Senate Submission Regarding Chronic Disease Dental Scheme Audits.

Please note that I wish for my name to be with-held from my submission and that my personal details remain unpublished for privacy reasons.

Participation in the Chronic Disease Dental Scheme

As a recent new-grad, I have been exposed to patients eligible for CDDS services for the past 16 months in a private practice setting.

The characterisation of patients at my place of employment (a private dental practice), is a mixture of both private patients and CDDS patients, although CDDS patients make up a very large proportion of patients.

It is my belief, and also practice philosophy, to be equitable, ethical and just in the distribution of dental services. It is for this reason that I believe the practice was initially drawn to be involved in the Medicare scheme. It was interpreted that the scheme was designed for those with a genuinely enhanced need for dental care.

It is unfortunate however, that a large proportion of CDDS patients, despite having a "chronic disease" and deemed by their general medical practitioner as eligible for CDDS benefits, actually do NOT have a significant illness which is impacting on their dental health. An example would be a patient with controlled hypertension and no other disclosed medical condition, or a patient with a history of previously treated cervical cancer with no other disclosed medical conditions and no medications or requirement for chemotherapeutic interventions – both of which have been referred to me in the past. I feel that this diverts services from those actually in need, and dentists should therefore have more involvement in the selection of eligible patients. It is, after all, a significant part of dental education and training to have an in-depth understanding of the medical conditions which impact on dental health in order to effectively diagnose, modify causal factors where possible, and provide effective, integrated treatment plans to those with medical conditions.

In addition to the over-burden of the sheer number of Medicare patients to our practice, there is also the problem of declining benefits. It would be expected that benefits would be adjusted to be kept in line with CPI, however It was brought to my attention when reviewing the CDDS benefits schedule, that the updates of the schedule have not only failed to keep up with CPI, but have actually seen a reduction in benefits payable for some items. This is particularly true for services that require laboratory input, such as dentures, and crown and bridge. This has meant that continuation of bulk-billing is unsustainable, unless we obtain much cheaper and inferior quality laboratory services from overseas, which we have neglected to do as we wish to support Australian and local business and to provide quality dental materials and services. Furthermore, our Medicare patients have become accustomed to and expect a system of no-gap payments, all of which has posed moral, ethical, and administrative problems for our practice.

Since the initiation of the scheme, it has been practice philosophy to treat CDDS by bulk-billing with no gap payment, with the impression that a much needed community service was being supplied by those in need. However, I feel that this is unsustainable within the existing climate of the scheme.

Information provided by Medicare

I feel that I have received very little and inadequate information directly from Medicare regarding the scheme, with most correspondence in relation to the scheme originating from the ADA. The sheer size and complexity of the requirements of the scheme necessitates an orientation in to the program. I feel dentists would require a personal consultation or information session in order to be able to properly understand the requirements of the scheme in order to have the confidence to adequately comply with the CDDS requirements. Furthermore, when our practice receptionists have had contact with Medicare, the information has, at times, been inconsistent and there have been instances where Medicare employees have refused to provide the required information or a reference number (these instances were reported to the ADA, as advised).

Experience with Department of Veteran Affairs scheme compared to Medicare

My experience with the Department of Veteran Affairs (DVA) has been a positive one, unlike my experience with Medicare. They remunerate adequately and timely for services provided and I also find that patients have a greater level of satisfaction and respect for the DVA scheme in comparison to the CDDS scheme – for instance, they do not have the frustrations of not being able to access certain services at the initial appointment.

Additionally, there are not the administrative difficulties involved in the DVA scheme, as there are with the CDDS, such as the requirement of treatment plans and itemised estimates and written and recorded correspondence to general practitioners etc.

Correspondence with Medicare

On numerous occasions, members from our practice have been in contact with Medicare with questions and need for clarification about certain aspects of the scheme, and responses from Medicare have been mixed. Occasionally, Medicare employees have been uncooperative and there have also been occasions where we have received conflicting advice, where one employee has given different advice from another. This has meant that I have developed a low level of confidence in the accuracy of the advice provided.

Patient benefits of the scheme

I have seen both the positive and negative outcomes provided under the CDDS scheme. I have been able to effectively treat certain patients under the scheme, with positive results, despite the difficulties associated with the scheme. However, in complying with the scheme, I have felt extremely limited and bound by the constraints of the scheme, which have produced much stress for myself and for my patients. For instance, there is a specific and limited list of items which are claimable at the initial appointment, which is not adequately comprehensive. For example, a scale and clean is not claimable at the initial consultation, however it is ludicrous to expect an adequate examination to be completed without a scale/clean, due to the visual limitations of extensive plaque and calculus, which is prevalent in a large proportion of CDDS patients. As a result, I have had

significant difficulties in writing a comprehensive treatment plan at the initial appointment. However, this is a requirement of the scheme, which means I must attempt an examination and hazard a guess at a plausible treatment plan and itemised estimate, and then bring the patient back for a scale/clean at a later appointment and repeat the process of the examination, treatment plan and estimate.

This has significantly reduced my productivity and had similar effects on patients, as they require more time off work, and have had to arrange additional transport etc for further appointments, which would otherwise not be necessary. This has been a large source of frustration for many patients and for the dental providers at our practice.

Additionally, the scheme does not allow for emergency treatment and relief of pain at the initial appointment. Despite the CDDS enabling financial access to dental care, there continues to be limitations in access to dental care within the community, whether it be in terms of physical, geographical, or psychological aspects, or dentist:patient ratios. As a result, treatment seeking behaviours by CDDS patients are frequently for emergency dental treatment and relief of pain. However, I am unable to provide relief of pain services such as extraction or pulp extirpation at the initial appointment, as the scheme requires that a comprehensive examination be completed, a written treatment plan submitted and accepted by the GP, and an itemised estimate provided to the patient. Hence, the constraints of the scheme have meant that by complying with the scheme, I am not always able to be an advocate for the patients best interests.

Administrative Difficulties

In addition to the aforementioned administrative difficulties associated with providing written treatment plans and recording correspondence with general practitioners etc., further difficulties associated with the scheme have included the administrative problems of keeping track of patients remaining Medicare benefit and timing of receipt of certain services (e.g. dentures) when they have sought additional care from other dental providers. This is important as patients are often unaware of their remaining balance and hence may exceed the CDDS benefit unknowingly. Also, the dental provider has limited means to verify which services have already been claimed by another practitioner and hence which items they will be remunerated for if they provide the service. For instance, this applies to the provision of dentures, which are claimable only every 8 years. It is extremely time consuming for staff to check such information with Medicare over the telephone.

Patient Attitudes

There has also been a demanding attitude amongst certain recipients, with a limited number of recipients attempting to take advantage of the scheme, with some patients demanding to expend the entire Medicare benefit and demanding more expensive treatments than are necessary. This, it seems, is because they have no personal financial investment in their treatment. Such patients require additional time to tactfully negotiate their individual requirements.

Recommendations

- Centralised/on-line note-taking system to allow efficient communication between medical referrers and dental providers. This would minimise the administrative difficulties. Direct correspondence should be limited to immediate and important issues only.

- Means-testing of the scheme to more effectively direct resources.
- More comprehensive service options at the initial appointment, with the inclusion of emergency and relief of pain item numbers and scale/clean.
- Direct access to Medicare records on-line to enable viewing of previously claimed item numbers in order to verify whether a benefit is claimable, e.g. for instances where patients have obtained services with another dental provider.
- Further education of the general practitioner regarding chronic disease which impacts on dental health and greater scrutiny by the general practitioner when assessing who is eligible for coverage under the CDDS.
- Adjustment of Medicare Benefits schedule to CPI

Alternatively, I believe that a new, directed, means-tested scheme which reflects that of the existing Department of Veterans Affairs scheme, would be a more effective alternative.