


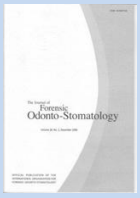

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AN AUSTRALIAN GOVERNMENT DENTAL SCHEME: DOCTOR-DENTIST-PATIENT TENSIONS IN THE TRIANGLE.

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ABSTRACT
Autonomy of participants is challenged when legislation to provide a public health service is weakly designed and implemented.
Background
Australia's Chronic Disease Dental Scheme was instigated to provide a government subsidy for private dental treatment for people suffering chronic illness impacting their oral health or vice versa. They were allocated AUD$4250 towards comprehensive treatment over 2 years with their eligibility determined by their general medical doctor.
Research
A qualitative research study was conducted to explore the experiences from the perspectives of the patient, medical and dental practitioner. One of the research outcomes identified a frequently reported level of discomfort in the patient/doctor/dentist triangle. Doctors and dentists reported feeling forced by patients into positions that compromised their autonomy in obeying the intent (if not the law) of the scheme. Additionally, dentists felt under pressure from doctors and patients to provide subsidized treatment to those eligible. In turn, the patients reported difficulties in gaining access to the scheme and in some cases, experiencing full or partially unmet oral health needs.
Reason for Conflict
Poor inter-professional communication and lack of understanding about profession-unique patient-driven pressures, ultimately contributed to dissonance. Ill-defined eligibility guidelines rendered the doctor's ability to gate-keep challenging.
Outcome of Conflict
Inefficient gate-keeping led to exponential increase in referrals, resulting in unprecedented cost blow-outs. Ensuing government-led audits caused political tensions and contributed to the media-induced vilification of dentists. In December 2013, government financing of dental treatment through Chronic Disease Dental Scheme was discontinued, leaving many Australians without a viable alternative.
Recommendations
There is a need for qualitative research methods to help identify social issues that affect public health policy process. In order to succeed, new health policies should respect, consider and attempt to understand the autonomy of key participants, prior to and throughout

***KEYWORDS*:** Autonomy, Australia, Chronic disease, Government Dental Scheme, Qualitative Research

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INTRODUCTION

Australia's Chronic Disease Dental Scheme (CDDS) aimed to alleviate oral health conditions that directly impacted on people with chronic disease.[1] The CDDS paradigm lay within the need to provide people with timely and affordable access to primary care, as a means to prevent the onset or worsening of their chronic health problems.[2]

The Australian Oral Health System is based on privately funded dental practices accessed by 85 percent of the population.[3] It incorporates a publicly funded service for eligible patients that varies from state to state, including children, the disabled, and low income patients. Public dental services are funded through a mix of Federal and State Government reserves. However, the public dental services fail to meet the demand for oral health needs in Australia.[4] The implementation of CDDS made some defining contributions to a particular group of patients many of whom may be eligible for public care but miss out due to prohibitive waiting lists to gain treatment.[3]

Additionally, many Australians consider the cost of private dentistry to be prohibitive.[5] People from low socio-economic backgrounds experiencing pain and infection, often seek symptomatic relief from alternative sources of care such as their general medical doctors. Unlike access to general medical care, private dental treatment is not subsidized by Medicare (the Australian Government's health agency).[6] The CDDS was the first scheme to pay Medicare benefits towards private dental treatment for eligible patients[7] since the 1990s.[3]

Eligibility to be part of CDDS was determined by a doctor, depending on the patient's chronic health experience and not their financial situation. Those deemed eligible were allocated AUD$4250 worth of funding through Medicare, to pay for services rendered by general and/or specialist dental practitioners and/or dental prosthetists over a consecutive two year period.[1] This group will be referred to collectively as dentists unless individual identification is required.

From inception in November 2007, the CDDS was fraught with controversy, receiving highly politicised media coverage alleging exploitation by dental practitioners.[7] By June 2008, 480 000 CDDS services had been provided at a cost of $79 million to the Federal Government. Citing cost-blow outs and over-servicing by dentists, the Federal Government attempted to close the scheme twice in 2008 with both attempts blocked by the Australian Senate. In October 2008, Medicare Australia announced the introduction of a compliance program and proceeded to audit dentists for administrative oversight. In December 2009, Medicare announced the finding of 28 dentists in breach of their administrative and billing requirements and sought redress totaling $21.6 million Australian dollars. After considerable legal, media and political attention, the fines were reduced to $0.5 million and the scheme discontinued on December 1,2012. To date, there is no comparable alternative available to those seeking dental treatment.[8] Despite this controversy and altruistic and theoretical underpinnings, very little research was conducted on the CDDS process and participant experiences, particularly at the user level. This paper will provide an insight into the complexity of the relationship between the three parties and a means of understanding the controversy

MATERIALS AND METHODS

Purposive and snowball sampling were used to recruit participants from diverse backgrounds with experience of the CDDS. The selection criteria were broad to include as many opinions and experiences as possible. However, as the data gathering and analysis process progressed,

participants with known divergent views or experiences were sourced through the initial participant pool.[9] The initial participant pool was also used to gain access to people who are less likely to initiate study participation due to social or geographical isolation.[10]

Thirty-three participants were sent letters of invitation and 31 participated. None refused. Two participants, a patient and doctor were sent letters of invitation, but were not required because the necessary level of data was achieved without loss of participants.

The research was undertaken using focus groups to refine topics identified in a literature review before developing a template used in semi-structured interviews. Two focus group sessions, each consisting of five participants - one consisting of dentists/personnel from the Sunshine Coast and the other. CDDS patients from metropolitan Sydney, were conducted. Each session ran for approximately 120 minutes. Analysis of the focus group sessions allowed for the refinement and development of semi-structured interview templates used in the interviews. Twenty-four in-depth, semi-structured interviews were conducted between April and August 2013. The interviews lasted between 30 and 180 minutes. All interviews and focus group sessions were conducted by the primary author, transcribed verbatim and analysed using content and then thematic analysis[11] with the aid of NVIVO 10 qualitative analysis software.

Ethics approval was provided by the University of Queensland's Ethics Committee (Approval number AW010213).

RESULTS

This paper will focus on the discomfort between patients, doctors and dental practitioners that was generated by the CDDS process and identified in the research.

Access to CDDS

Doctor's reported that Medicare's CDDS entry guidelines were imprecise and vague resulting in varying degrees of influence affecting their final decision to refer patients. One Doctor commented: *"All you had to have was a chronic medical condition that impacts on your dental health. What does that mean? Impact? So vague, so nebulous, that anybody with anything could argue for it." (Doctor 4)*

Whilst many factors influenced a doctor's referral process, a significant number of CDDS referrals were made due to demand from patients. Even doctors who resisted requests by patients who did not have a chronic disease, eventually bent to their demands and provided a referral. Doctor's who reported working in practitioner-saturated markets, felt that the need to please their patients conflicted with their role to be a gatekeeper. This is illustrated in the following statement. *"We're competing with each other for patients. … there's a lot of doctors thinking, 'Hey I'd better give that person what they want because I want that person to come back to me.'" (Doctor 4)*

Nine patient participants confirmed that pressure was placed on doctors by patients to provided referrals. Patient participants related seeking CDDS referrals after learning of the scheme from sources such as doctors' surgery staff, people receiving treatment through the scheme, dentists or the government dental services. *"Actually I found out through my wife's cousin who's a registered nurse and works out of my local doctor's rooms." (Patient 3)*

Pressures placed on doctors to provide access was further compounded by what was commonly called 'Doctor Shopping'. If a doctor refused to provide a referral, patients would visit many doctors in succession until one relented. Two patients discussed such a process during the focus group session. *"I had to go to two doctors to get it. The first one knocked me back*

and then I went to my doctor. So it wasn't easy to get." (Patient 8)

In addition to pressure from their patient base, doctor's related having patients present to their surgeries seeking referrals on the basis that a dentist specifically sent them for one. This concept was confirmed by dentists in this study, as illustrated below by one dentist justifying their position regarding the requests. *"They were patients who really needed dental treatment and they did have a chronic disease. They were the sort of patients that CDDS was for so I never had my request refused." (Dentist 7)*

However, doctors who reported feeling overburdened with the responsibility of gatekeeping government funds did not welcome requests for CDDS referral by dentists. Some doctors considered requests for referrals from dentists as an attempt to raise dentist's personal revenue. As a result, dentists' requests were often rejected and became a source of professional discord and misunderstanding between the health practitioners.

However, unbeknown to the dentists, doctors reported a secondary reason for not heeding dentist-driven referrals. Some patients were simply deemed ineligible. When this reason was related to dentists, all reported seeing many patients through the CDDS who showed no evidence of suffering from a chronic health conditions, despite presenting with CDDS referrals from their doctors. *"Indeed I had many patients, not several but many patients, who did not know why their doctor had sent them to the dentist except to get their $4,000.00." (Dentist 9) "There was nothing wrong with them. 'Are you taking any medication?' 'No. I'm not taking any medication.'" (Dentist 9)*

In response to such assertions, one doctor conceded that the vague Medicare entry guidelines allowed for some creativity on the doctor's part, to allow patient entry. Doctor's also reported feeling morally challenged when trying to provide access to patients with high needs who were not necessarily considered eligible.

By October 2011, 11 million services had been provided to 680 000 people.[8] Despite such monumental figures, all study participants reported a lack of promotion of the scheme with the result that people known to them, who were deserving, missing-out. Seven patients related that had they not specifically requested CDDS access from their doctors, they would not have received a referral. The failure for doctors to disclose such an important scheme was considered deceptive and unfair as illustrated by a comment made one patient. *"They don't tell you these things. It's as though it's for them to know and you to find out for yourself sort of thing. It's a secret society." (Patient 11)*

In response to patient grievances, all doctors reported a mounting pressure from the public as the predominant reason for failing to volunteer information. Doctors confessed to providing referrals only on request as illustrated by such a comment below. *"But we didn't go actively seeking these people did we? And I think human nature, being what it is, a lot of people that came and asked for it got it and probably didn't deserve, and some of the people who did deserve it didn't ask for it and didn't get it." (Doctor 3)*

Treatment and fees under the CDDS.

Medicare's CDDS schedule of fees was considerably lower than the standard fees for dentists in the study. In addition, dentists reported having to allocate increased administrative time to cover Medicare's needs. Some reported business losses due to Medicare's refusal to pay, or due to significant delays in paying for the treatment rendered. The cost in wages for staff to chase payments was high in relation to some of the missing fees, but the losses added up over time. However, most dentists chose to accept the reimbursement offered by Medicare

('bulk-bill' was the term used). They felt that patients would go elsewhere if they did not.

All the doctors in the study said they referred their patients to bulk-billing dentists unless the patients requested a particular dentist. This would also create tension with dentists who felt compelled to bulk bill.

All patients in this study said they were bulk-billed and eight of the twelve related satisfactory oral health outcomes but four reported incomplete treatment. Dentists reported cases where patients stopped attending once the $4000 mark was reached. Four dentists reported treating some patients for free to complete the patient's ideal treatment plan once funding through CDDS was over. Dentists and doctors also reported cases where people with referrals chose not to seek dental intervention.

DISCUSSION

Doctor-Dentist-Patient Tension

The design and implementation of the scheme required the cooperation between the three main interest groups and Medicare Australia. The results of this study indicate that each group faced challenges that remained unknown to the other significant groups. This led to unnecessary creation of tension and misunderstanding, resulting in avoidable professional divisions between dentist and doctor groups. Additionally, some patients felt disillusioned by their health practitioners billing, practice and referral behaviour, without entirely understanding the situations and limitations faced by the doctor or dentist in their relationship with Medicare.

Failed expectations from all parties led to a few members of each group (dentists, doctors and patients) performing or behaving in morally or ethically challenging ways. Doctors reported feeling overwhelmed by the demand for referrals, by their need to please people and maintain their patient numbers. Dentists felt undervalued due to the lack of inter-professional respect from the doctors. The scheme's limitations coupled with high patient needs resulted in some dentists performing procedures beyond their general scope of practice. Patients felt deceived by health practitioners for non-disclosure about the scheme and let down by the overarching aims of the CDDS, for not being able to overcome their treatment needs.

Moral Dilemma in Public Health Schemes

The CDDS was created to improve access to dental treatment for people with chronic health issues. It used doctors, the patient's most accessible health practitioner, as the gatekeeper. The entry guidelines set by Medicare Australia were designed to promote and support autonomous decision-making by doctors, to enable independent support of their patients' needs. Unfortunately, these guidelines did not envisage the complex behaviours of patient seeking health service and the intricacies of economic forces on the doctor's decision-making processes.

Health economists have examined the processes involved in making health-related decisions over many years. In his foundational paper, Arrow (1963)[12] described healthcare systems using the allegorical context of an economics market. Patients as the consumers were driven to purchase health, not as a commodity, but in a bid to retard death or overcome illness. Doctors were in the business of selling health, but delivered on expectations potentially motivated by altruism rather than pure business transactional efficiency.

However, the complexity of the decision-making process used by a doctor in determining final service delivery is affected by factors such as income for service, relationships with and market for patients and patient-driven service

requests, to name a few. In his concluding statement, Arrow relates how, "the logic and limitations of ideal competitive behaviour under uncertainty force us to recognize the incomplete description of reality supplied by the impersonal price system." (p149)[12] In other words, the unexpected social complexity affects health services and health economies more than we would like to imagine. These were issues faced by the CDDS where the intentions of the scheme's conception were frustrated by unconsidered social processes.

The lack of clarity over eligibility led to discord between various doctors and dentists. The personalisation of the referral process resulted in what was considered by some, to be the provision of unnecessary referrals to undeserving cases. The results of this study indicate the individual differences in opinion regarding who merited referral and who did not, leading to pointless dissatisfaction. Individual patients felt they deserved access over others, dentists found their professional referrals were ignored and doctors found their autonomy threatened by demands to provide referrals from patients and dentists.

CONCLUSIONS

This study provided insight into the effects of multidisciplinary involvement of health professionals when attempting to address the dental side of chronic illness and the resultant overspending on the budget. In the end, CDDS cost the government a considerable amount of money not by manipulative strategies of dentists or doctors, but by the poor guidelines and gate-keeping procedures implemented by Medicare. Had this issue been identified and the terms and conditions of eligibility been more precise, fewer but more carefully selected patients would have received referrals from their doctors, despite public pressure.

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