Submission by Lyn Morgain
Chief Executive Officer
Western Region Health Centre
72 Paisley St
Footscray VIC 3011
PH: 03 8680 1111

Submission No. 014
(Dental Services)
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Committee Secretariat
Office of the Clerk Assistant (Committees)
House of Representatives
PO Box 6021
Parliament House
CANBERRA ACT 2600

Dear Inquiry Committee Members

RE: The State of Public Dental Services in Australia, the Victorian perspective

As a major provider of public oral health services for children and adults in the west of Melbourne, Western Region Health Centre welcomes this inquiry into adult dental services with the aim of identifying priorities for Commonwealth funding. We provide oral health services across the western region of Melbourne and in 2012/2013 more than 10,000 people used our service operating from 6 adult and 5 paediatric chairs.

Poor oral health affects all aspects of people lives and is a particular issue within disadvantaged communities. Research continues to show associations between periodontitis and chronic health conditions as well as low birth weights in babies. Further to this, periodontitis showed a social gradient against household income, with a prevalence of 42.6% in the lowest income category (the client of the public oral health system).

Although there are approximately 114 400i Adult Health Care Card holders who are eligible to receive public dental care in the western metropolitan Melbourne planning catchment area, priority groups for our service are:

- Children (0-12 years) and young people
- Homeless people and people at risk of homelessness
- Pregnant women
- Refugees and asylum seekers
- Registered clients of mental health and disability services
- Aboriginal people

Although we are committed to providing holistic care to these groups, demand and

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funding pressures means that timely services cannot be provided to other eligible people. Furthermore providing services to these groups comes at a significant cost to WRHC. We therefore welcome the Inquiry as a commitment to the examination of the difficult issues we and our clients grapple with on a daily basis.

Although we are interested in all of the Terms of Reference of the Inquiry we would like to provide particular comment on the following:

- Demand for dental services and issues associated with waiting lists
- Coordination of dental services between the two tiers of government with privately funded dental services
- Workforce issues relevant to the provision of dental services.

We have also provided the following recommendations for the Committees' consideration which are explained in the body of the submission.

Recommendation 1

That a substantial and ongoing increase in funding be made available to public oral health services to meet the increased demand by priority clients and allow other eligible clients to be seen in a timely manner.

Recommendation 2

Funding is made available to public oral health services in to order to establish partnerships with local community dentists who would be contracted to provide services for better "general care" wait list management

Recommendation 3

That more oral health therapists be incorporated into the workforce for adult clients in a balanced manner; to address periodontal care and to redirect the workload that can be provided by this oral health professional, freeing dentist time for more complex procedures.

Recommendation 4

That all services be referred to as "oral health services" in recognition of the full range of care provided in public oral health care services

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1. Demand for dental services and issues associated with waiting lists.

As the committee is no doubt aware, the demand on the public system is extremely high. Western Region Health Centre like all publicly funded oral health services in Australia aims to provide quality and comprehensive oral health care to those in most need of care who otherwise would not be able to access care.

In addition to the priority groups outlined previously, we also attend to those in pain who are eligible to attend public oral health programs; Groups that are prioritised are not placed on a waiting list but are offered the next available appointment for general care. The care requirements for the priority groups are usually very complex including the requirement for interpreters, extensive periodontal care, anxiety and depression, poly-pharmacy issues and irregular attendance.

This often means that our resources are expended within the priority groups leaving eligible adult concession card holders clients languishing on waiting lists for extended periods. From the beginning of this financial year, the General Care waiting list has grown from 3129 adults waiting approximately 14 months, to 4399 people waiting a minimum of 20 months. Furthermore, the cessation of the Chronic Disease Dental Scheme has meant increasing pressure on our clinic with 476 “non-priority” people contacting the clinic between 1 January 2013 and 28 February 2013 requesting they be added to the General care waiting list.

Funding Constraints

The Victorian government supports prioritising high need groups for public dental services, and introduced a block funding model in 2011 which gave consideration to the increased cost of servicing these groups. through a 30% loading for Indigenous clients and 20% loading for Refugee clients Despite this WRHC is required to subsidise the Oral Health Program as the real cost of providing appropriate care is not sufficiently covered. The Table below shows the difference between the notional values of the care provided against the funding structure.

Part of the increased cost is due to waiving of fees for those priority groups without capacity to contribute the average $100 co-payment to help offset the cost of their care. This would be somewhat alleviated if more general wait list clients were able to be seen but demand by prioritised groups makes this difficult.

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TABLE 1: Comparative cost for Care

Priority Groups	**Average Number of treatment per client**	**Average notional cost** **A**	**% loading** **(only for Refugee and Indigenous clients)** **B**	**Financial Imbalance to the Oral Health program** **C= B-A**
Refugee/ Asylum Seekers	11.07	$885.63	$302.59	**- $583.04**
Homeless persons	5.70	$582.61	$252.16	**- $330.45**
Mental Health Clients	4.23	$295.91	$252.16	**- $43.75**
Disability Clients	5.27	$417.76	$252.16	**- $165.60**
ATSI clients	5.17	$400.46	$327.80	**- $72.66**

Recommendation 1

That a substantial and ongoing increase in funding be made available to public oral health services to meet the increased demand by priority clients and allow other eligible clients to be seen in a timely manner.

2. Coordination of dental services between the two tiers of government with privately funded dental services

In 2009-2012 our clinic formed a partnership with a local private dentist which enabled clients from the General care waitlist to be seen by the private dentist. The client referred to the dentist were those with less complex needs that could be

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treated relatively quickly. The private dentist had entered into a contract in which our clinic agreed to pay a percentage of the Department of Veteran Affairs Dental Fee schedule for items of care provided to the client.

The work generated at the private dental clinic equated to almost 20% of the throughput of the clinic, and worth approximately $350,000.00 per annum. The contract was not continued in 2012-2013 as demand by high need groups required that all possible funds to be spent "in-house" providing comprehensive oral health care to the priority groups.

Given additional funding a similar contact could be re-established. The advantages of the contract were not only a reduction in waiting times for general care; it allowed clients to be treated under strict annually assessed requirements such as Infection Control Audits and Dental Record keeping Audits, close to and coordinated with other community health allied services such diabetes education and podiatry

Recommendation 2
Funding is made available to public oral health services in to order to establish partnerships with local community dentists who would be contracted to provide services for better "general care" wait list management

3. Workforce issues relevant to the provision of dental services

Traditionally public oral health treatment for adults has been provided by dentists.
Over the past three years in Footscray we have developed an innovative model of care in which there is a 50:50 representation of clinicians between dentists and oral health therapists. This service delivery model is in practice in other community oral health program across Victoria and is currently a subject or research funded by Dental Health Services Victoria (DHSV).

This development occurred for two reasons;

- An apparent shortage of experienced dentists willing to work in the public system
- A need to provide care that is patient centred rather than a system that focuses on the repair of damage to teeth caused by a lack of prevention

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The fact that salaries in the public system for dentists are approximately one quarter of the possible earnings in private practice presents significant recruitment challenges. Our main recruitment pool are newly qualified dentists from overseas. As more than 30% of our clients speak a language other than English, employing a diverse workforce is reflective of our client group however communication can be a challenging issue. Added to this is the frequent inexperience of this workforce requiring the organisation to provide high levels of professional and personal support.

This leaves the current experienced staff with the added pressures of supporting and mentoring less experienced overseas trained dentists as well as dealing with their own challenging and complex clientele.

The increasing numbers of Oral Health therapists across Australia offers employers a cheaper workforce to provide initial oral health care, leaving the dentists to provide treatments to only those clients who require their specific skills.

On acceptance into the oral health program for general care a client first sees the oral health therapist who is able to diagnose caries, provide initial treatment plan for the client, provide detailed periodontal care, referrals for smoking cessation etc, and then refer to the most appropriate dental care provider; mostly this is a dentist. At this stage the treatment plan is reviewed in consultation with the client.

Recommendation 4

That more oral health therapists be incorporated into the workforce for adult clients; to address periodontal care and to redirect the workload that can be provided by these oral health professionals, freeing dentists for more complex procedures.

Replace *Adult Dental Services* with *Oral Health Services*

Although the Terms of Reference states that the Inquiry will investigate Adult Dental Services in Australia, The WRHC would ask the Committee to reframe this to consider Adult Oral Health Services. Modern public oral health services consider the mouth as a whole and integral part of overall health, not just teeth. The state of a person's gums and periodontal structure is vital to good oral health and good health generally. According to the National Survey of Adult Oral Health in 2004–06, periodontitis was found in nearly one-quarter of Australian adults aged 18 years and older.

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Oral health professionals also help their patients quit smoking; studies have shown that a 10 minute quit-smoking consultation by a health professional will aid 3% more smokers to abstain from smoking for six months or longer compared to those who receive no advice (Parrott, Godfrey & Raw 1998).

Recommendation 5

That all services be referred to "oral health services" in recognition of the full range of care provided in public oral health care services

[i] Department of Health Business planning and Communications Unit- original data from Centrelink 2011