Victorian Medicare Locals
Dental Briefing Pack 3

Further dental policy issues relevant to Medicare Locals

PURPOSE

To provide Medicare Locals in Victoria with information on current dental policy issues relevant to Medicare Locals.

As the peak body of dentists in Victoria, the ADAVB has primary responsibility for engaging with health reform processes and helping our members to understand the potential impact of these reforms on their services and relationships with patients. The ADAVB also takes an advocacy role in promoting oral health in the community.

In this briefing pack, the ADAVB would like to bring to the attention of Medicare Locals the following issues:

Paper 3.1: Closure of the Chronic Disease Dental Scheme (CDDS), the Medicare Teen Dental Plan (MTDP) and introduction of the Child Dental Benefits Scheme (CDBS)
Paper 3.2: Access to General Anaesthesia

Please see overleaf for a full table of contents of the ADAVB Medicare Locals briefing packs.

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Paper 3.1

Closure of the Chronic Disease Dental Scheme (CDDS), the Medicare Teen Dental Plan (MTDP) and introduction of the Child Dental Benefits Scheme (CDBS)

INTRODUCTION

The Australian Government announced on 29 August 2012 that the Medicare Chronic Disease Dental Scheme will be closed from 1 December 2012 and the Medicare Teen Dental Plan from 1 January 2014. The schemes will be replaced by the new Child Dental Benefits Schedule (CDBS) from 1 January 2014 and additional funding for adult public dental services from 1 July 2014.

The Child Dental Benefits Schedule (CDBS) will replace the Medicare Teen Dental Plan from 1 January 2014. This $2.7 billion measure will provide a Commonwealth funded capped benefits entitlement for basic dental services for children. The government has estimated that this initiative will provide 3.4 million Australian children aged 2 to 18 years, in families eligible under Tax Benefit A, with a total benefit entitlement capped at $1000 per child over a two year period.

The Scheme will provide for basic essential dental treatment such as check-ups, x-rays, fillings and extractions. However crowns, bridges, root canal and orthodontic items are excluded.

An additional $1.3 billion will be provided to states and territories from 1 July, 2014 under a National Partnership Agreement (NPA) to expand services for adults in the public dental system. The funding will assist up to 1.4 million low income adults to receive dental services. This measure builds on the 2012-13 Dental Waiting List NPA, which is focused on treating the 400,000 adults currently on public dental waiting lists.

ADA POSITION

- The ADA Inc (and therefore its State Branches) has supported the new funding arrangements on the basis that they are targeted and so resemble measures suggested in the ADA's DentalAccess proposal. ADAVB is therefore welcoming the proposed measures while noting that a gap in access to care will arise given the timing of their introduction.
- The ADA has expressed concern at the mode of closure of the CDDS in that it has given little consideration to the many patients currently receiving treatment, and has called on the Government to allow adequate time for patients to complete their treatment under the scheme (see Attachment A).
- The ADAVB has advocated for transitional funding for dental treatment of means tested patients to June 2014 and earlier availability of the Flexible Grants funding to allow infrastructure to be developed in time for the July 2014 increase in treatment funding.

KEY POINTS

Budget

- The Federal Government's new dental funding scheme will actually reduce their contribution to public dental services compared with present funding arrangements. After the closure of the CDDS on 30 November 2012, no Commonwealth funded care will be available for the disadvantaged (other than Veterans) until July 2014 – a 19 month gap.
- While the Government has made much of the allocation of additional funding it will actually spend less on eligible Victorian patients over the period between the closure of the CDDS on 30 November 2012 and the commencement of the new adult dental funding arrangements on 1 July 2014.
- About $170m p.a. has been spent on dental care for eligible Victorians under the CDDS in the last full year 2011/12. This amounts to almost $14.2m per month. Given the 19 month gap between the end of the CDDS and the start of the new adult dental funding arrangements, this equates to $269.16m.

Access to care

- Where patients are eligible for publicly funded care this treatment should continue to be funded by the Commonwealth. For example, diabetic patients, who need periodontal maintenance on an ongoing basis, faced with the sudden withdrawal of Commonwealth funding will have to fund their ongoing care privately. A transitional arrangement by which such patients could continue to receive dental care would help to ensure that the Government achieves its objectives in multi-disciplinary care for diabetics.
- Many patients in the 'special needs' category will also be badly disadvantaged by this hiatus. A member of the ADAVB, a special needs dentist, reports that around 30% of her patients used Medicare CDDS vouchers to pay for treatment. Patients in this category are some of the most vulnerable in society - they may be elderly, homebound, chronically ill, or in nursing homes.

Workforce capacity

- In recent years a number of reports had highlighted a shortage of dental practitioners. These problems now appear to have been addressed with graduates of the four new dental schools established since 2005 now entering the workforce, and increased numbers of graduates being produced by the dental schools and the Australian Dental Council examination processes.
- There is no longer the same pressure to expand the scope of practice of ancillary dental practitioners, and the capacity issue is primarily focussed on funding and infrastructure.
- For more information on workforce, see ADAVB Medicare Locals Briefing Pack 1 - Paper 1.3.

Infrastructure capacity

- The grant scheme by which new public facilities will be built and equipped is not due to operate until some time in 2014. This means that if additional workforce is to be accommodated to treat the additional patients the treatment funding is meant to cater for, States and territories will still be short of infrastructure capacity in mid-2014.
- Infrastructure upgrades should be done before increased treatment funding becomes available rather than causing bottlenecks due to lack of dental chairs and clinics.

MORE INFORMATION

See: http://www.health.gov.au/internet/main/publishing.nsf/content/dental+care+services

5 September 2012

Dental Package –As Always, The Devil is in the Detail

The Australian Government's redirection of dental funding to 2-17 year olds and away from the non-targeted Chronic Disease Dental Scheme (CDDS) is a sensible initiative as it is investing in the future. However, the mode of closure of the CDDS has given little consideration to the many patients currently receiving treatment.

The Australian Dental Association Inc. (ADA) Federal President, Dr Shane Fryer has raised concerns that many patients currently accepted into the CDDS will be unable to complete their course of treatment by the closure date of 30 November 2012.

"Providing patients with only 12 weeks to complete treatment demonstrates a fundamental lack of understanding about dental care by the Australian Government" stated Dr Fryer today. "Many of the patients being treated under the CDDS require complex care; some of which includes surgical procedures that need to be completed over a series of months, for example periodontal treatment. It is unreasonable to expect patients to now be responsible for the cost of procedures they consented to on the understanding their treatment would be covered by Medicare. Many patients will either abandon treatment or face bills they do not have the capacity to pay. If later treatment is possible the disruption to treatment continuity will lead to much of the treatment needing to be duplicated. Plainly, this is wasteful and could have been avoided with some considered forethought".

The ADA believes that at the present time too much attention has been given to achieving budgetary savings rather than focusing on maintaining government funded dental care before the planned implementation of the new programmes.

"Excusing this short-sightedness by laying the blame at the feet of dentists is the government's way of hiding behind the fact that the costs of the CDDS have blown out beyond budget. This blow out merely demonstrates the level of unmet need for dental services within the community. Since the inception of the CDDS the ADA has continually called for the replacement of this scheme with a more targeted proposal. It has regularly discussed remedial action with the government and outlined solutions to the issue of dentists not meeting all of the administrative requirements".

The ADA recommends that patients currently being treated under the scheme be given an adequate opportunity to complete their treatment. In the government's announcement patients have been given only three months for their treatment to be completed. Provision needs to be made for suitable applications for approval to be sought from Medicare if situations arise where this may be inadequate.

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Paper 3.2

General Anaesthesia (GA) and Dentistry

WHY DO MEDICARE LOCALS NEED TO UNDERSTAND ISSUES RELATED TO GA AND DENTISTRY?

Some patients can only be offered dental care under GA, but funding of hospitals and day procedure centres is so low that they can't afford to offer access to their facilities thus denying needy patients access to care. Medicare Locals in Victoria, charged with identifying and addressing service gaps within their regions, may be in an ideal position to positively contribute to the GA access issue.

Access to health care:

- Governments are responsible for ensuring that all people have access to safe, appropriate and effective health care.
- The Australian Charter of Healthcare Rights, published by the Australian Commission on Safety and Quality in Healthcare (ACSQHC), was adopted by Health Ministers in 2008. The first and foremost right is a right of access to health care.
- Health service organisations can contribute to the right of access by maintaining a health care environment that encourages access through appropriate management of facilities, equipment and supplies.
- It is not possible for health care organisations to meet the requirements of the Charter if funding arrangements prevent them from allocating facilities to essential procedures.

WHY DO DENTISTS USE GA?

GA is used to provide safe and comprehensive dental care for patients of all ages with behavioural, medical or other problems that preclude treatment in the usual dental practice setting. The use of GA reduces cognitive, sensory, and skeletal motor activity in order to facilitate the delivery of high quality, comprehensive dental services.

Procedures are performed on patients under GA when the procedure itself is complex, lengthy and cannot be performed in a dental practice. In some cases, the use of GA is not only necessary for the practitioner to successfully complete the procedure; it is also required for patient comfort.

WHO REQUIRES GA FOR DENTAL TREATMENT?

Those who require dental treatment under GA include:

- Patients with certain physical, mental, or medically compromising conditions
- The uncooperative, fearful, anxious, physically resistant or uncommunicative patient with substantial dental needs and no expectation that the behaviour will soon improve
- Patients that have extensive orofacial and/or dental trauma
- Patients with immediate comprehensive dental needs who otherwise would not receive comprehensive dental care
- Patients requiring dental care for whom the use of GA may protect the developing psyche and/or reduce medical risks
- Patients requiring significant maxillofacial surgical procedures
- Patients with dental restorative or surgical needs for whom local anaesthesia is ineffective because of acute infection, anatomic variations, or allergy
- Patients who require treatment not possible under local anaesthesia settings, for example, the removal of impacted wisdom teeth[1].

WHY IS ACCESS TO GA SO IMPORTANT?

Access to GA for dentists is extremely important as it allows those patients who are unable to undergo dental treatment in the usual dental practice setting to receive safe, effective and suitable dental treatment.

The ADAVB considers that those who require dental treatment under GA should be able to access this service just as easily as those patients who require a different procedure. The rationale behind this position is evident in the quote from the American Academy of Pediatric Dentistry:

"The need and justification for GA is the same, regardless of the procedural challenge or the areas of the body for which the procedures are performed. GA is provided because of the patient's inability to receive, tolerate or cooperate with medically-necessary treatment secondary to such factors as age, disability, or physical or mental impairment and not secondary to the nature of the procedure itself. For instance, GA coverage is routinely provided for such procedures as tonsillectomy and removal of cutaneous growths and lesions for infants and persons with disabilities when these procedures and others like them would be performed under a local anesthetic in an office setting for the typical adult and older pediatric patient."[2]

1 Jamieson, L & Roberts-Thomson, K. (2008) Dental general anaesthetic trends among Australian children. BMC Oral Health, 2006, Volume 6, pp16

2 American Academy of Pediatric Dentistry, Pediatric Oral Health Research and Policy Centre (May 2012) Technical Report 2, An essential Health Benefit: GA for treatment of early childhood caries, page 3.

DO ALL DENTISTS NEED GA FACILITIES FOR THEIR PATIENTS?

While most people will recognise that Oral and Maxillofacial Surgeons and Oral Surgeons need GA for treatment of trauma and cancer patients, it is not so well recognised that other dental practitioners also require these facilities. Those who need them on a frequent basis are mainly paedodontists dealing with children who require extensive and therefore long procedures, and special needs dentists dealing with disabled and other special needs patients who could not cope with treatments under only local anaesthetic or conscious sedation. Dental treatment undertaken under GA (when not possible in the dental chair) may include examinations, radiographs, scaling and cleaning, restorative and periodontal treatment. Other specialists and general practitioners will also have patients from time to time whose circumstances demand that their treatment is delivered under GA.

WHAT IS THE PROBLEM?

ADAVB members report that it has become increasingly difficult for dentists to book GA theatre facilities at private hospitals and Day Procedure Clinics (DPCs). The following issues have been identified:

- Longstanding lists are being removed from facilities for those Paediatric and special needs dentists whose patients need access to GA
- Time limits are being imposed on dentists for financial reasons where longer procedures would be more beneficial to the patient
- There is very limited access to GA facilities in rural and regional locations
- There is limited health fund cover for dental care in a hospital.

WHAT ARE THE PERCEIVED BARRIERS TO GA ACCESS?

- Health fund rebates are too low and structured to penalise hospitals and DPCs offering dental services particularly if longer procedures are required
- Hospitals and DPCs can earn better income from other treatment modalities
- The banding of Dental procedures is inequitable when compared with other medical specialties. Dental treatments administered under GA fall under the lowest private health insurance funding band.
- Medicare schedules do not recognise routine dental procedures are being performed in operating theatres.

OTHER CONSIDERATIONS

- ADAVB members report differing degrees of difficulty in accessing GA facilities
- There are inconsistencies in approaches to allocating theatre time by different organisations in Victoria
- The issue is not seen as consistent across Australia, possibly because of the different ways that private health insurance funds rebate hospitals across states and territories
- Because health funds negotiate fees they pay to each hospital and DPC, and these negotiations are confidential, no benchmark data can be compiled to fully assess the economic drivers of this problem

WHAT ARE SOME OF THE POTENTIAL IMPACTS OF LIMITED ACCESS TO GA?

Those patients who are physically, mentally or medically compromised, those with behavioural problems, those with phobias and those who require treatment not possible under local anaesthesia are unable to access dental services. This means that needy patients are being denied access to the best form of care and treatment to manage and prevent dental disease. Some of the possible outcomes of this are:

- An increase in dental disease: patients that need treatment under GA are not able to do obtain it
- An increase in extractions: with limited access to operating theatres, dentists cannot provide dental treatment in a timely manner and deliver restorations and preventative care
- An increase in dental fears and phobias: vulnerable patients, including young children, are being traumatised by treatment in the dental chair.

WHAT CAN BE DONE ABOUT ACCESS TO GA?

Given that Medicare Locals have a task to coordinate services to address gaps, ADAVB is keen to partner with Medicare Locals in ensuring that dental patients access the services required to receive appropriate, timely, effective and safe treatment.