida
142 Confidential
143 Jim Peters
144 Alex Shen
145 Philip Tregeagle
146 George Androutsopoulos
147 Dragan Flajnik
148 Linda Steinberg
149 Name Withheld
150 Olivia Alysandratos
151 Hong Vo
152 Confidential
153 Mary and Chris Arabatzis
154 Confidential
155 Philip Moss
156 Paul Werner
157 Name Withheld
158 Nick Taft
159 Allen Aylett
160 Damir Culic
161 Ken Koo
162 Australian Dental Prosthetists Association Ltd
163 Confidential
164 Australian Dental Association Victorian Branch Inc.

165 Oksanna Cooper
166 Shayne Hateley
167 Name Withheld
168 Kate Smith
169 Teri Simone Bueti
170 Joe Saad
171 Jaye Mosarevski
172 Consumers Health Forum of Australia
173 Louise Nawrot
174 Janine Indian
175 Thomas Dods
176 Amabelle Vamvalis
177 Name Withheld
178 Confidential
179 Confidential
180 Confidential
181 Chris Hart
182 Confidential
183 Keyhan Alavian
184 Paul Fagliarone
185 Megan Mannering
186 Confidential
187 Arthur Mills
188 Fong Yong
189 James Sung
190 John Casticas, Stephanie Catsicas, Peggy Catsicas, and Elise Dafinis
191 Leanora Lopresti
192 David Landau
193 Dhaval Gandhi
194 Confidential
195 Badrish Krishna
196 Meetal Shah
197 Maria Rowe
198 Rocco Bueti
199 Name Withheld
200 Benjamin Daoud
201 Department of Human Services
202 Confidential
203 Confidential
204 Devendra Rao
205 Name Withheld
206 Somchai Tongsumrith
207 Name Withheld

208 Australian Dental Association (Queensland Branch)
209 Australian Medical Association
210 Confidential
211 Lihn Nguyen, Lan Ngueyen, Jina Kim Michelle Truong, Asmono Truong and Maria Andersson
212 Alex Fibishenko
213 Rebecca Bevilacqua
214 Name Withheld
215 Confidential
216 Name Withheld
217 Xing-Kai Wong and Judith Ong
218 Name Withheld
219 Jimmy Yang
220 Joseph Lattouf
221 Eryn Agnew
222 Medhat Ramzy
223 Gareema Prasad
224 Confidential
225 Jessica Wei
226 Gilbert Runnalls
227 Andrew Murray
228 Annamaria Magnus
229 Stephen Tangney
230 Antony John Cope
231 Australian Dental Association
232 Confidential
233 Michael Johnson
234 Gregory Morris
235 David Issa
236 Name Withheld
237 Zoe Skourides
238 Adam Alford
239 Iain Indian
240 Felicity A Wardlaw
241 Bich Dien Tran
242 Gary Carson
243 Brian Ruttenberg
244 Ray Cheng
245 Albert Sharp
246 Robert Lansdown
247 Grahame Dudgeon
248 Sally McDermott
249 Confidential

250 Karen Whitehouse
251 Patricia Kefford
252 Confidential
253 Confidential
254 Oscar Kwon
255 Elias Dagher
256 Alex Vouliotis
257 Elayne Hien Tran
258 Confidential
259 John Lyster
260 Heba Aboushady
261 Spencer Wu
262 Helen Arabatzis
263 Suzanne Roberts
264 Stewart Cottis
265 Courtney Murray
266 Confidential
267 William Spencer
268 Carole Lamplough
269 Gwenyth Pedder
270 Confidential
271 Redian Rezfino
272 Gary Hibble, Tim Curran and Gavin Sidhu
273 Tony Cinque
274 Confidential
275 Mark Simpson
276 John Cistulli
277 Confidential
278 Confidential
279 Felicity Wardlaw
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287 Anthony Burges
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324 Confidential
325 Confidential
326 Tim Tierney
327 Robert Kreig
328 Confidential
329 Tammy Lemke
330 Jack Chen
331 Graham and Helen Lane
332 Peter Chung
333 P and J Buckham
334 C W Cooper
335 Nattalie Norris

336 Cathy Chandler
337 Irene Thorn
338 Confidential
339 Elizabeth Gorman
340 Narelle Lang
341 P D A Walder
342 Anne Summers
343 Australian Dental Association (NSW Branch)
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426 Confidential
427 Robert Hirsch
428 Vivien Munoz-Ferrada and Dr Peter Vickers
429 Kia Pajouhesh
430 Confidential
431 Dental Hygienists Association of Australia Inc
432 Australian Doctors Union

Tabled Documents

1 Australian Dental Association, correspondence, articles and news items provided to ADA members regarding the CDDS, tabled 1 May 2012.

Answers to Questions on Notice

1. Department of Human Services, answers to questions on notice taken at hearing 1 May 2012
2. Department of Health and Ageing, answers to questions on notice taken at hearing 1 May 2012

APPENDIX 2

Public Hearing

Tuesday, 1 May 2012,

Committee Room 2S1, Parliament House, Canberra

Witnesses

Australian Dental Association

Dr Shane Fryer, President

Mr Robert Boyd-Boland, Chief Executive Officer

Australian Dental Association (New South Wales)

Dr Mark Sinclair, President

Dr Matthew Fisher, Chief Executive Officer

Dr Jane Pinchback, Peer Adviser

Mr Bernard Rupasinghe, Policy Officer

Australian Dental Prosthetists Association *(via teleconference)*

Ms Sara Harrup, Chief Executive Officer

Department of Health and Ageing

Ms Kerry Flanagan, Deputy Secretary

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Ms Veronica Hancock, Assistant Secretary, Hospital Development and Dental Branch

Department of Human Services

Mr Ben Rimmer, Associate Secretary

Ms Philippa Godwin, Acting Deputy Secretary, Future Services, Rehabilitation and Compliance

Ms Jennifer Cooke, General Manager, Recovery, Health and Business Compliance

APPENDIX 3

Index of CDDS documents

Response to 19 September 2011 Senate Motion on *Health – Medicare – Chronic Disease Dental Scheme – Audits – Report – Order for production of documents*, presented on 19 October 2011, Item 30, *Journals of the Senate*, No. 60, 31 October 2011, p.1673.

Senate motion to produce Chronic Disease Dental Scheme documentation - due to be tabled by 31 October 2011

INDEX OF DOCUMENTS

Number	Document
1.	Media release by Australian Dental Association *Increase in the EPC Scheme welcomed* (14 August 2007)
2.	Letter from the Hon Tony Abbott MP, Minister for Health and Ageing to dental practitioners [sent 5 October 2007]
3.	Letter from the Hon Tony Abbott MP, Minister for Health and Ageing to dental prosthetists [sent 3 October 2007]
4.	Article by Australian Dental Association *Medicare EPC Scheme Advice* (16 October 2007)
5.	Department of Health and Ageing mail out to dentists and dental specialists (17 October 2007) -Medicare Benefits Schedule Dental Services Book (effective 1 November 2007)
6.	- Fact sheet *Information for dentists and dental specialists dental services under Medicare for people with chronic and complex conditions* (October 2007)
7.	Department of Health and Ageing mail out to dental prosthetists (17 October 2007) -Medicare Benefits Schedule Dental Services Book (effective 1 November 2007)
8.	-Fact sheet *Information for dental prosthetists dental services under Medicare for people with chronic and complex conditions* (October 2007)
9.	*Checklist for Dental Practitioners* webpage (4 February 2008 last modified)
10.	Letter including attachment (see item 11) notice from Department of Health and Ageing, Primary Care Financing Branch to Australian Dental Association *Discontinuation of Medicare dental items for people with chronic conditions and complex care needs items (85011-87777)* (3 March 2008)
11.	Notice from Department of Health and Ageing to Dentists and Dental Specialists *Notice to Dentists and Dental Specialists Discontinuation of Medicare dental items for people with chronic conditions and complex care needs items (85011-87777) (3 March 2008)*
12.	Letter including attachment (see item 13) notice from Department of Health and Ageing, Primary Care Financing Branch to Australian Dental Prosthetists Association *Discontinuation of Medicare dental items for people with chronic conditions and complex care needs items (85011-87777)* (3 March 2008)
13.	Notice from the Department of Health and Ageing to Dental Prosthetists *Notice to Dental Prosthetists Discontinuation of Medicare dental items for people with chronic conditions and complex care needs items (85011-87777)* (3 March 2008)
14.	Notice from the Department of Health and Ageing to Dentists and Dental Specialists *Notice to Dentists and Dental Specialists Discontinuation of Medicare dental items for people with chronic conditions and complex care needs items (85011-87777)* (6 March 2008)
15.	Notice from the Department of Health and Ageing to Dental Prosthetists *Notice to Dental Prosthetists Discontinuation of Medicare dental items for people with chronic conditions and complex care needs items (85011-87777)* (6 March 2008)

Number	Document
16.	Letter from the Hon Nicola Roxon MP, Minister for Health and Ageing to Australian Dental Association (30 June 2008)
17.	Letter from the Hon Nicola Roxon MP, Minister for Health and Ageing to Australian Dental Prosthetists Association (30 June 2008)
18.	Fact sheet *Information for dentists and dental specialists dental services under Medicare for people with chronic and complex conditions* (June 2008)
19.	Fact sheet *Information for dental prosthetists dental services under Medicare for people with chronic and complex conditions* (June 2008)
20.	Letter from the Hon Nicola Roxon MP, Minister for Health and Ageing to dentists (July 2008)
21.	Department of Health and Ageing, Medicare Benefits Schedule Dental Services book (1 November 2008)
22.	Fact sheet *Information for dentists and dental specialists dental services under Medicare for people with chronic and complex conditions* (February 2009)
23.	Fact sheet *Information for dental prosthetists dental services under Medicare for people with chronic and complex conditions* (February 2009)
24.	Fact sheet *Information for dentists and dental specialists dental services under Medicare for people with chronic and complex conditions* (April 2009)
25.	Fact sheet *Information for dental prosthetists dental services under Medicare for people with chronic and complex conditions* (April 2009)
26.	Department of Health and Ageing, Medicare Benefits Schedule Dental Services book (1 November 2009)
27.	Fact sheet *Information for dentists and dental specialists dental services under Medicare for people with chronic and complex conditions* (November 2009)
28.	Fact sheet *Information for dental prosthetists dental services under Medicare for people with chronic and complex conditions* (November 2009)
29.	Article from Medicare provided to the Australian Dental Association (December 2009)
30.	Media release by Australian Dental Association *Blow out in costs of dental scheme by dentists and GPs inaccurate* (11 March 2010)
31.	Media release by Hon Chris Bowen MP, Minister for Human Services, *Medicare Australia releases chronic dental audit findings* (8 June 2010)
32.	Letter from Medicare to dental practitioners advising of audit project to be undertaken (June 2010)
33.	Fact sheet from Medicare to Dental practitioners *What is an audit?* (June 2010)
34.	Department of Health and Ageing, Medicare Benefits Schedule Dental Services book (1 July 2010)
35.	Department of Health and Ageing, Medicare Benefits Schedule Dental Services book (1 November 2010)
36.	Fact sheet *Information for dentists and dental specialists dental services under Medicare for people with chronic and complex conditions* (November 2010)
37.	Fact sheet revised *Information for dental prosthetists dental services under Medicare for people with chronic and complex conditions* (November 2010)
38.	Department of Health and Ageing, Medicare Benefits Schedule Dental Services book (1 January 2011)
39.	Dental services under Medicare webpage (31 January 2011 last modified)

Number	Document
40.	Letter from Australian Dental Association to members *Important notice to all members that have provided services to Medicare patients* (24 February 2011)
41.	Media release by the Hon Tanya Plibersek MP, Minister for Human Services *Medicare finds systematic misuse of dental scheme (*20 March 2011)
42.	Letter from the former CEO Medicare to dental practitioners advising of increased audits (29 April 2011)
43.	Australian Dental Association news bulletin article *Get your house in order* (May 2011)
44.	Department of Health and Ageing, Medicare Benefits Schedule Dental Services book (1 July 2011)
45.	Letter from the Hon Tanya Plibersek MP, Minister for Human Services to Australian Dental Association (13 July 2011)