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SENATE STANDING COMMITTEE ON

COMMUNITY AFFAIRS

Monday, 27 August 2007

Members: Senator Humphries *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Allison, Boyce, Carol Brown, Patterson and Polley

Participating members: Senators Barnett, Bartlett, Bernardi, Birmingham, Mark Bishop, Boswell, Bob Brown, George Campbell, Carr, Chapman, Cormann, Crossin, Eggleston, Chris Evans, Faulkner, Fielding, Fisher, Forshaw, Heffernan, Hogg, Hurley, Hutchins, Joyce, Kemp, Kirk, Lightfoot, Ludwig, Lundy, Marshall, McEwen, McGauran, McLucas, Milne, Nash, Nettle, O'Brien, Parry, Payne, Robert Ray, Siewert, Stephens, Stott Despoja, Watson, Webber, Wong and Wortley

Senators in attendance: Senators Boyce, Humphries and Moore

Terms of reference for the inquiry:

To inquire into and report on: Health Insurance Amendment (Medicare Dental Services) Bill 2007

WITNESSES

Committee met at 9.32 am

HEWSON, Dr Neil David, Vice President, Australian Dental Association Inc.

Evidence was taken via teleconference—

CHAIR (Senator Humphries)—I declare open this public hearing of the Senate Standing Committee on Community Affairs. The committee is taking evidence today on the inquiry into the Health Insurance Amendment (Medicare Dental Services) Bill 2007. I welcome Dr Neil Hewson from the Australian Dental Association, who is joining us by teleconference.

Dr Hewson—Good morning.

CHAIR—Good morning, and thank you very much indeed for taking this call from us. I am Gary Humphries, the chair of the committee. With me in the committee room are Senator Claire Moore from Queensland, who is the deputy chair, and also Senator Sue Boyce from Queensland. Are you in Sydney, Dr Hewson?

Dr Hewson—I am actually based in Melbourne.

CHAIR—Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you, I understand.

Dr Hewson—Yes.

CHAIR—We have the submission that the ADA has provided and we thank you very much for that. Would you like to start with an opening statement about the issues that the committee is looking at? We have some questions to ask you but we are happy for you to make a statement to kick off.

Dr Hewson—Sure. Firstly, the ADA is very happy that the federal government has recognised that it does need to play a greater role in the provision of dental care to Australians, so we welcome this amendment to the act so that people will receive benefits if they have chronic disease. The ADA is also very pleased to see that there is some recognition of the importance of dental health and its relationship to general health.

We also note other federal government initiatives in recent times, including increased Commonwealth supported places to existing dental schools, the establishment of the School of Dentistry and Oral Health at Griffith University and the proposed establishment of a school of dentistry and oral health at Charles Sturt University, more rural clinical placement funding, the undertaking by the minister to conduct a dental workforce review, and dental scholarships for Indigenous students. However, the ADA strongly believe that the model of delivery that has been proposed is not appropriate for dentistry and for targeting those most in need.

I would like to make some comments about our position regarding Medicare in general. The ADA and others believe that Medicare is not a suitable vehicle for the delivery of dental care. The author of the original Medicare plan, Professor Deeble, recognised this and stated that the provision of dental care should not come within Medicare. He is quoted as saying at the first Senate select committee that the main problem with Medicare covering the dental industry is its basic uninsurability. He said:

… insurance works for best for things that are episodic and unpredictable. Dental illness is slow: it is not episodic and it is not unpredictable, because you know you have it for quite a long time. You do not suddenly discover that you have a dental problem. It should be treated, but it should not be treated within an insurance approach.

Two other Senate select committees have also concluded that Medicare is perhaps not the appropriate vehicle for delivering dental programs.

The ADA reaffirms its view that any dental program should be selectively targeted for those most in need and that there should be other programs with regard to whole-of-life preventative initiatives. With regard to the revised EPC program, there are positives in that, and one is the inclusion of dental prosthesis, which will create more comprehensive and effective outcomes for many patients. Another is the increase in funding available for dental treatment from the proposed $2,000 per year to $4,000 over two years, which effectively will mean that more people will be able to obtain a complete course of treatment than would be able to if the quantum were confined to $2,000. So this is an improvement on the scheme that is currently in position which, up till now, has failed.

We believe there are negatives to the scheme. The first and most important is that it is not targeted to the financially disadvantaged, when it should be the case given that limited funding is made available. Under this proposal, the very wealthy are still covered. It does not have the limitations on frequency of replacement of dentures, as is the case with the DVA program, and it does not utilise dental experts, as is also the case with the DVA program. The proposed rebate level of 85 per cent of DVA fees, a discount on already discounted fees, will make it extremely difficult for dentists to provide treatment on a rebate only basis. The development and inclusion into Medicare of more dental items outside the universal coding system, the Australian Schedule of Dental Services and Glossary, adds confusion and is not required.

The ADA does have a view on how the federal government could have a role in dental health. The ADA also understands that it will take time for measures—for example, the increased training numbers—to take effect. The ADA believes that the federal government could do the following things to improve the community's dental health. It could train adequate numbers of dentists and allied dental personnel. Steps have already been taken in this direction; however, as promised by the health minister, a review should be conducted before any more new dental schools are established. It could fund a dental program structured on the DVA scheme and targeted to the financially disadvantaged, with conditions on states to fund their programs to agreed levels. Such a program should cover the minimum costs of basic dental care. It could fund a postgraduate clinical placement year—which could also be called an intern program—with the states providing the infrastructure and the clinics. This would greatly assist with workforce shortages and would provide services in rural and remote communities and in the public sector. The government could fund oral health promotion as per the smoking cessation and the skin cancer promotions, which are already being done by the federal government. This is an investment in the future to save costs by reducing the need for dental treatment. It could promote and fund universal prevention measures such as water fluoridation. The ADA remains committed to assisting all governments to find the best ways to improve the community's oral health.

CHAIR—Thank you. I will ask you some questions that will allow us to go individually through the issues that you raised about the reasons that the Medicare model would not be appropriate for dental services. It is likely that a first blush impression of that comment would, on the part of someone who has worked with the present system, be that we already have a system for rebating health costs—for covering health costs and supporting the cost of those things—in the hands of the patient—that is, the Medicare system. I assume that the suggestion you are making is that a separate and different model needs to be established for dental services and it would be a departure from that and potentially more complex and costly administratively. Can you again run through the particular issues that you said would necessitate a different model from Medicare for dental services?

Dr Hewson—Ironically, one of the problems with Medicare is that it has certain rules that suit medicine but do not suit dentistry. That is part of the reason—

CHAIR—Give me some examples of those.

Dr Hewson—Universality is one. Government-funded schemes should be targeted and should not be universally available. I cannot remember all the other changes that would have to be made to the system. You do have an administrative model that works really well—that is, the DVA scheme. We believe that if you have got something that works really well in dentistry why not use that as your model and expand on that.

CHAIR—I am not familiar with the DVA scheme, and I am not sure that the rest of the committee is. Can you outline the reasons that that model is better than the Medicare model?

Dr Hewson—One of the other things that I do not think you can do under Medicare is put in limitations. For example, dentures can only be done every eight years or so under the DVA model. One of the other things that we believe is really important is that the DVA model has dental advisers who can keep an eye on things to make sure that people are not abusing the system. But, importantly, when you have people who are special cases, they can assess them and make sure that those people get the appropriate treatment, even though it might be 'outside' the normal run-of-the-mill regulation for that system. The DVA system has been in place for many years now and the advisers are extremely important and very helpful; they help people like me to give appropriate treatment to special patients. I might only need to use them once or twice a year, but when I do it is important to get a good outcome for that patient.

CHAIR—These advisers are advisers to the dentist, not to the patients?

Dr Hewson—No, they are employed by the Department of Veterans' Affairs, so they give feedback to the department on how the system is working and all that sort of stuff. Also, if they suspect that someone is rorting the system, they can detect that. If I have a special patient I might have to write a written report about that patient, which goes to the adviser. That adviser will then see whether it is a legitimate case and, if so, approve the proposed treatment plan or, if not, not approve it.

CHAIR—You mentioned the unfamiliarity of dentists with the way in which the Medicare system works. In your submission you say that, because of the low returns with the present rebate arrangements or the present item numbers that you can access through Medicare for dental services, most dentists have consciously stayed away from the current scheme. That is partly, I assume, to do with a lack of education of dentists about how Medicare works and

about how they can use it. Do you think there is likely to be a lot of consumer resistance, as it were, from dentists to become involved in the Medicare system?

Dr Hewson—I think part of that has been solved by Medicare adopting the Australian Schedule of Dental Services and Glossary coding systems, so that will make it a lot easier. That was one of the problems. But also the interaction between doctors and dentists was a problem. To be fair, that is one of the things that has been approved and one of the things that we have worked very hard on with the department. They have worked very hard to make that more user friendly for dentists; therefore making it easier to accept because of the administrative loads.

CHAIR—If this legislation is passed do you think, though, that there should be an active program to educate dentists about how Medicare works and to smooth the process of them becoming major users of it?

Dr Hewson—Of course. When the first program was introduced, the ADA, both federally and through its branches, ran a lot of articles, provided information to members, and there was a booklet. We have done it in the past and we will do it in the future. But we are all creatures of habit and dentistry is locked into a system of how it describes dental treatment. So any system to make it smooth and easy to be administered by dentists needs to have the same sort of system; as I have said, the adoption of those dental item numbers by Medicare will help a lot in that regard.

CHAIR—Finally, you are saying to the committee that you think that dental services should not be based on the universality principle that Medicare works on, that they should be means tested, in effect, so that the funding is directed to those on the lowest incomes?

Dr Hewson—Yes. One of the things I did not mention in the government initiatives is the rebate on health insurance, and so that also applies to ancillary cover. The recent national oral health survey clearly showed that just over half the Australian population were managing their dental requirements very well under the existing system and yet half were not because they are extremely disadvantaged and just cannot afford it—I think they called it the two Australias—and there are other people who perhaps need to be encouraged to make dentistry a higher priority. We think if you have that sort of divide, you should concentrate on those in most need. The other thing is that, if dentistry did come fully into Medicare, the overall costs would be large. Currently, the total spend on dentistry is about $5 billion, so you could imagine that, if it came under Medicare, the total cost could be anything up to $10 billion.

CHAIR—Thank you for that.

Senator MOORE—Thank you for the submissions. We have a couple. I am interested about the interaction between the ADA and the department and/or the government about the development of these processes. I know that you have a strong lobbying program, and I am just trying to find out, in terms of interaction, what role your association has had in the development of the way these policies will work.

Dr Hewson—We, with a lot of other people through the National Oral Health Alliance, have lobbied the federal government to take a role. We have spoken with both sides of the House about our view, which I have already explained to you, and then, once the government decided to go down a certain path, we had three or four meetings, I think, with the department

to try and make the EPC program, given all its constraints, as user friendly and as good as possible.

Senator MOORE—We have had quite a fulsome submission from the department. My understanding is that this round of dental projects has been built on the previous enhanced service delivery program that came out a couple of years ago. Was your association involved in any review or assessment of the previous scheme to see how it worked and, hopefully, to see whether the new round could be better?

Dr Hewson—I do not know whether we formally were, but certainly, in our discussions and our meetings with the department and our discussions with the minister and the shadow spokesman, we have expressed our concerns with the program.

Senator MOORE—Can you find out, just in terms of process, whether your organisation was formally approached about the previous round of enhanced—I forget the term, but you know what I mean—

Dr Hewson—Yes.

Senator MOORE—Was there any formal arrangement, as the chief professional group in the industry, to see what your concerns were and to give formal feedback? I totally understand the fact that you are regularly, through the National Oral Health Alliance, working with everybody, but, as it has been made clear to us that this is building on the previous program, I want to see what the process was to evaluate the previous program before going forward with the new one. I would just like to find out whether there was a formal approach. That would be good.

Dr Hewson—I will follow up on that for you—

Senator MOORE—That would be great.

Dr Hewson—but I can recall that we did have a meeting some time ago to get some feedback on that.

Senator MOORE—Good. When the first round was brought in, and also during the process after that, one of the questions that arose was the interaction between the medical practitioner and the dental practitioner. The programs rely on a referral from a doctor, and there was some discussion about how that worked and what the process should be. You refer to that in the submission. Could you let us know how you believe that is working and what that link is with the clear understanding that this program is only available if the dental issues can be linked to another chronic disease?

Dr Hewson—I think we understand that pretty clearly. In the past system the paperwork was a bit cumbersome, but I think that that has been addressed. We have had discussions with the department about conditions and the various relationships between dental health and chronic diseases, so that has been one area that I think has been pretty productive.

Senator MOORE—Is that done at the local level? The way I read it—and I have not read all the guidelines, and I really should, and I know that the new round of guidelines has not been not written yet—the process is that a local GP determines that their patient has one of a list of conditions that could be affected by their dental health, and then they refer to a local dentist. Is that how it goes?

Dr Hewson—Yes.

Senator MOORE—What kind of paperwork does the local dentist have to look at to make sure that it is all kosher?

Dr Hewson—I do not know the details of that—

Senator MOORE—Okay, I will follow it up with the department.

Dr Hewson—but I do know that we have discussed it and that the process will be more efficient and easier to do than it is currently.

Senator MOORE—In terms of the amount, we know that the previous program had a limited number of visits per year. The new program has a significantly enhanced amount of money and a patient can have work done to that level. Can you give me some idea of what 4½ grand covers in dental terms? I go to the dentist regularly and sometimes I pale when I see the bills. What kind of value is 4½ grand of dental work—what can it achieve?

Dr Hewson—If it does not involve really complex treatment it can achieve a lot. The Australian Dental Association is really happy that the amounts have been increased and that it is not now connected to the safety net—it is separate in that way—so we are quite happy with that. But if someone needed a couple of crowns, that would take up maybe $3,000 of it.

Senator MOORE—I will get some more detail from the department. To me, the figure is just one of those things—until you see the schedule and what it covers it is hard to get an idea.

Dr Hewson—The schedule is pretty comprehensive. A few things have been taken out. One of the reasons it is important is that often people who are chronically ill and have a lot of problems are also people who have very bad dentition and they are not able to be brought back to dental health very easily.

CHAIR—What is it that you said?

Senator MOORE—What is dentition?

Dr Hewson—Your teeth.

Senator MOORE—They have bad teeth?

Dr Hewson—Yes. Those two things often go hand in hand. That is one of the things we discussed early on. It is really good that the government took that on board, particularly allowing the $4,000 to cover two years but being able to have the work done in a year. You can get someone dentally fit without having to delay it—an excellent initiative.

Senator MOORE—Is that a term that is used—'dentally fit'?

Dr Hewson—Yes.

Senator MOORE—It makes sense to me but I have just not heard it before. So you are talking about someone's whole dental fitness?

Dr Hewson—Yes.

Senator MOORE—That leads me to my last question, which is about now being able to get dentures and other prostheses. There seemed to be a huge issue with the previous scheme

in that dentures were not covered. Under this one they are allowed to be covered. Are there any limitations from a dental point of view about what you can and cannot provide?

Dr Hewson—I do not think there are; that is one of our points. Under the DVA scheme—

Senator MOORE—There are limitations with time.

Dr Hewson—there are limitations as to how often you can replace these things, but this proposed EPC scheme does not have that. This is another one of those examples of where the Medicare rules do not often fit in very well with dental issues. We would suggest that there should be some limitations on that. With that rule, if there is a special case—it is justified and argued—it is one of the things you could go to the dental advisers for. They can assess it and say, 'Yes, this person does need to have dentures a bit earlier.' That ties together quite nicely the two things we think any dental scheme should have.

Senator MOORE—I have another question; your answer reminded me of it. I am interested in the dental adviser. In your submission and a couple of others we have a comparison of the DVA scheme and the enhanced scheme that the government has put forward. We hear many complaints from DVA people about their access to services. In terms of the dental advisers I am interested to know, from the association's point of view, how such a scheme would work within this program if it were to be considered and what the value of those people are. You mentioned it in your verbal submission but there seems to be a core difference. I will be asking the department as well from their understanding. We do not have a national dentist in the way we have a national physician or a national scientist. Also we had the chief medical—

Dr Hewson—Chief dental officers.

Senator MOORE—I know that in the past your organisation has been quite keen on having a national dentist, or whatever the right term is. But in terms of the advisory network and the enhancement of the program, how would dental advisers—which I know are in the DVA system—be able to operate within the system, however it pans out?

Dr Hewson—One important thing is that they are responsible to whatever scheme they are in—so they are responsible to the DVA system, not the providers. They are very useful for two reasons. Firstly, they are a good means of detecting 'medi-fraud', or whatever you like to call it—and unfortunately all professions have people who are likely to do these things. But the best thing—and you have to have rules in any scheme or it will not work—is that they enable people under, say, the DVA program to be treated properly outside the rules. They allow for special cases to be treated adequately and properly. That is their greatest value. Secondly, they are a good form of feedback for the government on how the scheme is going, where the problems are and how it needs to be modified and all that sort of stuff. They provide an independent or in-house resource to monitor any program as well.

Senator MOORE—So it is like an advisory council?

Dr Hewson—Yes.

Senator MOORE—From what I can see, every government has some sort of advisory council—ministerial advisory councils or professional advisory councils—that feeds in to

enhance knowledge and interaction. Is there anything of that kind in dentistry that you are aware of?

Dr Hewson—No, not that I am aware of. They are the only people I know, and they certainly do have that role within DVA. That is quite useful because the bureaucracy is constantly changing and people move around. So to have expert advice within your own system and not to have to rely entirely on lobby groups like ours is a really valuable thing for any program to have.

Senator MOORE—And you also link in the state-federal alliance. We all know that dental care relies on effective services at the state and federal level, but some kind of ministerial advisory group would be able to have state people on it.

Senator BOYCE—Dr Hewson, you spoke a number of times about the potential for people to be able to abuse or rort the system, as compared to the DVA system. Could you give us some examples of the way people might do that?

Dr Hewson—One example is dentures. You can make a denture each year. That would be one way. But you can propose a service in any health program. Where the advisers come in is that they have a bit of an idea of the patterns, so if something is a bit unusual they can detect it. The other thing is that, if something is unusual and it is genuine, the dentist can approach those people and talk to them about that case beforehand.

Senator BOYCE—I was just having trouble imagining someone rushing in to have extra fillings put in or something. I was wondering what sort of—

Dr Hewson—They might want a crown when something else might be quite adequate, or something like that. Patients might want to use the system, even though they are dentally fit, to have different types of restorations.

Senator BOYCE—As I understand it, the GP would not be referring people if they were dentally fit. Is that your understanding of it?

Dr Hewson—Yes, it could be.

Senator BOYCE—I am interested in the eight-year time limit on dentures within the DVA system. Could you explain how that was arrived that?

Dr Hewson—I think that just happened over time. Usually people need to replace dentures only if their mouth changes shape. Normally that only occurs over a long length of time. Your jaw has a base structure and then it has what is called the alveolar part, which is the special bone that holds teeth. When you extract teeth, there is no longer any function for that special part of the bone, so it tends to resorb away with time. It is progressive and goes on all the time, so dentures will eventually not fit because of that. So it was found over time that the eight years was an appropriate length of time and that, for most people, their dentures would remain and fit well within that time frame.

Senator BOYCE—Would you expect that, if most people's dentures were comfortable and functional, it would not be very likely that they would want new ones?

Dr Hewson—You might like a spare one, for example. If you drop one and it breaks, it is handy to have another one.

Senator BOYCE—As someone who leaves reading glasses all over Australia, I understand that.

Dr Hewson—It is a system that seems to work really well. As I said, if people do need them before that, the dental adviser role helps those people. No-one is missing out. I guess it is a bit of a mechanism for containing costs.

Senator BOYCE—We have received a submission from the Australian Dental Association and a submission from the Queensland branch of the Australian Dental Association. They comment in their submission that about 85 per cent of dentists are currently in the private sector and that there would appear to be adequate spare capacity to fill the need anticipated by an increase in dental services that would come through here. We have also had a submission from the Australian General Practice Network, expressing concern that the new arrangements may only benefit those in communities well served by dentists, which they characterise as 'central business districts and middle-class residential suburbs of major population centres'. I was wondering if you would like to comment on those two different approaches.

Dr Hewson—Ironically, my practice is in a low-socioeconomic area. When the Commonwealth Dental Health Program was in operation, we were able to see patients under that scheme. It will depend a little bit on location. There will be some rural and remote practices that will struggle because they are flat-out now. But, by and large, I think the experience with the Commonwealth Dental Health Program and under the voucher systems when they have operated in various state jurisdictions have shown that the profession is willing to see these patients. The people are spread over all practices, and you do not need each dentist to see a lot of these people a week. So I think there is a pretty good capacity to handle this. Of course, we currently have a workforce shortage and a maldistribution of the workforce. A lot of that, hopefully, will be addressed with the increased numbers that are now training.

Senator BOYCE—Due to the fact that this system will enable dentists to fill any spare capacity in practices that are not in very big population areas, I was also wondering if there might not be some potential to encourage people to set up practices in areas that they may not otherwise have seen as having a critical mass to support a practice.

Dr Hewson—I do not know whether there are many areas where that applies. I suppose that would apply in very small rural areas. It may, but I do not know. I do not really have a view on that.

Senator BOYCE—The Queensland submission says that child tooth decay rates are increasing. Would you talk a little bit about that and about what the Dental Association's response has been?

Dr Hewson—They are increasing a little bit but they are increasing from a very low rate up to a tiny little bit, so it is still a very small increase. The latest figures that have just been done indicate that they are perhaps now plateauing. The reasons for these we are not absolutely sure of. One of the possible reasons is that people are using a lot of bottled water which does not have fluoride in it. Another possible reason is this: to reduce mottling of teeth

and fluorosis of teeth, the current recommendation is that children under six use low-fluoride toothpaste. That may be having an effect as well. That is still something that is being monitored. We are still not sure why that has actually happened, but I think that, encouragingly, it looks like that little increase may be now plateauing out.

Senator BOYCE—Can you put a percentage on that?

Dr Hewson—We could send you that. But we are going from nearly the best decayed/missing/filled rate—DMFT is what it is called—in the world to what is still nearly the best, so it is not a huge, dramatic increase. But of course any increase is very worrying, so that is one of the things that are being monitored quite closely.

Senator MOORE—I am following up what Senator Boyce asked you. The national oral health survey seemed to indicate that some more research is going to be needed generally but also in particular on an issue of the fluoridation debate, which is always raging in Queensland, that unless people get their fluoride as children there will be a question about how effective it will be. Is that right? I remember reading something of that kind in that survey book.

Dr Hewson—The main effect of fluoride is now believed to be an ongoing one. Fluoride is actually really important for older generations too because a lot of older people have gums that have receded and so the roots of their teeth are exposed, which are softer and more susceptible to decay. Fluoride has a topical effect which is important. It also interferes with some of the bacteria that produce the acid in the plaque that causes decay. While it has some role in the formation of the tooth, it is more the ongoing thing—so it is not the case at all that it is only beneficial to children.

Senator MOORE—I am constantly surprised by how strongly people have views on fluoride. It ignites a room, particularly an ALP conference. Is there anything that you want to add, while you have got the microphone, in terms of the need for ongoing research into the whole area of dental services and dental care?

Dr Hewson—Yes, I think there is. The workforce is one of the things—not only the numbers, but the mix of it. One example is that the Charles Sturt set-up is going to be half BOH and half dentists. We would argue that in a rural area you actually need dentists. In fact, you might even need to have a program where dentists do another year before they practise rurally, because in rural and remote areas you are on your own and you do not have the support systems and you are not in a position where you can refer things off, like I can here in metropolitan Melbourne—so there is research needed there. I am sure that if you asked us we could come up with other things that need to have more research done into them.

CHAIR—Dr Hewson, thank you very much for your evidence today. It has been very useful as a way of kicking off our inquiry this morning. Thank you for the submission that you provided as well.

Dr Hewson—My pleasure.

CHAIR—You have taken a couple of things on notice.

Dr Hewson—Yes, the child decay rates and the formal arrangement regarding the feedback on the current enhanced primary care system.

CHAIR—We have to report by the middle of next week, so it would be of great benefit to the inquiry if you could provide those to us as early as possible.

Dr Hewson—Okay.

CHAIR—Thank you.

Proceedings suspended from 10.15 am to 10.29 am

ECCLES, Mr Richard, First Assistant Secretary, Primary and Ambulatory Care Division, Department of Health and Ageing

ANDREATTA, Mr Lou, Assistant Secretary, Primary Care Financing Branch, Department of Health and Ageing

CHAIR—Welcome. I think you are familiar with the information on parliamentary privilege. As departmental officers, you will not be asked to give opinions on matters of policy, although this does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. We thank the department for its submission. Would you like to make an opening statement about the issues before the committee?

Mr Eccles—No. However, there are a few items that I think it would be appropriate to clarify, given the evidence from the last speaker, but I am sure they will be picked up in the planned questions and answers.

CHAIR—I would expect so.

Senator MOORE—Mr Eccles, you will give them to us at the end of your submission, if none of us has been astute enough to ask those questions.

Mr Eccles—Indeed. I have a list.

Senator MOORE—I am just wanting to make sure of that.

CHAIR—I am sure we will be astute enough—but just in case. How is the $4,250 different from other Medicare item rebates? Are there other services or items available through Medicare that have a financial cap?

Mr Andreatta—The majority of items on the current Medicare benefit schedule are a fee-for-service arrangement. There are limitations within the item descriptors on some. This means that you may be limited to three of those particular services per year. With the dental measure, we are talking about a limitation of a course of treatment for a period rather than a limitation of a particular service.

CHAIR—Let me give an example. I suppose dialysis is not a good example because that is usually done in hospitals. Let us say that I was sick and had a need for ongoing access to a particular item number.

Mr Eccles—Care plan, maybe.

CHAIR—Care plan—okay. If, over the course of a year, I were to run up $6,000 in total expenditure on that item through a Medicare subsidy and my doctor bulk-billed, the total $6,000 is covered by Medicare, isn't it?

Mr Eccles—That is right.

CHAIR—But, if I had an equivalent chronic condition that led to $6,000 worth of dental care expenses, expenditure by the taxpayer would be limited to $4,250, wouldn't it?

Mr Eccles—That is right.

CHAIR—Is that situation paralleled in any other area of Medicare?

Mr Eccles—No.

Mr Andreatta—Not in Medicare.

CHAIR—Could you explain how a course of treatment over two years works. Let us say that I need dental care. It is provided over two years but three years later I need the same kind of care again. Can I access it again?

Mr Eccles—Yes, you can, but you need a new referral from your GP. There would be no problem at all with that. I think there are limitations on some items. Mr Andreatta will go into detail about dentures. That is a good point to clarify as it was one of the issues raised before. There are limitations on how often you can get dentures.

Mr Andreatta—Correct. We have adopted a similar policy to the DVA schedule—that is, dentures are limited to one set every eight years. However, after the eight years, we allow new dentures on exceptional circumstances—breakage or loss. So, in that respect, we have mirrored the requirements in the DVA schedule.

Senator MOORE—Is that within the eight years?

Mr Eccles—Yes, it is within the eight years. Generally speaking, it is one set of dentures per eight years, but, if there are exceptional circumstances, there is going to be no problem with accessing the second set.

CHAIR—In what way is this course of treatment limited to the two-year period? Let us suppose that I had a series of work done on my mouth over three years. Why am I not covered for the third year?

Mr Eccles—You will be, but what happens is that you are entitled to $4,250 every two years and, at the end of those two years, you basically get cranked back to zero, and then you can access another $4,250. Initially, as announced, it was $2,000 per year but, in the detailed discussions with the industry and after further consideration, it was thought that it would be beneficial to have a two-year limit at a much higher rate, to enable people to get higher-cost procedures, like a set of dentures, without forcing people to have high out-of-pocket costs. If, for example, you received $3,000 worth of treatment straight up, you would be able to access a fuller rebate.

CHAIR—Understood. I will ask one further question and then invite my colleagues to ask questions. On the idea of a chronic condition being associated with poor oral health: it is a very difficult, an almost philosophical, argument, as to whether the poor oral health leads to the chronic condition or whether the chronic condition leads to the poor oral health. We have heard, for example, in another inquiry that people with poor oral health very often suffer from poor cardiac health. Is there any sense that one needs to lead to another? How clear are the connections? How clear do the connections need to be? For example, if a person suffers from a weak heart or has cardiac problems, can it be assumed, because of that other evidence just referred to, that there is a general association—that therefore whatever they need to do to their dental position is covered by this rebate?

Mr Eccles—Professor Horvath alluded to this at Senate estimates. Our understanding of the impact of poor oral hygiene, poor dental health, on chronic conditions is growing all the time. In particular, there is a growing body of evidence about the link between heart disease

and poor dental health. It is important to bear in mind that this is about people presenting with chronic conditions where, in the GP's view, they would benefit from dental treatment. That could be early-stage gum disease, acute infection or a whole range of things, but the focus is very much on people with chronic conditions who do need dental health care.

CHAIR—Because of that chronic condition?

Mr Andreatta—No. Under the enhanced measure that we are talking about now, people would be eligible to access these items where their oral health is either impacting on their medical condition, their chronic condition or their general health. So it is a broader eligibility criterion that we have adopted.

Mr Eccles—It is the same pathway into the general practice—it is people with team care plans or people who are under a GP management plan where, in the doctor's view, their oral health is impacting on, or is likely to impact on, their health.

CHAIR—So if I have, say, shingles, I am not going to be able to access this?

Mr Eccles—I am not a doctor but I do not think shingles is a chronic disease. But if you had diabetes and, in the doctor's perspective, your poor oral health was impacting on that, then there would be no problem—you could enter the pathway, if you like, and be referred on.

CHAIR—Do you regard it as being relatively clear to both doctors and dentists how this will work? Do you think you will be fielding many questions from people asking, 'Is this covered? Is that covered?'

Mr Eccles—There is no doubt we will, although the discussions we are having with GPs, at the GP groups, indicates that they believe they are clinically capable of assessing the eligibility against this criterion that is going to be in the MBS item without too much additional guidance. That said, we certainly have plans for information to go out to all GPs. We may sponsor some education programs as well, to make sure that GPs are fully aware—given that they will be the gateway—of the opportunities and options under this.

Senator MOORE—Thank you for the submission, particularly attachment B, which I found very useful in terms of trying to get my head around what we have already been talking about.

Mr Eccles—Was that the case study?

Senator MOORE—No. It was the comparison between existing and new MBS items. We have been talking about the previous scheme for a couple of Senate estimates, trying to wade through how it is working, whether it could do better and why there are so few. We have been dancing through that, and to see this is very useful to try and get our heads around the difference. The point that you were just discussing with Senator Humphries about the difference in eligibility criteria seems to me to be quite significant from the old one to the new one about changing the onus. Is that purely a GP's determination or are there going to be guidelines that tell them how it will operate?

Mr Eccles—It will be a GP's determination to interpret the guidelines, if you like. As is standard practice, we develop the Medicare benefits descriptor, which will outline for the GP the circumstances that they can refer on to a dentist, but it will be left to their clinical judgement.

Senator MOORE—I would imagine that there is a degree of rewriting that has to happen because we are going from three to a number of new ones.

Mr Andreatta—But we are looking at around 450 new items; it is a schedule of items.

Mr Eccles—Something that came up before in the earlier evidence was that this will be based quite largely on the DVA schedule, which is one of the things that resulted from the consultation that we had with the ADA.

Senator MOORE—I know that throughout the process there is a link with the DVA one, and we have now got the DVA fact sheet on their dental services. Do you know how many of the 450 are mirrored in DVA? It would be very useful to have another box with the DVA.

Mr Eccles—We will be able to do that soon. The schedule is not finalised yet. Once the legislation goes through, then the schedule gets finalised. Obviously, we have got drafts and have been working with the ADA but I think it is fair to say there is substantial mirroring of items even down to the numbering that they use to minimise the administrative burden on dentists. I think it is fair to stay that there is substantial mirroring of the item types and descriptions.

Senator MOORE—One of the submissions—and I am sure you have read all of them, Mr Eccles and Mr Andreatta—makes the point that dentists are used to working with a current system and their whole administrative system is based on that. One of the submissions talks about how they have got so many codes and the Medicare process, with which they have not had a great deal of familiarity until now, is going to have another series of codes imposed over it.

Mr Eccles—When we were trying to establish what may have been suboptimal with the last program, we spoke to the ADA. We undertook a series of visits to all the state branches and we held a formal meeting at the request of our minister with the ADA. One of the key messages from them was to optimise uptake and minimise the administrative differences between the tried and true process and whatever you wanted to bring in. That is essentially one of the reasons why we are focusing on the DVA schedule.

Senator MOORE—We have got the aims of the legislation. We have not had overall expectations of the actual detail about what is going to be covered and how. When do you think that will be available?

Mr Eccles—Very soon after the legislation has passed it will be the subject of a ministerial determination as a standard practice for these things, so it will be at that point.

Senator MOORE—I have to state my standard problem in terms of approving things without knowing what the detail is. Until you see exactly what is going to be covered by the new process and how it is going to work in the system, it is difficult to get a sense—

Mr Eccles—I think the issue you are striking at is the parliamentary process where the legislation does not go into the administrative details.

Senator MOORE—Yes. We have got a proposal that this is going to be how the new scheme will operate and we have 450 new MBS items which are going to be picked up by this legislation and we do not know what they are.

Mr Andreatta—We could give you the broad description of what they contain. We do have that. They are based on the DVA system. It is almost identical.

Senator MOORE—Good. That would be really useful. Senator Boyce was talking about this in her previous questions. The DVA system is operational. The previous enhanced system with the dental process—there were lots of questions about why more people did not use it and we had discussions about that. The government is introducing a new one, which you are implementing, so we know what is covered. If you have a family that is DVA covered, you can see what has gone wrong with that system, if anything, to see whether you have learnt from that in the new one. It is that whole process.

Mr Eccles—We will liaise with our minister's office and find out—

Senator MOORE—What we can get. It is a huge increase—from three, which we have had since 2004. Is that right?

Mr Eccles—Yes.

Senator MOORE—There have been three items, and now there are going to be 450. That is a huge difference.

CHAIR—Following on from that question about the guidelines, will these things that Senator Moore has been talking about be disallowable instruments?

Mr Eccles—Yes, they are ministerial determinations, so they certainly will be—

Senator MOORE—So they will go through regs and ords, won't they?

Mr Eccles—Yes.

CHAIR—We theoretically could call them in to get looked at.

Senator MOORE—Yes. It is on ongoing issue. You have heard us ask about the legislation and the guidelines, and the actual nuts and bolts are still being written. It is difficult. get that to us, if you can, after you get the ministerial approval. Let us know if we cannot have it, and we will ask why—though that will not be a question for you. There have been a lot of concerns and questions and media reports about dental. It would be very useful if you could tell us what is covered and what is not.

That leads me to my next question, which I asked the previous witness. Where does the figure of four and a half thousand dollars come from? Is that based on anything? You did tell me that when it was first being discussed it was $2,000 a year, and that was out in the public domain. Where has $4,250 come from? It sounds like a lot but—

Mr Eccles—It partly came from a discussion that we had with the ADA towards the end of last year about what kinds of things could be expected when someone with a chronic condition needs to have some sort of restorative or dental care. We had to find a figure essentially somewhere and the science behind it was working with the profession to understand what fairly comprehensive treatment regime may be needed for these sorts of things. It would be expected that $4,250 over two years would be able to cover not only the more basic things—the cleaning and the counselling and the advisory functions—but also some of the more complicated aspects like extractions and partial upper and lower dentures; they should be able to fit in around that figure. There are a whole range of different items. The

figure of $4,250 reflects our judgement on what would be a suitable upper limit for the range of care that might be needed. There could well be instances where people require more expensive treatment, of course, but we thought that $4,250 was about right as an upper limit.

Senator MOORE—How does that compare with the DVA scheme?

Mr Eccles—The DVA scheme does not have a limit of $4,250. It does not have a limit at all. There are some aspects where I think it is a bit like an authority scheme—the way PBS works—where a dentist might need to ring DVA and get permission for particular treatments. In that aspect it is slightly different to DVA; it is using the same spine or the same schedule, but the administration would be different.

Senator MOORE—So has there been any examination of the DVA expenditure to see what the average amount is for different treatments to come up with something, the modelling?

Mr Eccles—Yes. That was one of the things that also influenced that.

Senator MOORE—Is that public?

Mr Eccles—I do not know; I would need to check that.

Senator MOORE—I am interested generally about the kind of research that has been done around the existing scheme and what data has been studied to churn out what we now have, which is a system that has evolved. From the time this was first talked about to now, with the legislation that is going to come before us, there has been an evolution. It is really positive that things have been considered and changed, but we want to find out what led to the changes and how much of that information is public.

Mr Eccles—We can look at that.

Senator MOORE—That would be good. In respect of appeal rights and discussion rights, the initial decision about the treatment is with the doctor.

Mr Eccles—With the GP, yes.

Senator MOORE—And it has to be part of a program that they spell out—for example, this is linked to your diabetes or your cardio or whatever. I did not ask the dentist this, but in a local community it is possible that the person knows their dentist and their doctor. And it is possible that you could have a discussion around—

Mr Eccles—Collusion?

Senator MOORE—I am from Toowoomba, so everybody knows most people. Warwick is an even smaller community, where people do know each other. So it is possible that the dentists and the doctors have a pretty good working relationship and work pretty closely together and with the hospital. What is the process? Is it possible that there is a way—and I am deliberately not using the term 'collusion'—of getting a multidisciplinary team to look at the best possible practice for your patient? If there is a disagreement, what is the system for them to say, 'I think this should be covered; I do not think this should be covered,' and get an independent assessment?

Mr Eccles—I am not sure if I have it completely right, but the whole MBS is based on a large element of trust in the health professional.

Senator MOORE—Sure.

Mr Eccles—Medicare Australia will be doing its usual compliance audits, as is the case for anyone who receives the Medicare Benefits Schedule. There will also be the opportunity for complaints through the standard health complaints processes. Also, the professionals here will be covered by the oversight of the PSR, the Professional Services Review. So there are those things. Are you talking about it at a more local level, where a doctor may disagree with—

Senator MOORE—Yes, if there is a discussion point, particularly with the new determination that is having or is likely to have an impact. To me that gives more discretion.

Mr Eccles—That discretion is solely in the general practitioners' domain. But I imagine it happens on a very regular basis that there are tensions in views between health professionals and they have a robust chat and the GP then revisits their consideration of these fees.

Senator MOORE—Does that go through HIC?

Mr Eccles—The robust chats amongst the local—

Senator MOORE—No, the discussion about whether something should be covered or not by Medicare.

Mr Eccles—You are talking about the potential to enhance the program down the track.

Senator MOORE—Possibly, but I am also talking about whether there is an issue about whether someone thinks that, for instance, getting new dentures—to use a really straightforward example—should be covered under this program or not.

Mr Eccles—There is certainly the capacity for that sort of advice and clarification to be provided, yes.

Senator MOORE—Good.

CHAIR—People can also shop around for different doctors if they are not happy with what their doctor says.

Senator MOORE—If you can find them.

CHAIR—Yes.

Senator MOORE—I was listening to the previous speaker, and he was talking about the role of dentists in developing policy and the fact that the oral alliance has a lobbying capacity, the ADA is a professional group and there are others as well. What is the system within the department for getting advice on dental processes? We know that with psychologists there is the advisory group and a committee that is looking at mental health stuff. In other areas of health and ageing there are specialist advisory committees. They are mostly done for the minister but some are departmental. What is the process with oral health?

Mr Eccles—Within the primary care area, which I look after, the terms 'formal' and 'informal' can be a little bit loose and be bandied around. There is no ongoing committee to advise on dental health. That said, the processes that we put in place when it was apparent that the last series of items were not being optimally used were, I think, very thorough. That might just clarify what the previous person said, and they will come back to you with a perspective on the consultation.

Towards the end of the last calendar year, there were discussions held with each chapter or office of the ADA. The ADA are a federated structure and their views sometimes differ considerably from state to state.

Senator MOORE—That is unusual!

Mr Eccles—We undertook a series of visits to each of them to try to understand the reasons for the difficulties but also the opportunities to make things better. We realised that it was not sufficient to only go state by state, so we drew together the ADA as a national body. The minister asked us to get a handle on these very issues. In December last year, there was a formal workshop held where we went through everything that we had heard. That, in a way, was our main mechanism for getting advice. Since then, I do not think a week has gone by where there have not been significant phone calls or visits between the department and ADA nationally. There has been quite considerable consultation.

Senator MOORE—Was that the first such gathering that you are aware of?

Mr Andreatta—A formal gathering of the ADA?

Senator MOORE—That kind of consideration and consultation on dental health.

Mr Eccles—I do not think that would be the case. This was brought very much together around the MBS items.

Senator MOORE—Was the previous one an ending program, or was it just—

Mr Eccles—It is ongoing.

Senator MOORE—I think there was a public acceptance of your statement that the previous programs were not receiving expected optimal take-up.

Mr Eccles—That is right.

Senator MOORE—It was a reaction to that—

Mr Eccles—Absolutely.

Senator MOORE—Before you went further—

Mr Eccles—That is right. It is not uncommon for us to monitor uptake of MBS items. If the profession tells us things may not be targeted, then we tweak. I guess the issue here was the size and nature of the tweak.

Senator MOORE—So you had that gathering, and since then there has been ongoing discussion. Are you aware of whether there has been any discussion about having a formal oral health advisory group?

Mr Eccles—I am not aware of that at this point. There could well have been meetings involving other areas of the department.

Senator MOORE—Can we find out?

Mr Eccles—I can certainly find out.

Senator MOORE—Thank you. I am just trying to get a snapshot of where we are as a country with oral health, because there have been a series of things feeding into this item, not the least of which was the national survey that came out earlier this year and the expectation

that that will come up again so that we will get these processes. I am just trying to understand where we are as a country in our interaction with oral health. I know primary care is very focused around the medical aspect—

Mr Eccles—That is right.

Senator MOORE—but I want to see beyond that

Senator BOYCE—Is there any mechanism for the $4,250 limit to be indexed in any way?

Mr Eccles—That would be a decision for the government when we start monitoring—

Senator BOYCE—Yes, but there is nothing in—

Mr Eccles—There is absolutely nothing that would preclude those considerations in the future.

CHAIR—I assume that there is a regular review of the adequacy of item numbers of the Medicare schedule and that they would change from time to time.

Mr Eccles—That is right. A lot of that is undertaken in the Medicare benefits division.

Senator BOYCE—That is what I thought.

Mr Eccles—They have the overall responsibility for this aspect of it.

Senator MOORE—So the Medicare bunch are looking at that as a regular aspect—

Mr Eccles—They look at this whole book very regularly.

Senator MOORE—I think they know that whole book!

Mr Eccles—I think they do.

Senator BOYCE—I am just trying to understand the GP management and team care plans and the aged-care spin-off of that. Are the only people who would have these plans people with chronic and complex conditions, or are there other cohorts who would too?

Mr Eccles—No. They are targeted at people with chronic and complex conditions.

Senator BOYCE—Would you expect that more plans may be developed as a result of this? Could there be people with chronic and complex conditions who do not currently have plans—

Mr Eccles—We are always hopeful that anyone with a chronic and complex condition gets the best care possible. We are not factoring in a boom, but we always hope. There has been a very steady upwards progression in the use of these multidisciplinary items. It has been, I think, one of the most significant changes in Medicare. As the health professions get used to it, there is more and more uptake of these chronic care items and the use of allied health workers. I would expect that progression to continue.

Senator BOYCE—In their submission, the Australian Dental Association expressed their concern about the treatment of special needs patients who require treatment that cannot be undertaken in a private surgery and who may need to be hospitalised for these dental treatments and about whether these people are covered.

Mr Eccles—Hospital treatment is not covered by these. We would see that as clearly being the responsibility of state and territory governments on the basis of its in-hospital nature.

Senator BOYCE—That was what I was trying to understand. There would not be two sets of costs in there, would there? They are not asking whether the dentist is covered whilst he is treating in a hospital or—

Mr Eccles—The dentist would not be covered treating in hospital under the Medicare arrangements.

Senator BOYCE—So that would require that special needs people had these dental treatments carried out in a public hospital?

Mr Eccles—I am not altogether clear about the special needs people. This is something that we will go back and talk to the ADA about. I am assuming they mean people who have a chronic and complex condition but the nature of whose dental work is such that it cannot be undertaken in a dental surgery.

Senator BOYCE—Or perhaps that the nature of their ability to simply sit still and have a local anaesthetic while potentially frightening things are done to them is such that it is in the patient's best interests for them to have a general anaesthetic rather than a local anaesthetic.

Mr Eccles—These items do not cover in-hospital care. There is an awful lot of high-end activity dental surgery that does take place in the private sector in private rooms. We will speak to the ADA to try to get a handle on these special needs.

Senator BOYCE—I have personal experience of people with intellectual disabilities who have had to have the treatment that you might have had sitting in a dentist chair done in a hospital because a general anaesthetic was going to produce a better outcome for everybody involved.

Mr Eccles—In-hospital care is not covered under this item.

Senator BOYCE—And you are going to talk to the ADA about this?

Mr Eccles—As you would understand, we received these submissions very recently, and we will obviously be raising a couple of points and, in particular, clarifying items where we can satisfy some of the concerns raised straightaway.

Senator BOYCE—I am sure that is not the only situation; there might be people who require such global treatment that a general anaesthetic is the better option.

Mr Eccles—That certainly could be the case, but it is important to remember that these MBS items are not designed to replace the obligation on the states and territories to provide public dental health services.

Senator BOYCE—Absolutely.

Mr Eccles—This is a supplement for those with chronic conditions. I think our minister has been clear that this is not designed to alleviate the responsibility of the state and territories.

Senator BOYCE—Theoretically, it should free up some cash to be spent in this area, should it not? You are bringing some quite new ideas into the Medicare system from DVA, with the limit. Are there any implications for Medicare in general that have been discussed?

Mr Eccles—No. Whenever we embrace another profession, we need to amend the way that we communicate, the way that we deal with the professions and the way that we encourage linkages. We went through this when we started to have items involving the allied health professions. We realised that we needed to have a more formal engagement with the professional bodies and we needed to make sure that any communications that we had about these things were not just targeted at general practice. One of the implications of this for MBS will be a broadening of that communication activity as well.

Senator BOYCE—I am thinking more about an administrative way—whether there would be other areas that might benefit from being viewed through this new prism, so to speak.

Mr Eccles—We are always looking at how things are tracking to see how they are going to be relevant across the board, and I think this will be included in that, but nothing springs to mind.

CHAIR—I will ask a couple of questions on that issue of whether the connection between a chronic condition and the impact on a patient's general health is well understood by dentists and doctors. The submission by Professor Spencer from the University of Adelaide makes this point:

> … classifying those medical conditions which are adversely affected by poor oral health is a difficult task. Poor oral health may quite plausibly affect nearly all medical conditions through pathways involving reduced ability to chew, altered food choice and decreased nutritional value of foods consumed. Alternatively oral symptoms may adversely affect quality of life, reducing coping and self-efficacy.

He goes on to say that there are 400,000 people under a GP management plan and team care arrangements in Australia and, he says, potentially all of them could find themselves having a connection between their chronic condition and the need for some sort of dental work. If this is the view of the Professor of Social and Preventive Dentistry at the University of Adelaide, presumably it connotes some level of confusion in the broader community. The ADA makes the same point: dentists have kept away from the system up till now. They are not terribly familiar with it, and there may well be some lack of clarity about what sorts of conditions are covered. What flexibility do you have to start to adjust this system if it turns out that the number of people accessing it is either far too few given the assumed level of need in the community or, alternatively, much greater than is expected under the estimates made?

Mr Eccles—We will be monitoring this very carefully, as I imagine others will be as well. As with any of these things, there is the potential for an amendment to the ministerial determination to change eligibility and to review those aspects. On the fundamental point about the capacity of GPs to understand the item, that is why it is going to be very important that we get the information and the communication activities right.

We know that the professional associations that represent dentists and the GP groups are working together to try and work out how we can make sure that GPs, who are going to be the starting point for this, have a better and more comprehensive understanding of the link between how they care for someone and when dental treatment might be useful in managing someone's chronic condition. We are very aware of that, so that will be something we will be doing up front, and we are going to be pretty well ready to go as soon as or if the legislation is passed. From that point, it will be a matter of monitoring the uptake, monitoring the progress

and continuing the dialogue with the GP groups and the dental groups, just to make sure that we have got this as right as we can.

CHAIR—I assume that access to these item numbers is demand driven, so that if the uptake is much greater, as Professor Spencer postulates, the outlays will simply have to increase to cover the level of take-up that is going on.

Mr Eccles—Yes, much as is the case with any Medicare item.

CHAIR—At a philosophical level, did the government consider the proposition that was put by the ADA that this should be different to the Medicare principles generally and it should be means tested, given that there is a very high cost associated with this and we should perhaps drive the dollars needed in this area to where people have lower incomes rather than to all potential users?

Mr Eccles—I am not aware of the broader considerations of government, other than that the focus of this item was to rectify the situation or to improve the items and the focus on people with chronic conditions. That is where we started with this.

CHAIR—Was consideration given to using the DVA system? You have already mentioned that some elements of the DVA system have been picked up, but, according to Dr Hewson, others have not. Was there a point reached in the discussions about this where you decided that you would pursue the Medicare model as opposed to the DVA model?

Mr Eccles—I think the Medicare model is considered to be the most appropriate means for, if you like, the mainstream population. One of the benefits of this is the focus on improving the links between general practice and dentistry. The approach of building on the Medicare schedule was by far the most efficient, effective and well-understood mechanism. Dr Hewson made mention of other aspects of the DVA approach. We did turn our minds to a whole range of things, but it ended up like this because of its principal focus on helping people with chronic conditions to get a broader range of care than they currently have access to and on helping GPs understand how dental health can improve the health of people with chronic conditions.

CHAIR—The ADA also made reference to the fact that there had been a fairly poor take-up by dentists of those three schedule items so far and that many dentists were a bit wary about getting enmeshed in the Medicare system because they regard it as a bit complex. You say that an eligibility criterion for accessing the rebate is that a dental practitioner has to be registered with Medicare Australia. Can you tell us what proportion of dentists are already registered with Medicare Australia?

Mr Eccles—I think 85 per cent work in the private sector, and all of those would be registered. I would not have a sense of the 15 per cent who are working in public centres. They could well be registered as well for their own purposes. I am advised that once they are registered with the state board they are automatically registered with Medicare Australia.

CHAIR—So they are all plugged into the system?

Mr Eccles—Yes.

CHAIR—And they would be able to use the new computer software that is being made available to doctors to access Medicare?

Mr Eccles—Is this MBS Online?

CHAIR—Yes.

Mr Andreatta—We have had discussions with Medicare Australia about the suitability of that system for dental practitioners. They have assured us that the functionality can be used by dental practitioners. I believe that the ADA are currently talking to Medicare Australia to work out how they can get access to the system when it becomes more widely available. Our hope is that they do take that on board and use that electronic claiming facility for these MBS items.

CHAIR—Do you accept that you will still need to do some educating of dentists about how these items will work, in what circumstances GPs will be able to give them access to the system and the quoting process, which is quite important?

Mr Eccles—Absolutely. We certainly accept the need for information and education for dentists as well, particularly when it comes to the administrative aspects: the requirement to provide a quote, the role of Medicare Australia's hotline and all the things that were outlined in our submission about how we expect the process to work. There will need to be some education information provided.

CHAIR—Will that be done primarily through Medicare itself, or will it be done through professional associations?

Mr Eccles—It would be us and Medicare as one going to the ADA and using the ADA, if you like, as one means. I am sure that we will also be directly approaching dentists as part of information campaigns. Most likely, we will do it through the ADA.

Senator MOORE—In your submission on page 4 you give us the revised allocation for the four years straight from the finance bizzo. Just to clarify, are the little boxes 'Health and Ageing' and 'Medicare' internal on-costs? Staffing, training, travel or anything like that comes under those things?

Mr Eccles—Absolutely.

Senator MOORE—And the top line is the expected usage of Medicare; is that right?

Mr Eccles—That is the estimated.

Senator MOORE—I just wanted to make sure that is what those figures are. Because we do not have a dental stream or an oral health stream within health and ageing—there is no dental bit—about how many people are involved in oral care across the department?

Mr Eccles—I would have to think—

Senator MOORE—Can you get that for us? I know there is a question that I usually ask at estimates, but it has come up in the costing under Health and Ageing.

Mr Eccles—So how many people in the Department of Health and Ageing have—

Senator MOORE—are involved in this process: oral health? I would imagine that it would be primary health and it would be workforce.

Mr Eccles—It would be population health. It would be acute care division.

Senator MOORE—I just want to get an idea because I am trying to get my head around the costings. That is not a high level of administration as programs go that are there. It does seem quite reasonable. I am just trying to get my head around what that covers.

Mr Eccles—Certainly, no problem.

Senator MOORE—In terms of Indigenous health I know that there is a separate program. I have two questions: one is on Indigenous issues and one is on aged care. In that wonderful attachment B there is a clause that talks about people in an aged care facility, and that is a big issue. We will go to Indigenous issues first. Is Indigenous health and dental care done separately? I am trying to get my head around the fact that we have identified that with Indigenous Australians and chronic illness there is a very high number of people who have been diagnosed with acute chronic illness—if we can use that term.

Mr Eccles—Absolutely.

Senator MOORE—In terms of linking that with dental services to look at the whole area of dental care, are they picked up in this money or is there a separate bucket?

Mr Eccles—Obviously Indigenous Australians are able to access this program. It would be the Office of Aboriginal and Torres Strait Islander Health that looks specifically at the oral health needs of people from Indigenous backgrounds.

Senator MOORE—Is any funding in this allocation looking at that area or is that totally separate?

Mr Eccles—No, it is separate.

Senator MOORE—So do Indigenous Australians wanting to get treatment claim under the Medicare payment?

Mr Eccles—At the moment we would expect that Indigenous Australians would access this Medicare item in the same way as everyone else.

Senator MOORE—Sure, like anyone else.

Mr Eccles—I do not know, I would need to take that on notice.

Senator MOORE—Could we get some further information? In my mind I am trying to figure out once again the bigger picture in terms of the response to oral health. This is one element, and it is looking particularly at chronic health; and I know that Senator Boyce's questions on people with disabilities touched on that as well. The ADA mentioned in their submission a couple of paragraphs about special needs and focus. I am trying to get my head around making sure that everybody can get access to it, and if it is not here then where is it?

Mr Eccles—You are looking at particular targeted strategies for the Indigenous population?

Senator MOORE—Yes, to make sure that they are picked up in terms of chronic health and the linkage with dental care—and which bucket of money that comes out of—in a program where any Indigenous person could actually claim this with their Medicare card, like anyone else, if they knew about it. The way your submission has set it out at the beginning is that there are separate schemes, including programs managed by DVA and the Department of Defence. I take it that those are for service personnel?

Mr Eccles—Yes.

Senator MOORE—And then there is the Office of Aboriginal and Torres Strait Islander Health. I would like to find out what is being done in that stream.

Mr Eccles—Certainly, we can find that out.

Senator MOORE—I turn now to aged care. On page B it links the changes. The first item points out the different eligibility and the new item numbers, which we are hoping to get details on. I am just not sure about people who are in an aged care facility. How does it work for them? Is there an expectation that they would use a separate system because they have healthcare cards or because they are older Australians? For my peace of mind, can you explain how it would work if you were a resident in an aged-care facility?

Mr Andreatta—Under the current chronic disease management items, if a GP contributes to a multidisciplinary plan that the aged-care facility has ownership of then that patient is included in the access to these new Medicare items. Having said that, they are also able to access dental care that is provided outside the MBS.

Senator MOORE—Because of their health care?

Mr Andreatta—Correct. The aged care facility, in its own right, would also be providing some dental services, I expect, through the state system. This initiative certainly targets the same patients. They could access both funding streams.

Senator MOORE—I know you have given us the current uptake figures for the EPC dental items, and on page 3 of your submission you have a historical record of how many people have used the current system. Is there any way we can find out how many of those were from aged-care facilities, as they are a separate group underneath the program?

Mr Andreatta—I will find out if that is technically possible. I am told it is difficult, but we will take that on notice.

Senator MOORE—It would be really useful if you can find that out. In previous discussions we have had around aged care and in a couple of inquiries this committee has held into aged care, general oral care is a key component. Whilst a lot people within that group use dentures, some do not, and that point that was being made about diet is very real for those people. We would like to know how effective the scheme was, because those people in an aged-care facility were particularly mentioned. I would like to find some detail on that.

Mr Eccles—No problem.

Senator MOORE—Just skimming through attachment B, I take it that the dentures item mirrors the DVA scheme, with the exception of the difference of the eight years, in the kinds of prostheses that people can use?

Mr Eccles—When you get the printout, you will see a section that goes to prosthodontics.

Senator MOORE—That is a good word. Is that the special making of things like that?

Mr Eccles—That is right.

Senator MOORE—So the eligible providers under the new schedule will be dental specialists and dental prosthetics?

Mr Eccles—That is it. They are included now.

Senator MOORE—And that is the difference?

Mr Eccles—That is right.

Senator MOORE—Will the forms be nice and simple?

Mr Andreatta—We have spoken to both the dental and the GP professions and they have both said the referral form that they currently use under the EPC items is the most appropriate way of communicating between the two provider groups. So we have retained the referral form that is needed, though we may streamline it a little in terms of the content. That is the vehicle that we will be using for that communication and referral process.

Senator MOORE—Is the expected kick-off date 1 November? Is that what you are planning?

Mr Eccles—Yes.

Senator MOORE—Did we miss any of the things you needed to clarify?

Mr Eccles—I will just check my list.

Senator MOORE—I will be very disappointed if we did miss any.

Mr Eccles—You got them all.

CHAIR—You would have heard the ADA refer to dental advisers that are used in the DVA system. Is there merit in having a similar concept in respect of this scheme?

Mr Eccles—Logistically and financially, it would be another level. I do not think they are necessary to achieve the outcomes we are trying to achieve. There are a number of reasons cited by the ADA for dental assistants. Part of it was for the ongoing review to make sure that there is a legitimacy of care. I believe that we have mechanisms in place through Medicare audits, through complaints and through the role of the PSR in monitoring this activity to be able to give us the same level of comfort on that. The logistics of having for a whole-of-population another stream of employees, if you like, employed by the government is not something that we entertained. We believe that the outcomes of getting people with chronic health conditions to get appropriate dental care can be achieved through the package that is on the table.

CHAIR—Thank you very much for the evidence you have provided today. It has been very useful in clarifying what is going on with this legislation.

[11.27 am]

SPENCER, Professor Andrew John, Social and Preventive Dentistry, University of Adelaide

Evidence was taken via teleconference—

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you, I understand.

Prof. Spencer—Yes, it has.

CHAIR—We thank you for the submission that you have provided to the committee. We have a couple of questions arising out of that but, before we put those to you, would you like to make an opening statement about the issues that the committee is examining today?

Prof. Spencer—Certainly. I think it would be widely recognised in the dental profession, and may eventually be recognised within the community, that this bill represents quite an important event in the financing of dental services in Australia. It is an important but somewhat constrained step in improving oral health and access to dental care for a particular subgroup of the Australian population.

I want to make a number of specific points about the bill. The bill's premise is limited to people who have chronic conditions and whose poor oral health actually affects their underlying medical condition or the management of that condition. This accepts the notion that dental care and oral health in some ways are only important when they complicate the management of an underlying disease. I have used a quote from the US Surgeon General, 'You cannot be healthy without oral health,' to indicate that a strong argument should certainly be made that oral health is important in its own right and not just because of its impact on any underlying chronic medical condition.

My second point is that defining what underlying medical conditions could be adversely affected by poor oral health is quite a difficult task. While there are some obvious situations—I could use the example of diabetes—where poor oral health is thought to complicate the management of a diabetic patient's condition, there are many situations where our evidence base linking poor oral health to a medical condition is far less well developed. So this leaves quite a bit of uncertainty about just what conditions should be included in this particular bill.

I have tried to give an example, which perhaps is somewhat extreme, where it could be argued that poor oral health leads to an altered capacity to chew, which flows on to changes in choice of food, which might flow on to changes in the nutritional value of people's diets, all of which could affect the underlying general health of anyone within the community. Also, poor oral health might lead to people experiencing symptoms they might struggle to cope with, which certainly might lead them to feeling less able to manage their health in general—the notion of coping and self efficacy over their health—which again might rebound on how their general medical conditions might be managed in their lives. I think at one end of the spectrum it is possible to argue that almost any medical condition that someone has might be affected by poor oral health. Drawing a line about what medical conditions will be in and what medical conditions will be out of this particular bill, and the provision of care under it, is quite a difficult task.

My third point is simply about the definitions of the medical conditions that, in the end, will be included and, therefore, who will get dental treatment under the bill. It might be argued that this might not be very much of an issue. Past experience has been that the uptake rate of dental treatment under these sorts of arrangements in the last several years has been very low. But the bill actually outlines very substantial financial support for dental care. It is now some 10-fold higher than was previously the situation, and it is likely that many additional people will be seeking dental care under the bill's arrangements. Therefore, if you work through some simple calculations—maybe they are worst-case scenarios—you find that the bill and the attached financial impact statement imply that around 45,000 people, at the lowest end of the estimates, would receive dental care under these arrangements. That is something like one in eight of the people who are currently being managed under GP management plans and team care arrangements. It becomes a bit of an issue as to how general practitioners will choose which patient of eight that they have under such plans will receive dental care.

The documentation that I have seen does not clear up this issue particularly well. It implies that this would be left to the clinical judgement of the general medical practitioner. While that is an appropriate starting point, it certainly does not indicate how in the future we should learn from the experiences had by general practitioners and dentists under such a bill and how we should refine and finetune the selection criteria of just what medical conditions are appropriate for a person's dental care to be covered under such a bill.

The last area I have tried to highlight is that the provision of dental services is a fairly substantial expenditure of the Australian government. It will rank second behind the 30 per cent private health insurance rebate paid towards dental insurance in terms of the quantum of dollars involved. Therefore, I think it behoves us to ensure that the expenditure and the services under it are monitored well and that we ensure that we get the maximum benefit for the community out of that expenditure. I have made some suggestions as to how there needs to be a focus on collection of information at both a patient level and a population level to appropriately evaluate this sort of program over the next four years.

CHAIR—Earlier you raised a point concerning the uncertainty about what chronic conditions can connect with a person's general health or their oral health. That is an issue which has been ventilated quite a lot in the committee hearing this morning. I point out that the department did confirm that the cost of the item will essentially be demand driven so that if indeed there are not 45,000 but 145,000, or whatever the number of people, who claim these rebates then that will be the number of people treated. It will not be rationed or limited by the number of dollars currently allocated in the bill. That question leads then to the other question: with the uncertainty that you have pointed out about just what the connections are that a doctor needs to make between chronic conditions and oral health, in terms of our recommendations to the Senate, are there any suggestions you can make to us as to what we can do to eliminate or reduce that uncertainty?

Prof. Spencer—The only reasonable suggestion that one can make at this stage is we need to learn from research that is actually being conducted in this area. We need to collate what is known from the existing research literature about the links between poor oral health and underlying medical conditions and maybe the effectiveness with which they are managed. The

research literature in this area is not huge. That is a 'one direction only' effect that the bill outlines, and that eliminates many known linkages between oral health and general health where maybe general health is impacting upon oral health, which is the opposite direction to what this bill implies is its underlying premise. Clearly, we need to be learning from on-the-ground experience of general practitioners, dentists and patients involved in such a program as this. I think it increases not just the necessity for there to be a rigorous evaluation of how these sums of money are used but also the value of linking specific research activity—it might initially be through general medical practitioners—and increasing the emphasis on research to determine just what the impact is of improving the oral health of their patients with chronic diseases under these sorts of schemes or how they assess it in terms of general health outcomes of those patients.

CHAIR—So you would recommend that, as the legislation is rolled out, there be more research and that the uptake and the nature of the uptake be monitored, but you would not suggest that we change the provisions of the legislation at this point?

Prof. Spencer—It really is, I think, a very difficult task to sort of rationally draw a line in the sand about exactly what medical conditions would be in and what medical conditions would be out at the moment. There is a lot of interest in the dental community and the wider public health community about possible links between oral disease and systemic or general health. But many of these have a reasonably limited level of evidence available to support them. We would talk about the jury still being out. I think that is the difficulty that people would face in trying to draw up a prescribed list of medical conditions at the moment, as the evidence really just is not strong enough to substantiate what is put on the list and what is left off the list.

Senator MOORE—Following on from the point that you are making, my understanding is that this scheme is actually building on the pre-existing scheme that has been around since 2004 and that there has been extensive effort made to see what caused the less than optimal uptake—and I am trying to get those words absolutely right—of the previous scheme so that we can build on a better one in the future. Have you had a chance to have a look at the previous scheme?

Prof. Spencer—I have certainly had a look at some of the available statistics on the previous scheme and have published in the *Medical Journal of Australia* some brief comments upon those. All we really had was what I basically call 'encounter data'. It just indicated the total number of individuals who had been supported for their dental services under the old rebates over time. I certainly did not have access to any further information on, for instance, the age and sex breakdown of those people or any of their other social characteristics and I had no information on the underlying medical conditions they may have had. There is a lot that I do not know about how the previous scheme was working, but we all know that there was a very low uptake under the previous scheme.

Senator MOORE—Were you involved in any of the discussions that were held, in terms of looking at moving forward, and any of the industry consultations about the program?

Prof. Spencer—No, I was not.

Senator MOORE—My understanding from today's evidence from the department is that the guidelines under which this scheme is going to operate are very much based on what was in existence, impacted by the feedback that they have had from the industry, while also mirroring what is happening with the DVA scheme. So it is all a bit of an amalgam. The guidelines are going to pick up the issues that you were raising around giving support to GPs in making their decisions about who they would consider should get this and who should not. I imagine they would be public guidelines. So it may be useful for you, if you do get the chance, to have a look at that.

Prof. Spencer—Certainly.

Senator MOORE—That seems to pick up a lot of the concerns that you have raised in your submission and in your evidence today; that it is about what constitutes a stimulant for people having access to this or not—and we have not got those yet.

Prof. Spencer—They will be important. The comment that I was going to make was certainly anecdotal. I think the low uptake of the previous iteration of this sort of program really rested on some issues like the rebates being set up in a way which was really quite at odds with the way in which the vast majority of dentists in Australia practise—that is, a fee-for-service basis within their private general practices. The notion of a flat rebate for a first, a second and a third visit or consultation was really at odds with the way in which dentists will raise their fees for any individual patient and, through that, to whoever is funding the service. Certainly the new scheme pulls it into line with programs such as the DVA one in which dentists have participated extensively in the past.

In terms of the dentists' participation, I think the new arrangements are much more aligned with their usual practices. What is a little less certain is how medical general practitioners make their decisions about what patients to even seek to refer to a dentist. I do not really know whether the existence of this new scheme is going to generate greater activity from the GPs, but my feeling—and this is just a sort of hunch here—is there is such a substantial level of funding available for dental care that this will in a sense be patient demand driven, and I would imagine that general practitioners will be very quickly under request from their patients to organise a referral for general dental care.

Senator MOORE—Yes. One of the things the department has said is that there is going to be an extensive education campaign for GPs and dentists about how this scheme will operate. I think that has come out of the feedback they have had with the first scheme as well. I forgot to ask the department about the community information campaign about how they will be advised about their rights in this process—I might ask that later. You are actually at the university dental school in Adelaide; is that right?

Prof. Spencer—Yes, I am at the School of Dentistry, University of Adelaide.

Senator MOORE—I am also interested in the workload implications: if this is going to generate more people being able to access services what the impact is going to be there. Have you got any comments on that?

Prof. Spencer—I was going to immediately respond that we are talking fairly marginal increases potentially in the demand for dental care, if the numbers involved are 45,000 or 90,000. Although we have a fairly tight sort of supply of dental services in the community at

the moment, we are not talking such huge numbers of new and additional visits to dentists and services that would be involved in this particular program that it would cause me undue concern. What I think I should be well aware of is the comment that you have attributed to departmental representatives this morning—that is, if the demand is several times higher than what might be anticipated under this program, the size of the program will simply grow. It is possible that there is a very large group of people in our community who have various chronic medical conditions which could be included under this scheme. Diabetics alone would be a substantial number of people, if they all received what we would call medically necessary dental treatment under this bill, getting quite an additional amount of dental care. There may be some difficulty in obtaining appointments and care within reasonable time periods.

Senator MOORE—In terms of access, one of the things that came out was that, whilst it is very clear that the public health system is there to provide dental services to a range of people now, this is addressing the fact that there needs to be better access for some people—I think the figures we have been told are 85 per cent of dentists in Australia now work in the private system.

Prof. Spencer—Yes, they do and certainly this bill would cover dental care that is for people who are going to be largely outside of the eligible group for public dental care, but that is not entirely the case. Among those who are eligible for public dental care, around 60 per cent of them seek their dental care in the private sector. Many are old or older adults in our community. Many will have medical conditions that may actually see them seeking to be part of this GP management plan and the team care arrangements, but the numbers could grow quite quickly.

Senator MOORE—Yes, and your submission talks about the numbers of people who are under a GP management plan and team care being estimated at approximately 400,000. I do not think any scheme is looking at that degree of increase, but somewhere between 45 and 400. Planning for the future along those lines is really important to make it work.

Prof. Spencer—Absolutely. And there is almost a tenfold difference there. If it were to flow through into the financial impact of this bill, you would be talking about very substantial amounts of funds flowing into dental care. I feel that accentuates the need for there to be rigorous monitoring and evaluation, in the sense of having at least an associated notion of more formal research—collaborative partnership research between the medical and the dental professions—about the benefits that might flow from people's full oral health being attended to, in terms of the management of their medical condition.

Senator MOORE—To the best of your knowledge, is there any research of that nature happening now?

Prof. Spencer—In very briefly responding to the invitation last week, I returned to some material that I had aside on this sort of area. There are a limited number of studies of key areas where the management of people's medical condition seems to have been compromised by poor oral health. There are examples: diabetes is one where the link seems to be reasonably accepted. With patients who have heart problems that actually require surgery—valve replacements and the like—clearly there is some evidence that the effectiveness, the outcomes, of the surgical interventions for their cardiovascular disease are influenced by poor

oral health. With renal disease, in renal dialysis and other things, poor oral health is thought to be important. And for anyone who is presenting for transplantation, poor oral health is thought maybe to work against the best outcomes for that. So not all of these are—transplantation certainly is not—what we would call chronic medical conditions, which seems to be the definition that is being used for the medical circumstances in which this bill would operate.

There are numerous other examples where medical and dental conditions are thought to be tightly linked but, again, it is not necessarily in the direction of the poor oral health influencing the general health. I might mention things like irradiation for head and neck cancers. We know that leads to dramatic complications in terms of oral health, but the directionality there is exactly the opposite of that in the premise behind this bill.

Senator BOYCE—Professor, you just talked about transplantation, but surely a transplant would only occur if someone did have a chronic condition—that is, there would be an underlying chronic condition that had led to the transplant being necessary.

Prof. Spencer—That might be the case, and I did not get any sense, when I read the bill, that transplantation, for instance, would be something that would be managed by a GP management plan and team care arrangements. I guess that simply shows that I do not know exactly what medical conditions will be in or out of those sorts of arrangements.

Senator BOYCE—Do you have knowledge of the state dental services and systems and their operations?

Prof. Spencer—I head up a centre that looks at all population oral health matters across Australia, so we deal a lot with states and territories.

Senator BOYCE—You commented in your submission that there are a lot of Australians with poor oral health who would not obtain dental services under the bill. Compare that with a statement in the federal Department of Health and Ageing's submission which points out that, in Australia, state and territory governments are responsible for the planning, funding and delivery of public dental services—including that to concessional patients and children. I wonder if there will be any opportunity here for the state services—which appear to be chronically underfunded and have enormous waiting lists—to improve their delivery.

Prof. Spencer—I think there is. This bill will certainly impact upon the delivery of public dental services at the state and territory level insofar as the eligible clientele for those public dental services are people with chronic medical conditions. The existence of Medicare dental services arrangements would either draw some people out of public dental care—which they might be eligible for and waiting for—into the private sector for those services or it might simply retain people outside the system who will obtain their care in the private sector instead of seeking it in the public sector.

CHAIR—That is a good thing. Obviously the state systems are pretty overloaded at the moment and drawing people into the private sector would surely relieve the overall burden of unmet need in the dental system at the moment.

Prof. Spencer—The only tempering comment I would make to that is that some 60 per cent of those who are eligible for public dental care already seek their care in the private sector.

Senator BOYCE—Is that not because the public sector simply does not function?

CHAIR—Yes.

Prof. Spencer—It is a combination of things really. Some of it might be regarded as a comment upon the long waiting lists for general dental care in the public dental services. Some of it might be for people being regular visitors to a private dentist for most of their adult life and, when they retire and obtain the age pension, making them eligible for public dental care, they want to continue to get care from a private practice dentist they have come to know. So it is a bit hard to work out exactly the dynamics by which many of those people make choices about seeking their care in the private sector.

CHAIR—On the question of the cost of the scheme, in evidence this morning the witness from the Australian Dental Association questioned whether the Medicare model—the universality principle in the Medicare model—was appropriate for this scheme. They suggested that a different model might be applied, for example, where access to the scheme was means tested. Do you have any thoughts about whether Medicare is the right kind of model for this kind of access to dental care?

Prof. Spencer—This is not a universal program; this is a targeted program where eligibility is defined by the existence of a chronic medical condition and being—

CHAIR—But it is universal in the sense that it is not means tested. Anybody in any income bracket can access this.

Prof. Spencer—There certainly has been some discussion since the policy was announced that there would be individuals who are financially very independent and very capable of financing their own care, and who may also be privately insured, who will end up being eligible for this sort of program. In an environment where there are many adults in the Australian community who are struggling to purchase private dental care, some people might feel that that is relatively inequitable.

CHAIR—What do you feel?

Prof. Spencer—This is not applying the basic universality principle to dental services; this is a targeted program. In some respects the individuals who are targeted here are those who are ill. That is always a good starting point for targeting a program. Whether one wants to add a second layer of eligibility using income or assets tests or something like that is, I think, a secondary question here.

Senator MOORE—I have a question on the cost. I am trying to get my head around the amount of treatment that can be covered, because the program is built on the program that offers three sessions at around $200—to $4,250 over two years. Where do you think the figures come from? I know you do not know exactly, but do you have any idea? Secondly, from a dental perspective, is $4,250 worth of services an amount that could reasonably be seen as an average treatment cost?

Prof. Spencer—This is clearly well-supported dental treatment in terms of the capping that is applied here at $4,250 within a two-year period. The expenditures that the community in general make on dental care are much lower than that. The average adult in Australia seems to spend a figure in the low $300 range a year on dental services. That average is of course made

up of many people who are spending very little because they are not visiting dental services—or they are visiting public dental services and receiving dental treatment in the main at no direct cost to themselves—through to people who are spending very large amounts of money. This would appear to be quite generous support for the management of these people's dental needs. It would certainly cover all routine dental care very adequately. The reason why it is that high is that there is clearly an indication that some less than routine dental treatment will also be covered under the program. That pushes the maximum ceiling up.

Senator MOORE—How much do dentures cost?

Prof. Spencer—I could not give you an exact figure, but if you are talking about full upper and full lower dentures they are probably in the order of $1,000 to $1,500. A single partial denture might be in the same sort of range—maybe $1,500. If you include crown work of various sorts—maybe endodontic treatment crown work—then you can very quickly find yourself looking at several thousand dollars for a treatment plan.

Senator MOORE—One of the big differences in this scheme compared with the previous one is the inclusion of those things. It was very much demand driven. We heard from the community that, for many people, that was one of their major costs. My understanding is that this scheme is very much mirrored on the DVA system, which does offer those things.

Prof. Spencer—It does and it does seem to be mirrored on the DVA arrangement. The only comment that I would make is that the spirit that surrounds the provision of care under DVA is that these are people who have put themselves in harm's way for the nation's good and we have every reason to provide them with the best of care. At its maximum limit, this scheme seems to open the door to a very high quality of dental care being provided to those people who are eligible.

Senator MOORE—Some of the questions that I have left with the department to look at concern the impact on people in aged care facilities and also Indigenous health. Has your school done work in either of those areas specifically?

Prof. Spencer—Absolutely.

Senator MOORE—If you have a look at the department's submission, they have given us a very useful diagram that compares the existing scheme with the new one, and the changes. A component that has been put in both is that if people who live in aged care facilities have one of the GP-generated programs, they will be eligible for this. I am trying to get a sense of how many people in aged care facilities access private care in this way. Secondly, we have evidence from other hearings that chronic disease is particularly evident in the Indigenous population and you would therefore think that their access to these services would be higher, percentage wise, than that for other parts of the population. The department is going to look at Indigenous take-up of these schemes as opposed to specialised Indigenous dental services, which we are getting some figures on. Do you have any comments on those two special needs groups?

Prof. Spencer—We have conducted quite a lot of research among both groups. It would be reasonable to say that a high percentage of older adults in Australia who are in residential aged care facilities would have a chronic condition and complex needs. Therefore, a very high percentage of the 150,000-odd Australians who are in residential care might fit the criterion in

terms of chronic disease. What I am unaware of is what percentage of the people in aged care facilities are under a GP management plan or team care arrangements.

Senator MOORE—We have asked the department to see whether they can find out.

Prof. Spencer—I do not know the answer to that but it would be a very interesting thing to know. If they are not under such arrangements at the moment, I am sure that there are going to be patients and dentists who would like them to be. In the area of Aboriginal health in Australia, we are all well aware of the very high rates of particular chronic conditions such as diabetes, which I would have thought would have captured a high percentage of the adult Aboriginal population into such a program, theoretically. But again I am unaware what percentage might have their medical needs managed in a way where they satisfy the basic criterion of already being in a GP management plan and team care arrangement.

CHAIR—Thank you for your evidence today and the time you have spent with the committee. It has been very useful indeed.

Committee adjourned at 12.08 pm