AUSTRALIAN DENTAL ASSOCIATION INC.

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9th October 2012

Mr Ian Holland
Secretary
Standing Committee on Community Affairs Legislation Committee
PO Box 6100
Parliament House,
Canberra, ACT 2600

By email

Dear Mr Holland

Re: Inquiry into the Dental Benefits Amendment Bill 2012

The Australian Dental Association Inc. (ADA) would like to thank the Standing Committee on Community Affairs Legislation Committee (the Committee) for the opportunity to comment on the Inquiry into the Dental Benefits Amendment Bill 2012 (the Bill).

The ADA is supportive of the initiatives included in the Bill. Investment in the oral health of children is a sound and sensible investment as it may result in a long-term monetary saving for government and the community by minimizing future deterioration in dental health. There is a substantial body of evidence indicating that early intervention and preventive treatments provided early in life are a proven and well-established method to prevent poor dental health in later life.

However, the ADA is concerned that this scheme must be well designed and that the mistakes associated with the introduction of the Chronic Disease Dental Scheme (the CDDS) are not repeated.

Consultation with the profession

As the Committee would be aware, there have been substantial problems associated with the administration of the CDDS. Many of these problems could have easily been avoided if adequate consultation had occurred with the dental profession prior to the introduction of the CDDS.

In her second reading of the Bill, Minister Plibersek indicated that her Department will consult with the profession. The ADA believes that this consultation should be extensive and commence as

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soon as possible. The ADA would further suggest that the Department might wish to set up an advisory committee to assist in the design of the scheme. This model has been used successfully elsewhere.

Schedule of services

It is critical that the schedule of services available for children under the subordinate legislation Bill is comprehensive, i.e. inclusive of all relevant preventive and therapeutic services. Treatment regimes must be flexible enough to allow for the clinician to provide treatment that is patient-focused and provides for long-term oral health solutions. The dental profession is best placed to advise on the type of services that should be offered.

For example, crowns were specifically included in the definition of complex treatment. However, advances in treatment means that the application of crowns using the Hall technique is actually more conservative than a restoration.

Another area for consideration must be the inclusion of hospital and day-stay based procedures provided under general anaesthetic for children within the scheme. Many children require procedures to be done under sedation but currently these are not covered. This is an essential treatment modality in many cases and has to be included.

Furthermore, the legislation should allow for the provision of services by all members of the dental team, as is the case under the Department of Veterans Affairs Scheme, and also allow for co-payment arrangements to ensure that dentists are encouraged to participate.

Age for eligibility should be lowered

The ADA would also argue that children from 0-17yrs should be eligible. We know that preschool children develop dental problems and it is important to encourage early dental visits prior to the age to two years. The ADA (and others) recommend the first dental visit at 12 months. Certainly the cost of doing this would not be significant, but will help to send an important message about prevention. See copy of ADA Policy Statement 2.3.1-Delivery of Oral Health care: Special groups: Children.

Education

The experience of dentists with the introduction of the CDDS provides the evidence that any new publicly funded scheme must be supported by an extensive education and training programme of the profession, practice administrators and the general public.
As was made evident in the submissions by the ADA and others to the Senate's Finance and Public Administration Legislation Committee Inquiry into the health Insurance (Dental Services) Bill 2012 No. 2, there was little education provided to dentists about the requirements of the CDDS.

At the same inquiry, the Department of Human Services' (Medicare Australia) claim that dentists were educated because they had written to them on six occasions. As was demonstrated, the Department's idea of education and information sharing was less than adequate.
The ADA is keen that this experience not be repeated.

It is proven that the lack of education of the profession led directly to the high rate of administrative noncompliance in the initial years of the scheme, at least until early to mid-2011.

The ADA has significant processes in place to provide formal and informal education to the profession and is well placed to provide advice on the most appropriate forms of communications and education programmes required to ensure that the profession is adequately prepared for the introduction of any new arrangements.

Administrative requirements

It is equally important that the administrative and reporting components of the scheme are not overly burdensome on practitioners.

The CDDS required the patient's medical practitioner to act as a gatekeeper for the provision of dental services. The design of the CDDS reflected a medical model of service delivery. Dentistry operates within a different service model. Dental electronic health records, recall systems and billing services were not designed to work with the Medicare Benefits Schedule. This has been repeatedly evident to the Department of Veteran Affairs (DVA) when they examine the incidence of online versus manual billing practices for dental items. This shows that 99% of all claims to the DVA for dental benefits are claimed manually. This will need to be factored in to the administrative arrangements, and dentists are best placed to provide this advice. The ADA would be happy to offer further advice on these issues.

The ADA is aware that much of the resistance to the Bill is the perceived gap in services for patients who are currently receiving treatment under the CDDS while states and territories increase their capacity to deliver additional services. The ADA understands that the CDDS has allowed most states and territories to substantially reduce waiting lists as patients previously waiting for public dental services were eligible to receive treatment from a private provider. There is potential for this practice to continue.

Many jurisdictions have processes in place to purchase dental services for public patients from a private dentist. This system could be enhanced to ensure that those patients who have previously been treated under the CDDS, but who are not able to pay for continued treatment could, if eligible, continue to receive their treatment by moving across from the Commonwealth funded model to the state model with minimal disruption to care. This will ensure that waiting lists don't suddenly blow out while public dental services increase their capacity to offer services.

The ADA strongly believes that in order for the new arrangements to operate effectively, the input of the profession is critical. It is the ADA's hope that the Committee will make specific reference to this in their recommendations to the Parliament.

The ADA would be happy to expand on any of these points verbally or by further correspondence.

Yours sincerely

Dr F Shane Fryer
Federal President

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