Submission to the Australian Senate on the Medicare Chronic Disease Scheme.

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

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History of the Medicare Chronic Disease Dental Scheme.

The Medicare Chronic Disease Dental Scheme (CDDS) was commenced by the previous Coalition federal government. In its initial phase a relatively modest sum was allocated to provide treatment to patients whose dental disease may have been contributing to their overall chronic ill health. As a consequence of the low uptake by the dental and medical professions the scheme was reconfigured, starting November 2007, by increasing the payment for treatment and expanding the scope of services available. The new scheme provided patients with access to $4250 in federal funding for provision of dental care.

This scheme commenced shortly before the Coalition lost office and the incoming Labor Government had stated that it would scrap the scheme and replace it with a new Commonwealth Dental Health program. Initially the new scheme was slated to closed in June 2008 however legislation to wind up the scheme was not passed by the Senate. In the succeeding years the Government has committed to finish the scheme a number of times, most recently on the 31st March 2012 and prior to this the 31st December 2011. At this point the CDDS continues to operate.

Initial response to the program was of course mixed and little attention was paid to the scheme as it was expected to end within six months. Many practitioners had little exposure for some time to the CDDS but when they did the information coming from Medicare offices was often confused and aimed primarily at informing that the program was to cease. Medicare staff still seems to be confused about the CDDS and its implementation, recently my staff have contacted Medicare and been informed of information that was obviously incorrect, this was primarily based on patient eligibility.

Given the widely advertised winding up of the scheme it is highly likely that many dentists were of the same opinion as the Medicare staff and as it was unlikely to affect their practice did not fully investigate the scheme. When activity started to increase a year or so later the advice they then received was often confused and inaccurate and mistakes were made, these mistakes on the whole were innocent and had no impact on the care provided to their patients.

Public funded Dentistry

Private dentistry in Australia has had little exposure to government schemes in the past with over 70% of dental services being privately funded. The States have had public systems which predominantly relied on employed dentists working in public clinics. Eligibility criteria for access to these clinics varied from state to state but in some areas up to 50% of the population were deemed eligible for treatment in public clinics. As the number of public sector dentists amounts to less than

10% of all registered dentists there is no way that all eligible patients can be seen and treated except through the provision of the most rudimentary dentistry.

The Federal Government has run, through the Department of Veterans Affairs, a program to provide health care including dentistry for eligible war veterans, their widows and dependants. This scheme provides a wide range of services to this group and fees are, on the whole, pitched at around 80% of the average dental fee. The majority of dentists in Australia have worked with the DVA scheme primarily in recognition of the commitments made by this group of people despite the relatively low fee level (overheads account for approximately 70% of all dental fees). Administration of the DVA scheme is generally good, with little additional paperwork required and payment generally within four weeks. Auditing must occur but has never been at the same level as the Medicare CDDS audits. On the whole this has been a relatively user friendly program that has provided benefit to this select group of Australians.

There are of course significant differences in the program. The DVA scheme has a capped group of people eligible, it does provide an extensive range of treatment with only some limits on treatment and/or monetary limits, these are primarily on the more expensive fixed crown and bridge items or dentures.

Personal experience of the scheme

In June 2011 I received notification from Medicare Australia that they were conducting an audit on patients of mine treated under the CDDS. The information and request for an audit were solely via letter, at no time has Medicare directly contacted me to discuss these issues. Subsequently I have had little communication with Medicare even though over 10 months have elapsed.

I would also make the comment that Medicare has sent at least some letters addressed to me to the wrong address, being 179 Victoria Road, Drummoyne, an address that I have never practiced at. The question has to be asked as to what other information has been sent to the incorrect address.

As a consequence of this request for a self-audit I reviewed the number of patients seen at my practice under this scheme to ascertain compliance or not with the scheme.

Analysis of the flow of patients enrolled by their general medical practitioner (GMP) provides an interesting insight into the activity of this program. From the figures of patients seen in my practice it shows a very slow up take for the first year or so and then acceleration from the beginning of 2010 as more people became aware of the program and their GMP referred them on.

Time period	2007 2nd half	2008 1st half	2008 2nd half	2009 1st half	2009 2nd half	2010 1st half	2010 2nd half	2011 1st half
Patient numbers	1	11	6	8	11	13	16	15

My decision to treat patients under the scheme has been strongly influenced by the perception that the majority of patients enrolled in the programme were not financially well-off and many had delayed appropriate dental care because of the costs of this care. For example, many patients who were existing patients of my practice and treatment had been basic patch and fill or emergency care

with no development of a full treatment plan and provision of a preventive regime. Under this scheme I was able to provide these patients with the most appropriate level of care as their individual financial situation no longer dictates treatment outcomes they were previously restricted too. I was now able to develop a comprehensive treatment plan for these patients and provide ongoing preventive care, exactly as the scheme intended

On reviewing the patients treated under the CDDS up to August 2011 there are a number of observations worth noting;

- 82 patients had been referred to my practice for treatment under the EPC from 1st November 2007 until August 2011.
- These patients are scattered from around Sydney, although predominantly from Drummoyne and surrounding suburbs.
- There is no single medical practitioner who has referred a significant number of these patients.
- The majority of patients had not accessed the full amount of funding made available to them under the scheme.
- Of the patients seen, 20 had not been seen at the practice prior to the scheme commencing and of these 20; seven referred patients have not started care.
- The average patient was a 69 year old female. Only 7 patients were under the age of 50, of these two had Down's syndrome.
- Only 16 (19.5%) were still employed or working in some role.
- 52 (63.4%) were on a pension. The remainder were either self-funded retirees or their financial situation were not disclosed.
- The most common chronic illnesses were diabetes (15.85%), elevated blood pressure (47.6%), cardiac illness (25.6%) and osteoporosis (24.4%). These diseases are to some extent to be expected in elderly patients but are amongst the chronic diseases with the strongest links to adverse general health.
- The majority of patients had multiple chronic illnesses and were taking multiple medications with the concomitant problems caused by polypharmacy . Many medications individually predispose patients to decreased salivary flow, in situations where multiple medications are taken this is further exacerbated. This leads to a greatly reduced ability to provide protection and affects the patient's ability to function, leading to a greatly accelerated caries rate and a decreased ability to use dentures leading to problems in eating an appropriate diet and social embarrassment.
- 39 patients (47.6%) were bulk billed for all treatment, an additional 12 (14.6%) were bulk billed for a portion of their treatment with 7 (8.5%) patients not seen or billed at any stage. This meant that less than 30% of patients were asked for a contribution for the care

The de-identified patient list is attached as appendix A, showing patients age, place of residence, date initially seen, major medical issues reported and the amount of money used under the scheme at August 2011.

Ministerial and media claims

Comments made by the former Minister for Human Services and current Minister for Health, Ms Tanya Plibersek MP about dentists allegedly rorting the CDDS bring no credit on her and falsify the true situation for the majority of dental practitioners and the benefits that have been provided under the scheme.

My understanding is that Medicare has in fact uncovered no evidence of "rorting" by the vast majority of dentists nor have they been actively investigating fraudulent activity. The focus has been simply on compliance with technical aspect of the scheme rather than an investigation into appropriate usage or failure to provide billed services.

Much of Medicare's auditing relies on compliance with relatively small details, some which in many cases fly in the face of common sense or even decency. The auditing relies on section 10 of the legislation to try and claw back funds. Issues with these areas commonly relate to:

- **Preparation and communication of a treatment plan to the patient prior to treatment commencing**. This is undoubtedly considered best practice in educating patients in what they are committing to. In some cases however treatment required was minimal and self-explanatory – some patients only required cleaning and some very basic restorative work. In many cases dentists performed treatment as bulk billed procedures and the logic was that as there was no financial cost to patients a quote was not required. Whilst a proposed treatment plan should be prepared in almost all cases patients had a discussion on treatment and had agreed to proceed. Failure to provide a written treatment plan being a justification for refunding of monies is an inappropriate action without some prior consultation and counselling.

- **Preparation and communication of a report to the referring general medical practitioner (GMP) prior to treatment commencing**. Again a seemingly small issue, in the cases I have treated I have never had one case of feedback or questioning from a GMP on the treatment proposed or the dental condition. The majority of medical practitioners have limited knowledge and understanding of dental practice and procedures and for many dentists this process of writing back to a referral source was seen more as a courtesy than a necessity. Again the claims for refunds on failure in this aspect seem a complete overreaction without first counselling on expectations.

- **Provision of some treatment prior to treatment plan formulation or correspondence with the GMP**. This in many ways is the most ridiculous and contentious part of the process, for many of these patients after years of neglect their teeth and oral condition were very poor, they had significant deposits of dental calculus (scale), plaque and stain that obscured the oral condition.
  It is usual practice in many dental surgeries to clean teeth so the oral health can be properly assessed, in fact not cleaning teeth and the surrounding soft tissues would increase the likelihood of mistakes being made and failing to diagnose condition making the initial treatment plan almost worthless. Medicare takes a very short sighted view that cleaning constituted treatment and as such was not appropriate. Disregarding the difficulty in assessing conditions it also required patients, many with mobility issues, needing to make multiple appointments for simple procedures.

- **Provision of emergency treatment**. In some cases patients present in pain, Medicare's poor understanding of this situation meant that dentists should have given a treatment plan and written a letter to the GMP before providing pain relief. Obviously this is not a practical or morally acceptable solution and dentists felt ethically bound to get people out of pain, i.e. commence treatment before the letters were written. Medicare has accepted some item numbers of treatment for relief of pain but again demonstrate a complete lack of understanding of dental practice and the general skills required to perform complex procedures.

- **Billing of a service prior to the service being provided**. In practice many dental procedures, especially more complex ones such as dentures and crown and bridgework, are spread over time and with multiple appointments. It is not an uncommon practice to bill patients for at least some of the work prior to the final issue of a denture or crown and this has been endorsed in the Australian Dental Association schedule of item numbers as a reasonable practice. Whilst not a common event it certainly occurs that patients do not reattend for completion of treatment leaving the dentist with out of pocket expenses and no remuneration for time already spent treating the patient, the practice of billing on completion at least allows the laboratory or practice overheads to be covered. Medicare however has taken a view that billing can only occur at the completion of treatment and that this widely adopted practice is tantamount to fraudulent activity.

- **The types of treatment provided**. Much emphasis has been placed on the provision of high end procedures such as crown and bridgework, dentures or dental implants and the implication that these types of procedures are either unnecessary or simply based on the desire to take more money from the system. The concept that most if not all crown and bridgework is cosmetic is completely erroneous. The majority of dentists would consider that much of their fixed prosthetic work is driven by functional needs rather than cosmetic. In cases where patients have been restricted in their access to dental care, the likelihood of large cavities or restorations requiring more complex procedures is quite high. Conventional fillings such as amalgam or composite resin are likely to fail more rapidly than porcelain or cast restorations.

Future Involvement

The actions of Medicare in chasing refunds of fees based primarily on compliance with technical aspects of the legislation is likely to have a detrimental effect on future participation by private sector dentists in government funded dental care.

Dentists as a general rule feel an obligation to try and help those within the community who are financially disadvantaged and require dental care. It is of course not appropriate that the small group of dentists should be the only ones who share the burden of providing care to the disadvantaged. In my experience the CDDS has enabled many needier members of the community to access appropriate dental treatment and stabilise their oral health. Whilst some abuse of the scheme may

have occurred it is certainly not of the scale often described by Ms Plibersek and in the media generally.

The outcome of the Medicare audits will, in all likelihood, be a reluctance to participate in government schemes if they risk being penalised for attempting to help those in the community who have often been unable to access appropriate dental care in a timely fashion. Furthermore it will increase the cost of dental treatment as dentists seek to repay debts incurred and an increase in mnay practice overheads such as professional indemnity insurance increasing by a significant percentage

Conclusion

Whilst there is no doubt that the CDDS was not an ideal solution for the provisions of dental care to many of Australia's disadvantaged population and something of a money pit, there can be no doubt that it has provided significant amount of benefit to those people who could access it. Whilst the notion of a universal dental scheme is unlikely to occur, a targeted plan aimed at improving access for Australia's disadvantaged, utilising private practitioners and a wide scope of practice should be the ultimate objective.

The majority of dentists did not participate primarily to gain significant financial benefit. In many cases the fee levels are below that required to run a financially viable dental practice. Many dentists are well aware that the costs of dentistry are prohibitive for some within our community and much pro-bono work is done by my profession. Critics of the cost of dental treatment are usually ignorant of the factors involved in a dental practice. Reviews of practice overheads consistently show that the costs of running a dental practice are around 70% of income generated, for many people in our community even if dentists dropped fees to a break-even point it would still be too expensive. The levels of rebates under the CDDS are in many cases were well below the 70% of normal practice fees.

Nobody has ever condoned fraudulent practice within dentistry or any other healthcare sector. If Medicare were to audit with an intent to target those who claimed for work that had not been commenced and with no intention of being done or other fraudulent intention then there is no doubt few within dentistry or the wider community would object to this process.

There exists in Australia a need to develop a system to allow better and more equitable access to dental care, especially for those who currently struggle to access care. For this to occur the Australian Dental community has to be fully involved and onside with the process. The current actions of Medicare seeking punitive and in some cases severely financially damaging actions against dentists and others who have failed to comply with mere technicalities will ensure that this cooperation is less likely. Whilst the government has an obligation to ensure appropriateness of any expenditure the truth is that the vast majority of dentists have contributed within the spirit of the scheme and have provided a beneficial service to their patients.

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Code	Age	Lives	First seen EPC	Billed	Employment	Bulk Bill	Medical conditions
1	62		20/12/2007		pensioner	yes	osteoporosis, hypercholesterolemia , psychiatric issues
2	76		7/01/2008	$3,694.35	pensioner	some	Heart attack, pacemaker
3	87		21/05/2008	$4,099.70	deceased	yes	dementia, elevated Blood Pressure, hypercholesterolemia
4	55		25/08/2008	$3,132.85	pensioner	yes	multiple psych and physical issues
5	73		5/09/2008	$1,788.50	pensioner	yes	Kidney, prostate cancer,
6	64		16/09/2008	$4,385.60	security guard	some	elevated Blood Pressure, cardio issues
7	65		2/10/2008		pensioner	yes	muscular dystrophy
8	67		11/11/2008	$4,434.35	pensioner	yes	diabetes, elevated Blood Pressure, hypercholesterolemia, stroke
9	75		11/12/2008	$2,373.10	pensioner	yes	Depression, elevated Blood Pressure, diabetes
10	57		30/01/2009	$3,407.30	pensioner	some	Sjogrens syndrome
11	52		26/02/2009	$0.00		no	Stress, hypercholesterolemia
12	83		31/03/2009	$2,466.25	retired	yes	renal disease, elevated Blood Pressure osteoporosis
13	54		17/04/2009	$349.50	pensioner	yes	Hypertension
14	70		21/04/2009	$3,785.30	retired	no	Paget's
15	86		22/04/2009	$1,382.40	retired	yes	Heart attack, elevated blood Pressure, Hypercholesterolemia, Parkinson's disease
16	77		7/05/2009	$1,479.05	pensioner	yes	Elevated Blood Pressure, asthma, gastric issues, cardiac disease
17	79		30/06/2009	$730.65		yes	Elevated Blood Pressure, depression
18	86		12/08/2009	$1,159.50	pensioner	yes	osteoporosis, elevated blood pressure, hypercholesterolemia
19	83		14/08/2009	$1,441.60	retired	yes	Rheumatoid arthritis, joint replacements, osteoporosis,
20	56		14/08/2009	$1,742.30		no	Arthritis, Elevated blood pressure
21	84		18/08/2009	$2,189.70	pensioner	yes	BP, osteoporosis, gastric issues
22	74		21/09/2009	$801.15	retired	yes	Elevated blood pressure diabetes, bleeding disorder, cardiac disease
23	54		28/09/2009	$257.70		yes	
24	55		27/10/2009	$980.80	retired	no	Diabetes, GORD
25	72		9/11/2009	$3,181.40	pensioner	yes	Elevated blood pressure, heart attack, asthma
26	62		10/11/2009	$2,329.05	nurse	no	infective endocarditis, faulty heart valve

27	79		30/11/2009	$4,105.40	pensioner	yes	Parkinson's disease, elevated blood pressure
28	84		18/12/2009	$938.35	pensioner	yes	Dementia, rheumatic fever, elevated blood pressure
29	82		5/03/2010	$759.95	pensioner	n	Elevated blood pressure, cardiac disease, osteoarthritis
30	65		19/03/2010	$1,739.80		n	Diabetes, BP
31	91		30/03/2010	$2,248.95	retired	no	Elevated blood pressure, cardiac disease, osteoarthritis
32	64		20/04/2010	$3,018.70		some	Carcinoma, depression, hypothyroid, hormone therapy
33	66		6/05/2010	$2,302.75	teachers aide	some	osteoarthritis, joint replacement, rheumatoid arthritis
34	33		10/05/2010	$348.00		no	Hep C, carcinoma
35	84		11/05/2010	$628.40	retired	no	Elevated blood pressure, GORD
36	85		11/05/2010	$217.70	retired	no	carcinoma, osteoarthritis, cardiac disease
37	66		20/05/2010		retired	yes	Elevated blood pressure, stroke
38	24		25/05/2010	$3,082.90	pensioner	some	Psychiatric illness, drug dependency
39	74		26/05/2010	$678.30	pensioner	some	Depression, osteoarthritis, cardiac issue, EBP
40	84		15/06/2010	$4,781.00	pensioner	yes	Heart disorder, hypothyroidism, depression
41	57		28/06/2010	$1,136.25	pensioner	yes	Diabetes, valve replacement, elevated blood pressure
42	64		15/07/2010	$449.15	pensioner	yes	Diabetes, elevated blood pressure
43	73		27/07/2010	$1,677.80	pensioner	yes	Heart disorder, hypercholesterolemia
44	72		3/08/2010	$4,290.85	pensioner	yes	Diabetes, elevated blood pressure
45	60		24/08/2010	$2,112.60	hair dresser	no	Liver and kidney disease, depression
46	52		26/08/2010	$764.70	teacher	no	Immunity issues
47	66		26/08/2010	$1,407.30		no	Elevated blood pressure, hypercholesterolemia, depression
48	62		16/09/2010	$182.00	pensioner	no	osteoporosis, Diabetes, asthma
49	77		21/09/2010	$857.15	retired	no	Sicca syndrome, gastric issues
50	40		1/10/2010	$129.00	pensioner	yes	Downs syndrome, multiple issues
51	71		7/10/2010	$1,818.35	pensioner	some	Elevated blood pressure, diabetes, asthma, anaemia, depression
52	86		19/10/2010	$854.80	pensioner	yes	Elevated blood pressure, hep C, osteoarthritis
53	54		1/11/2010	$135.90	retired	no	Diabetes, Elevated blood pressure
54	58		3/11/2010	$1,983.65		no	cardiac issue ,depression

55	84		11/11/2010	$300.80	deceased	yes	cardiac disease ,joint replacements, Elevated blood pressure
56	58		9/12/2010	$298.40	draftsman	no	Depression
57	28		18/12/2010	$70.00	pensioner	yes	Down syndrome, multiple issues
58	89		6/01/2011	$1,790.00	pensioner	no	Osteoarthritis, Elevated Blood Pressure, depression
59	50		25/01/2011	$257.00		no	rheumatoid arthritis, headaches chronic
60	85		21/02/2011	$0.00	not billed	not seen	arthritis, GORD, osteoporosis, hypercholesterolemia
61	59		22/03/2011	$527.05	pensioner	some	cardiac issues,
62	84		31/03/2011	$422.40	pensioner	some	Elevated blood pressure, osteoporosis, thyroid
63	68		11/04/2011	$287.05	retired	yes	Elevated blood pressure, Cardiac issues, diabetes
64	62		19/04/2011	$614.00	pensioner	yes	Sjogrens syndrome, osteoarthritis, osteoporosis
65	90		28/04/2011	$1,471.10	pensioner	some	joint replacement, elevated blood pressure, depression, GORD
66	48		16/05/2011	$1,121.95	bookkeeper	yes	Crohns disease, depression
67	76		17/05/2011	$251.80	pensioner	yes	elevated blood pressure, anti-coagulants, angina
68	92		17/05/2011	$1,773.00	pensioner	no	Heart, osteoporosis, multiple other issues
69	66		14/06/2011	$152.00	pensioner	some	hypercholesterolemia, depression, elevated blood pressure
70	69		16/06/2011	$229.00	pensioner	no	Stroke
71	87		21/06/2011	$40.50	pensioner	yes	osteoporosis, anaemia, hypercholesterolemia
72	77		22/06/2011	$0.00	pensioner	yes	carcinoma, rheumatic fever, glaucoma,
73	71		4/08/2011	$0.00	retired	yes	Heart attack ,Elevated Blood Pressure, hypercholesterolemia
74	84		9/08/2011	$0.00	pensioner	yes	Elevated blood pressure, carcinoma, cardiac disease
75	77		not seen	$0.00	pensioner	not seen	Cardiac disease , Rheumatoid arthritis, osteoporosis, elevated blood pressure, hypercholesterolemia
76	67		not seen	$0.00	retired	not seen	Elevated Blood Pressure, depression, joint replacement
77	75		not seen	$2,594.15	chef	no	diabetes, Elevated Blood Pressure
78	85		not seen	$0.00	pensioner	not seen	Cardiac disease, GORD, depression, joint replacement
79	79		not seen	$0.00	pensioner	yes	Joint replacement, depression
81	31		not seen	$0.00	pensioner	not seen	kidney transplant, vision problems
82	78				actor	yes	GORD, Elevated Blood Pressure

Average	69						