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Australian Healthcare and Hospitals Association

Submission to the
House of Representative Standing Committee on Health and Ageing
Inquiry into Adult Dental Services in Australia

14 March 2013

Introduction

The Australian Healthcare & Hospitals Association (AHHA) welcomes the opportunity to provide a submission to House of Representative Standing Committee on Health and Ageing inquiry into Adult Dental Services in Australia.

The Australian Healthcare & Hospitals Association is Australia's largest health care group, representing providers of public and not-for-profit health care services. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Medicare Locals and primary healthcare providers, universities, and individual health professionals and academics. We are uniquely placed to be an independent, national voice for universal high quality healthcare in public hospitals, aged care, community and primary health sectors.

The AHHA believes that an improved oral health system is an essential part of a more equitable and effective health system. Oral health is a vital component of overall health and well-being. Poor oral health impacts negatively on people's ability to fully participate in society and can lead to malnutrition, unemployment and social isolation. If untreated, oral problems develop into more serious health conditions requiring intensive treatment and hospitalisation.

The long-term trends suggest that the degree of inequality in dental care access has increased over the last 30 years and these inequalities appear to have been influenced by government policies[1]. The community's lack of access to affordable dental health services means that Australia ranks among the bottom third of OECD countries for rates of dental decay among adults[2]. There is also

[1] Australian Institute of Health and Welfare Dental Statistics and Research Unit 1996, *Commonwealth Dental Health Program*, Research Report 3, University of Adelaide

[2] National Health & Hospitals Reform Commission Final Report 2009

evidence that the oral health of Australian children has declined, reversing the gains made in the 1970s and 1980s[3].

Our goal is for all Australians to have universal access to preventive and restorative oral health care, regardless of their ability to pay.

The AHHA recognises that a universal access scheme would require a phased implementation, commencing with a focus on early intervention and treatment for disadvantaged groups concurrently with enhancing health promotion and prevention programs. The Government's expansion of the Teen Dental program to include young children and provide treatment services is an important step in improving children's oral health. The commitment of additional funds from July 2014 provides the opportunity to make progress towards universal access for adults.

Response to Terms of Reference

(a) Demand for dental services across Australia and issues associated with waiting lists

Demand for dental services in Australia continues to grow resulting in increasing pressure on public dental services.

The predominant eligibility requirement for public dental services is a current Health Care Card or Pensioner Concession Card which covers approximately 5.1 million Australians While this provides a mechanism for low income persons to access dental care, barriers remain to accessing services, such as limited supply of services, absence of services in some locations, waiting times to access care, co-payments in some jurisdictions, cultural and language barriers.

While clients with emergency and urgent needs are prioritised for care, the imbalance between supply and demand can result long waiting times for general care in the public sector which in turn results in only around 10% of eligible clients being seen in the public sector each year.

Ideally a pattern of dental attendance includes regular preventive care, i.e. check-ups, at a frequency relative to the person's individual risk factors and history. The capacity to provide a regular check-up or recall service for adults is extremely limited in the public sector due to the limited resources and the demand for emergency and urgent care.

One-off allocations of funding for waiting list blitzes can achieve temporary reductions to waiting times however it does not address the fundamental structural barriers to care and waiting times will inevitably increase after completion of a blitz. Funding allocations and programs which promote a focus on throughput do little if anything to address underlying barriers to care or to improve oral health at a population level.

[3] Mejia GC, Amarasena N, Ha DH, Roberts-Thomson KF & Ellershaw AC 2012. Child Dental Health Survey Australia 2007: 30-year trends in child oral health. Dental statistics and research series no. 60. Cat. no. DEN 217. Canberra: AIHW

***Recommendation 1**: That the NPA for National Partnership Agreement (NPA) for adult public dental services be structured to provide a foundation for sustainable improvements in access to public dental care.*

(b) The mix and coverage of dental services supported by state and territory governments, and the Australian Government

The final report of the National Advisory Council on Dental Health describes the overlap in responsibilities and services supported by state and territory governments, and the Australian Government. In the past, the distinction was considerably simpler, with states and territories solely responsible for funding and delivery of public dental services, and the Australian Government's contribution consisting of the private health insurance rebate and funding of services for veterans through the DVA scheme.

The introduction of Medicare funded services through the Chronic Disease Dental Scheme and the Medicare Teen Dental program has shifted the balance of responsibility and this will be further affected by the introduction of the Grow Up Smiling program and the NPA for adult public dental services.

Public dental services are guided by the principle of delivering the greatest good for the greatest number of people. As such public dental services are well placed to utilise additional funding allocations to maximise the benefits to the population and effectively target services to marginalised groups. While there are clearly limitations to the capacity of public services to meet the demand for care, there is also a history of collaboration between the public and private sector, through outsourcing and voucher programs, that can enhance access.

The majority of oral disease is not an acute illness which can be assessed, treated and cured within a single course of care. Oral disease is recognised as a chronic disease by the National Public Health Partnership, along with other conditions such as ischaemic heart disease, Type 2 diabetes, and arthritis. While oral disease is predominantly preventable, it requires effective ongoing care to manage and stabilise the disease

The application of a simple fee-for-service funding model linked to the provision of individual service item numbers is not an appropriate approach for oral health services.

The limitations of an opened ended item number driven funding program were seen and realised within the Medicare Chronic Disease Dental Scheme, which will providing services to many people who may otherwise not have accessed care, resulted in high and increasing costs and did not necessarily deliver services to those most in need.

In order to target services to those who are most in need, the allocation of funding under an NPA for adult public dental services must recognise the complexity of care and resources required which cannot be accurately reflected within a simple item number driven approach.

Additionally the NPA provides an opportunity to facilitate the provision of high quality care through incentives that encourage evidence-based minimal intervention treatment plans in preference to out-dated drill and fill approaches.

The Practice Incentive Program (PIP) used in primary care provides a model for consideration. Under the PIP, general practitioners can receive additional payments for providing an identified package of care to specific patient groups eg: diabetes care plans, asthma management plans.

A similar model should be considered for inclusion in the NPA. As an alternative, or in addition to, standard item number based payments or throughput volume models, provision of agreed evidence-based treatment and management plans to identified patient groups could attract additional loadings.

As an example, current care standards recommend that people with Rheumatic Heart Disease should receive a dental check-up at a frequency relative to their risk status and disease state. The application of a standard payment for the item number associated with a check-up do not reflect the additional resources required to provide regular care to a relatively small and dispersed client group. A PIP payment for could offset the additional resource requirements and encourage delivery of care in compliance with the guidelines

***Recommendation 2**: That the NPA funding model incorporates the additional costs associated with the effective and appropriate management of a chronic disease.*

***Recommendation 3**: That the NPA funding model be structured to provide incentives for provision of evidence-based preventive care.*

***Recommendation 4**: That the NPA funding allocations and funding model be structured to provide progress to universal access to dental care.*

(c) Availability and affordability of dental services for people with special dental health needs

The National Oral Health Plan defines special needs clients as those with intellectual or physical disabilities, or medical or psychiatric conditions, that increase their risk of oral health problems or increase the complexity of oral health care

The provision of care to complex and high needs clients is predominantly a public sector function as the economic realities of care to this group do not support the private practice model. The challenge in managing care provision to this client group is the limited data available to describe the population's size, distribution and treatment needs.

There has been limited progress on addressing the actions detailed in the National Plan and the allocation of funds to these actions should be a priority.

As with other chronic diseases the Aboriginal and Torres Strait Islander population carries an excessive burden of oral disease. The then Rudd Government's proposed Commonwealth Dental

Health Program included activity and funding allocations specifically targeting Aboriginal and Torres Strait Islander peoples. However the allocation of the funding was based on the standard COAG population based distribution resulting in activity targets and funding allocations to states and territories that did not reflect the distribution of the Aboriginal population.

Collaboration between the public sector and Aboriginal Community Controlled Health Organisations is critical to improving access to care and health outcomes for Aboriginal and Torres Strait Islander peoples.

The aging Australian population combined with increased rates of tooth retention are further contributing to an increased demand for dental services. Additionally the increasing prevalence of chronic disease is resulting in an aging patient population with multiple co-morbidities and risk factors producing an increasingly complex pattern of disease and treatment needs.

The prevalence of oral disease is linked to the living situation of the aging client which those living in residential care environment having up to three times more untreated decay than those residing in the general community.

The National Oral Health Plan identifies the need for multidisciplinary approaches to oral health assessment, maintenance of oral hygiene and access to timely, affordable and preventively focused care to ensure the oral health of older people. The Better Oral Health in Residential Care program (BOHRC) was developed to support oral health care management in residential care facilities. This is an evidence-based and evaluated program which was implemented across the country in 2009-10. However the impact of the program has been limited due to one-off funding for training in an industry with a high staff turnover. The allocation of funding to support further implementation and support of the BOHRC program has the potential to significantly improve the oral health of vulnerable older Australians.

***Recommendation 5**: That funding is allocated to enhance oral health information systems to support more complete and accurate data collection to enhance understanding of the size and needs of the special needs patient population*

***Recommendation 6**: That the actions in relation to the provision of care to special needs clients described I the National Oral Health Plan be implemented*

***Recommendation 7**: That funding allocations to states and territories should be on the basis of the population distribution of the specific target group rather than the population as a whole.*

***Recommendation 8**: That the NPA support collaborative arrangements between the public sector and ACCHO providers.*

***Recommendation 9**: That funding is allocated to support further implementation of the BOHRC program*

(d) Availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations

The geographic inequities in access to dental care are well documented with the ratio of providers to population in urban areas around twice that of rural and remote areas. Concurrently there is clear evidence that the oral health of rural and remote residents is poorer than their metropolitan counterparts.

The additional costs associated with provision of care to residents of rural and remote areas are recognised in the IHPA Pricing Framework through the incorporation of pricing adjustments. The 2013-14 framework includes loadings for outer regional residents of 8.0%, remote - 15% and very remote - 24%.

Access to dental services is compounded by limited access to transport and restrictions on access to Patient Assisted Travel Schemes (PATS) for patients with dental conditions. The criteria and restrictions on PATS access vary between jurisdictions resulting in limited and inequitable access to general and specialist care. The development of consistent criteria would be beneficial.

***Recommendation 10**: That funding allocations to jurisdictions be weighted to reflect the additional costs associated with service provision in rural and remote areas.*

***Recommendation 11**: That eligibility for PATS for dental conditions be reviewed and standardised across jurisdictions.*

(e) The coordination of dental services between the two tiers of government and with privately funded dental services

After many years of minimal involvement in the funding of dental programs by the Australian Government there are now a myriad of programs being administered by a range of Departments and Agencies. There is a significant risk of inefficiency, duplication and waste as a result of an uncoordinated approach to the planning and implementation of new initiatives and integration with existing programs.

This is evidenced in the multiple initiatives with associated allocations for capital investment which have resulted in a patchwork of building, refurbishment and equipment programs including the Graduate Year programs for dentists and oral health therapists, the Mobile Indigenous Infrastructure program, the Health Workforce Australia student placement and training programs, the regional/remote private practice relocation and establishment programs and University dental school expansions.

There is an urgent need for cross-Department coordination of the Government's oral and dental health reform program to ensure that the maximum benefits are delivered in an efficient and equitable manner.

The AHHA is concerned that the Commonwealth Department of Health and Ageing does not have a clear source of independent, evidence-based advice around public dental care, particularly when programs need to be implemented in a complex federal environment in which state and territory

dental services are also provided. This form of advice is distinct from negotiations that are held with the States and Territories in the context of Health Ministers' meetings or COAG.

The AHHA strongly believes there is a need for a body to provide regular advice on the design, implementation and progress of the Commonwealth's dental programs, particularly given that the significant level of funds will be expended in the coming years.

The absence of an oral health advisory group from the DoHA structure has been highlighted through recent publication of lists of Government agencies, committees and advisory groups. While existing DoHA advisory bodies cover areas such as mental health, aged care funding, influenza, suicide prevention, dementia, pathology, pharmaceuticals, preventive health and marketing of infant formula, there is no source of advice in relation to oral health.

The announcement, by the Minister for Health on 13 March 2013, of the establishment of the position of Chief Allied Health Officer again emphasised the absence of high level advice in relation to oral health issues within the Government.

The capacity of a body to provide clear and balanced advice has been demonstrated through the work of the National Advisory Council on Dental Health which drew on the knowledge and experience of a broad range of stakeholders from the public, private and non-government sectors.

***Recommendation 12**: That an ongoing oral health advisory body be established to inform Government policy decisions and the implementation of Government programs.*

***Recommendation 13**: That the position of Chief Dental officer be established to provide high level advice and advocacy for dental issues.*

(f) workforce issues relevant to the provision of dental services

The oral health workforce consists of a variety of providers with overlapping skills and competencies.

The historic state and territory based regulation of practitioners resulted in differences in the legislated scope of practice, particularly for dental therapists.

Variation in practice was further influenced by local policy and practice reflecting the service priorities of different state and territory programs.

While the establishment of national registration and reviews of scope of practice have improved clarity of scope of practice issues and the current HWA oral health workforce project will further inform the development of oral health workforce plans and structures, considerable work is still required to achieve the National Oral Health Plan action of removing barriers to the full use of the skills of the whole dental team.

Decreasing prosthetic training for dentists at the undergraduate level is increasing the demand for dental prosthetists. The aging population will further increase this demand.

There is significant scope to increase the contribution of non-oral health providers to the oral health of the population particularly in the area of health promotion, education, disease identification and referral and preventive care.

Nationally recognised competency and training units have been developed targeting workers in the aged care, education, childcare and community care sectors.

The application of fluoride varnish to the teeth of at risk clients is an evidence-based, safe and effective preventive intervention. While training programs to enable registered nurses and aboriginal health workers to apply fluoride varnish have been established in the Northern Territory and trialled in other locations, legislative barriers exist in some jurisdictions which inhibit the broader implementation of this and other evidence based effective programs.

***Recommendation 14**: That funding allocations support the full use of the full range of skills of the dental team*

***Recommendation 15**: The legislative barriers to the expansion of fluoride varnish programs and other safe, effective preventive programs be removed*

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