PO Box 520 St Leonards NSW 1590
14-16 Chandos Street St Leonards NSW 2065 Australia
Tel 02 9906 4412 Fax 02 9906 4676
ABN: 95 174 118 424

AUSTRALIAN DENTAL ASSOCIATION

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Mr Mark Fitt
Committee Secretary
Senate Economics Legislation Committee
PO Box 6100
Parliament House
Canberra ACT 2600

By email: economics.sen@aph.gov.au

Dear Mr Fitt,

The Australian Dental Association (ADA) appreciates the opportunity to provide a submission to the Inquiry into the Budget Savings (Omnibus) Bill 2016 (the Bill). Given the time constraints of responding to the call for submissions, the ADA will confine its comments to the Dental Services measures outlined in the Bill, i.e. replacing the Child Dental Benefits Schedule (CDBS) with the Child and Adult Public Dental Scheme (caPDS).

The ADA is extremely disappointed with the proposed savings measure as the CDBS is an invaluable and unique scheme which has a strong focus on early prevention and has been instrumental in delivering long term oral health benefits to Australians and financial benefits to the Australian economy. The rationale underpinning this policy direction and the initial design of the scheme were informed through the consultative processes of the National Advisory Council on Dental Health which reported in February 2012.[1] The circumstances that existed in 2012 in relation to the oral health of Australians has not substantially changed since that time.

Despite being mostly preventable, oral diseases, which are prevalent and chronic, are among the most common and costly health problems experienced by Australians.

While there was a period of improvement in oral health among Australian children, tooth decay in this age group has been on the increase since the mid-1990s. As reported by the AIHW the proportion of children who had experienced tooth decay in their baby teeth was around 48% with the number increasing for permanent teeth to over half the population by the age of 12. [2]

The Council of Australian Government's own oral health plan *Healthy Mouths Healthy Lives* [3] has highlighted the high incidence of poor oral health among Australian children and its unfair spread across the community. Children in the lowest socio-economic areas experience 50%-70% more decay affected teeth then children in the most advantaged areas.

For adults, around one in ten have untreated tooth decay and approximately 23% have moderate to severe gum disease with rates increasing to double that in adults who are socially disadvantaged or on low incomes.[4]

CDBS

One of the 4 guiding principles of *Healthy Mouths Healthy Lives*[5] is the provision of accessible and appropriate dental services including prevention and health promotion. It recognises that oral diseases will only be adequately addressed if Governments support programmes which focus on prevention, particularly among children. The CDBS was designed to tackle this issue.

[1] National Advisory Council on Dental Health, Final Report of the National Advisory Council on Dental Health, 23 February 2012.
[2] AIHW 2014. Oral health and dental care in Australia: key facts and figures trends 2014. Cat. no. DEN 228. Canberra: AIHW.
[3] Health Mouths Health Lives Australia's National Oral Health Plan 2015-2024 Council of Australian Governments 2015.
[4] Ibid
[5] Health Mouths Health Lives Australia's National Oral Health Plan 2015-2024 Council of Australian Governments 2015

The CDBS delivers dental care to Australia's neediest children where they can access it best. The new caPDS proposes to expand the eligible population to all children, not just those in lower socio-economic groups. This new scheme will be less focused on the children who are at higher risk of poor oral health.

Dentists report that since the scheme commenced, they are seeing children who had previously never visited a dentist along with many returning for treatment, having previously stopped due to cost. It also allowed families to have all their children treated not just those at school. According to Hartford and Luzzi, results from the National Dental Telephone Interview Survey show that almost 70% of pre-schoolers in 2010 had never visited a dentist.[6] The CDBS covered children in this age group.

The purported "poor" uptake of the CDBS is cited as justification for its closure in the Regulation Impact Statement (RIS). The ADA is of the view that similar patterns of attendance are seen in other government funded dental programmes where cost is not an impediment. For example, the Department of Veterans' Affairs Fee Schedule of Dental Services for Dentists and Dental Specialists demonstrates similar utilisation rates. A second factor to consider, with perhaps the exception of South Australia that supports a school dental programme, is the similar participation rates currently in state and territory public dental schemes which provide universal access to children currently.

What is more likely to be a factor in its success or failure is the lack of awareness about the scheme in the community. Two separate reviews of the CDBS were conducted in the last 12 months; one by the Australian National Audit Office (ANAO)[7] and the second by an independent panel conducting the Third Review of the Dental Benefits Act 2008.[8]

The ANAO report noted that the take up of the CDBS has been relatively low but rather than support the conclusion that the CDBS should be terminated, it concluded that the availability of dental care to eligible families should be more effectively communicated.

The Report on the Third Review of the Dental Benefits Act 2008 chaired by the Commonwealth's Chief Medical Officer, Professor Chris Baggoley AO, noted the success of the CDBS in 'targeting the oral health of young Australians at an age where preventative measures can be most effective'. The panel noted low take up was attributable to poor communication of the existence of the scheme to eligible families and concluded that this needed to be improved.

To determine the fate of the CDBS based on low take up when responsibility for that low take up was due to poor promotion smacks of hypocrisy. Its failure was government induced and one could be skeptical to suggest inaction by Government was designed to provide justification for closure.

Furthermore, evidence published in the Report on the Third Review of the Dental Benefits Act 2008 demonstrates that 97% of children who accessed CDBS services did so at no out of pocket cost. If this scheme was to be extended to eligible adults as well, then there would be a mechanism for these adults to access dental care in the private sector at no out of pocket cost. A number of jurisdictions apply a co-payment for treatment in public dental services so the impact on patients has not been fully disclosed in the RIS.

With increasing levels of disease evident, now is not the time to terminate a scheme which provides increased access for children to oral health services in the name of short term budget savings. The termination of the CDBS will hurt disadvantaged Australians the most because it will force children back into an overstretched public dental system. In some rural areas, where there are no public dental clinics, some children will miss out altogether.

caPDS

The proposed caPDS has many limitations not the least of which will be Australians' ability to access care under an already under-resourced and overloaded public dental system.
Even with increased funding for public dental services, their capacity to treat an increased eligible population in an appropriate time frame will not be sufficient. The reality is that there will be longer waiting times leading

[6] Harford JE & Luzzi L 2013. Child and teenager oral health and dental visiting: Results from the National Dental Telephone Interview Survey 2010. Dental Statistics and Research Series no. 64. Cat. no DEN 226. Canberra: AIHW.

[7] ANAO Report No. 12 2015-16 Administration of the Child Dental Benefits Schedule

[8] http://www.health.gov.au/internet/main/publishing.nsf/Content/Dental_Report_on_the_Review_of_the_Dental_Benefits_Act_2008

to an increase in expensive emergency care and less capacity to provide proven and cost-effective preventative care and timely conservative treatment. Without access to services in primary care through private practice, there is likely to be greater pressure placed on general medical practices, emergency departments and hospitals by patients seeking treatment for dental problems.

In 2012-13, more than 63,000 Australians were hospitalised for acute potentially preventable dental conditions. Young children have the highest rates of preventable hospitalisations due to dental conditions. In 2011-2012, 7,791 children aged 0-4 years and 13,503 children aged 5-9 years were admitted to hospital for dental conditions.

Patient choice will be removed, particularly impacting upon adult Australians in outer regional and remote areas who do not have easy access to a public dental clinic. The RIS states that one of the problems contributing to poor oral health particularly in adults on low incomes, Aboriginal and Torres Strait Islander people and rural and remote populations is that public dental services face great pressure in providing services to eligible people. With an expectation that they will now treat an additional 600,000 patients under the caPDS, the demand on these services cannot possibly be met. Public dental services would need to treat an additional 11,500 patients per week. This is totally unrealistic.

The RIS states that the States and Territories achieved a reduction in waiting times for adults under the National Partnership Agreement on Treating More Public Dental Patients by employing additional staff, extending opening hours for clinics and increasing the contracted use of private sector dentists to deliver services to public dental patients. It is expected that the new scheme will allow the jurisdictions to increase service volume and control waiting times by increasing infrastructure and workforce and reduce their reliance on contracting with the private sector. Yet there is nothing evident in what is proposed that requires states and territories to take such steps. The RIS fails to acknowledge that the only reason jurisdictions were able to achieve a reduction in waiting lists was because they outsourced care to the private sector. The RIS then goes on to contradict itself in describing how the scheme will be implemented by proposing that the new scheme will allow the states to maintain existing private sector arrangements and build on these where necessary. The ADA would posit that without the use of the private sector the caPDS is unlikely to achieve its target. 15% of dental practitioners in Australia cannot reasonably be expected to meet the oral health needs of 40% of the Australian population, the adult component of which has higher levels of oral disease, and higher levels of untreated oral disease than the remainder of the adult population, unless dental care is to be strictly rationed or limited in scope.

It is unclear how the funding can be used for infrastructure and workforce positions when the grants available are subject to the jurisdictions providing treatment in the first place to receive their 40% allocation of the efficient price of the dental service provided.

If the caPDS is to commence, then the ADA urges the Government to divide up funding according to the size of the eligible population in each jurisdiction, and also attach productivity targets. In the absence of these controls, there would be no assurance of equitable provision of funding to each jurisdiction.

Transparency and Review of the Dental Benefits Act

Section 68 of the of the Dental Benefits Act 2008 currently requires an independent review of the Act every three years, with the report to be tabled in Parliament. The Bill proposes to change this, so that the next review will be conducted by the end of 2020, and that this will be the last independent review.

The Bill states that "*the government will continue to monitor the operation of the Act, and does not consider triennial statutory reviews to be necessary*". The ADA questions this. The public have a right to know how their funding is being spent, and what benefits they are receiving for this. Section 68 of the Act provides for a transparent and independent reporting process, which is accessible to the public. This section should therefore be maintained.

Impact on private dentists

The Government states that the closure of the CDBS is not expected to have a significant impact on private sector dentists. It argues that "before the introduction of the CDBS, around 80 percent of children – or around 4.4 million children – visited a dental practitioner annually. Of the children who visited a dentist annually before the CDBS began in 2014, some 3.7 million were treated in the private sector…"

The new public dental funding mechanism will have a significant negative impact on private dental practitioners, as the changes proposed in the Bill direct funding away from private sector providers, in favour of public clinics. Given that all children would then be eligible for the caPDS, more than 4.4 million children could be directed away from private dentists annually, and funneled into an already strained public dental system, where they will likely need to wait longer to receive the care that they need. Directing all children away from private dental services would certainly have an impact on private dentists.

Furthermore, if this approach was to be sustained over a long period of time it would also impact the scope of practice that a private dentist utilises, being limited to adult patients, and those children whose families choose not to access public care. The proposed changes to the Act therefore have the potential to fundamentally change the way that the private dental sector operates. The discussion in the Bill gives insufficient consideration to the impact of this, and the ADA therefore urges the government to engage in further consultation with the private sector prior to amending the Act.

Consultation with relevant parties.

On page 83 of the RIS, it is reported that consultations have taken place with the ADA. This is an interesting interpretation of the word “consultations”.

Representatives from the ADA did attend a meeting with representatives from the Department of Health and were provided with an outline of the proposed Budget measure however, it was made clear at this meeting that the new scheme was not up for debate; ADA was being advised of the direction the Government would be taking. The two ADA representatives that attended were unable to provide details of the discussions to any other party, including the ADA Executive Committee, due to a confidentiality agreement that the Department of Health insisted on before any information could be shared with the two representatives.

It is also stated on the same page that the ADA

a) does not support the exclusion of the private sector from directly accessing Commonwealth funding; and
b) that it is seeking expansion of items and increased schedule fees under the CDBS.

This is not the whole story.

ADA had repeatedly drawn attention to the fact that 85% of the dental workforce is employed in the private sector.

A 2014 report on Australia’s oral health workforce[9] found that there is substantial extra capacity available in the dental workforce, which could be utilised to deliver more services to higher-risk populations. Given that the majority of dentists work in the private sector, this would need to be achieved through a partnership of public and private providers. Reducing the number of available providers to only those who work in the public sector will further limit access to care. Any changes to the Dental Benefits Act need to consider the best way to maximise access to care for priority populations, rather than adding extra strain to an already overloaded public dental system. To not use this capacity would be unconscionable while patients languish on waiting lists in pain or discomfort.

On the second point, the ADA has proposed extending the CDBS to other priority populations with a fee schedule that reflects the complexity of older Australian’s treatment needs so this comment is being used out of context.

Rural and remote Australians will be more disadvantaged

As indicated earlier, both children and adults in rural and remote Australia will be most affected by the proposed changes. The Dental Relocation and Infrastructure Support Scheme (DRISS) was established to encourage dentists working in metropolitan or inner regional areas to relocate their practice to a more rural or remote location.

Many of the 100+ dentists who have established practices in more rural locations relying on DRISS funding did so in the knowledge that many of the patients in that community would be able to use their entitlement under the CDBS at a private dental practice. The closure of the scheme could place some of these practices in an unviable situation and result in the community losing a dentist. Government funding provided to establish the practice would also be wasted.

This is in effect one decision of the Commonwealth Government working in opposition to another Commonwealth funded programme.

If the Commonwealth Government really wanted to improve the oral health of the community while still being fiscally responsible, and had there been true consultation with the dental profession, there are a range of initiatives that could have been considered to achieve this aim including reducing the threshold for eligibility under the CDBS as well as introducing an additional component to the scheme that would have allowed the targeted adult group of recipients to also access timely and appropriate care without increasing the burden on an already burdened public dental system. Noting that the most common range of claims for children accessing the CDBS was in the range $100-350 the benefits available could have been reduced. The caPDS should include performance criteria that the jurisdictions must meet including the provision of emergency treatment for dental pain within 3 days either in a public facility or require outsourcing to a convenient private dentist. Also in remote areas where there is a private practice but no public facility within one hour of travel, outsourcing should be required. Without such performance controls, the new scheme is in effect, the Commonwealth stepping away from meeting its responsibilities to the Australian community.

The ADA would be very willing to provide further information to the Senate Inquiry if required.

Yours sincerely,

Dr Rick Olive AM RFD
President