To: Senate Finance and Public Administration Committees

PO Box 6100 Parliament House Canberra ACT 2600.

Re: The *Health Insurance (Dental Services) Bill 2012 [No.2]*

I am writing to express my opinion and concerns about the conduct of the federal government over the past 2 years with regard to CDDS audit activity against the dental profession. Two of my professional roles, one as a dental specialist in the public dental service, at the , and the other as professional consultant for the , enable me to make a number of comments regarding the CDDS scheme, in particular the poor design of the scheme, the difficulties in interpretation of the scheme rules and regulations, and the stress this scheme has brought to bear on most members of the profession.

Firstly, in my capacity as a specialist periodontist working for for over 11 years I have had significant experience of treating underprivileged and chronically ill patients. I welcomed the introduction of the CDDS to assist with delivery of dental care to patients who spent lengthy times on public waiting lists. In my experience many patients who are forced to wait for dental care end up having teeth removed, which is a poor reflection on the government when in many cases this is preventable with timely intervention and loss of teeth has ongoing physical and emotional impact on patients.

The CDDS, by recruiting private dentists to assist with this group of patients, many of whom were waiting for public services, stood to be a great success in collaborative service delivery. I know that many of my colleagues who, being fully committed in the private sphere did not have the opportunity to work in the public system, participated in an effort to make a difference and contribute in a tangible way to an area of need. As overheads in a private practice are high many subsidized the delivery of care to CDDS patients or made losses in treating them.

In my specialty I treat patients suffering from diabetes and other chronic condition such as coronary heart disease, the very types of patients expected to benefit from the CDDS scheme. However, it has become evident over time that some referrals from medical practitioners as gatekeeper for referral of patients have included many patients with conditions which have no evidence based relationship to oral health.

MCA advice to dentists has been that they (dentists) are not the experts in being able to determine eligibility, and that once a referral has been initiated they must accept that the patient has an eligible condition. If dentists have

questioned medicos they have had to bear the brunt of criticism from them and anger from patients.

I believe that the criteria for CDDS referrals has not been prescriptive enough which reflects the poor planning and detailing of the scheme, low standard of documented information disseminated to both medicos and dentists and lack of direction to medicos about what evidence based relationships exist for oral and general health.

However I believe that many referrals have been genuine and assisted with keeping public waiting lists lower than would otherwise be expected.

Secondly, my experience in the public sector makes me familiar with administrative paperwork and distillation of information from a number of sources. However the CDDS scheme information I received initially when I was still in private practice (and by all dental practitioners) was not well documented or easily understood. Many dentists work in single person practices and may only deal with Department of Veteran Affairs, which over many years has provided succinct and easily understood directions for participation in the scheme. To my knowledge there have been no administrative problems with the DVA scheme and no cause for dentists to ring the ADAVB for advice.

Contrary to the DVA experience, an large portion of my time in my role as a professional consultant has been giving advice and trying to source answers to queries raised by ADAVB members about the CDDS. In many instances I have struggled to be able to interpret or answer due to the lack of direction in written information and the conflicting responses from Medicare staff. I have attempted to contact MCA for qualification or clarification many times and it is frustrating that a number of queries cannot be answered.

In my experience dentists are now spending an unrealistic amount of time on paperwork, getting negative feedback from medicos when they try to confirm paperwork has been received in order to verify that Section 10 requirements have been met, and have to spend time checking with MCA rather than providing services. Some are afraid to delegate to administrative staff as they know they will be responsible for any errors. This takes time from service delivery, adds to the cost burden and is a major factor in dentists opting out of the scheme and not being prepared to participate in any future one.

Examples of questions to which I have received conflicting answers are:

1. In 2011 the question about hygienists delivering care under the CDDS: I was informed by 2 staff that they did not know the answer but assumed that

hygienists could provide services: this was later confirmed by a call back from a supervisor. It is now understood that hygienists, who provide services under their employer's provider number for all other third parties, cannot provide these under CDDS.

It has been long recognized that efficient delivery of dental services needs the integration of auxiliaries in the dental team. By denying the ability of hygienists to assist chronically ill patients under the CDDS is in my opinion reprehensible as it disadvantages chronically ill patients who need maintenance of their oral condition to improve systemic health. The CDDS scheme should enable such care to be delivered in the private sector so this group of patients does not have to be on lengthy public waiting list to the detriment of their general health.

2. Process of providing paper work in the instance of a new referral being issued (at the beginning of a new year) when a course of care has not been completed: conflicting responses that

    a. yes, it should be treated as a new referral and paperwork repeated under Section 10, with a new treatment plan to be issued, and

    b. no, continue with the plan and no need to resend paperwork.

As there is no reference to what constitutes a course of care in any CDDS documents, or what to do at the end of a calendar year where treatment plan items have not been completed, the answer seems to be at the discretion of the MCA staff member.

3. Clarification regarding bulk billing or gap payment and use of the HICaps machine: the enquiry to confirm that part payments could be put through as per the MCA HiCaps information which contradicted the CDDS instructions took 5 phone calls and staff insisting that this was clearly answered on the website (it is not which is why I rang) . In the end it was agreed that dentists can still process the bulk bill payment through the HiCaps machine but I am nervous about giving this information to members as in the past incorrect information (about hygienists) was given. I find I am becoming more wary of answering member queries and do so with a caveat that "that is what MCA told me recently but it might change"

In my role at the ADAVB I have observed that

- All members of the profession are aware that there may be a small number of dentists who have acted inappropriately and have no hesitation in agreeing these dentists should be pursued

- All members I speak to are highly stressed about "getting audited" and having to refund money to MCA despite many having only received 40% of the total fee as an employee, or having paid out costly laboratory fee: all

realize the implications of this and that it will make their future practice precarious if not impossible if the debt is pursued.

- A number of older practitioners have voiced the opinion that these punitive measures are making them think about retirement. This is worrying as a large cohort of dental practitioners is approaching retiring age and losing them early from the workforce will make service delivery more difficult.

- Some dentists are very concerned despite having treated a small number of patients and the anxiety is affecting them personally or their practices.

    - One has a terminally ill wife and he is very concerned that he will be audited for 30 patients, 5 of whom did not meet section 10 requirements. At this stage of his life it is the last thing he should be worrying about.

    - Another country practitioner has been vilified by patients who have travelled long distances but is too afraid to provide services on the same day. His practice has lost a number of patients including families of the CDDS patients he has had to delay. They have threatened him with HSC notifications and accused him of lack of duty of care. He now worries that he will have to face an HSC case.

- Those who may have been non compliant in early stages with section 10, but are now compliant are still exceedingly concerned by reports in the media (despite MCA stating that leniency will be shown if they have changed behavior) about pursuit of debt recovery by MCA and many have stopped accepting CDDS patients to protect themselves from this threat.

- Many members have employed staff to administer the scheme, which has pushed up service costs. In many practices dentists do not make any profit from CDDS patients and this has been a real cost burden for practitioners.

- Many members state that they will not take part in any future dental schemes as they feel that the MCA is using the profession as scapegoats in a badly designed scheme which did not provide enough instruction for dentists prior to commencement or in the early stages when MCA first knew there were some administrative errors. Overwhelmingly dentists have become compliant once they were made aware of the requirements. Many feel that this has not been taken into account or publicized along with the non compliance issue.

In summary, I believe that if the CDDS had been a targeted scheme with better educational material provided to all dentists and medicos prior to introduction, section 10 breaches would not have occurred

It is a system failure of the CDDS not a deliberate act by dentists . Dentists routinely have to comply with numerous OHS and regulatory obligations, so the very fact that there has been such a dogs breakfast of the CDDS and no other compliance field surely indicates that it is not a mass decision on the part of dentists not to comply with CDDS, but an inherent problem with the scheme: otherwise dentists would be

breaching multiple regulations with subsequent prosecution evident across regulatory fields: and they are not!

The worst aspect for me personally is that as a public sector dentist, the punitive way that MCA has pursued dentists means that many will be unlikely to participate in any future schemes and so the more than 10,000 dentists that have assisted in provision of care to patients in need will cease, and waiting lists in the public sector can expect to sky rocket and once again public dental patients will suffer.

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