

Australian Dental Association Inc.

Inquiry into Adult Dental Services in Australia

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Executive Summary

As the peak body representing both public and private sector dentists across Australia, the Australian Dental Association Inc. (ADA) understands the oral health needs of the community, the shortcomings in care delivery and the factors that are influencing delivery of sustainable, safe quality services.

Australians more than ever are retaining their natural teeth, have better oral health, and are maintaining this status by eating well, maintaining good oral hygiene and visiting the dentist regularly. Good oral health is also the result of exposure to reticulated water fluoridation and applied preparations containing fluoride e.g. fluoride tooth pastes, newer dental materials and advances in technologies.

However, there are certain groups within the community who continue to suffer from poor oral health. The reasons for this are many and varied, but regardless of socioeconomic status, age or location, every Australian should have the right to good oral health care.

In Australia, the majority of dental services are provided by dentists in the private sector, while the various state and territory government clinics provide basic levels of dental services to those with health care concession cards and in some areas to all children.

In 2014, the Child Dental Benefits Scheme (“Grow Up Smiling” – GUS) will take effect and will provide up to \$1,000 over two years for eligible children to receive dental treatment. Some 3.4 million children will be eligible for services under this scheme. While the precise details of the scheme have not yet been determined, it is clear that this initiative will lay the foundations for many children to have improved oral health for the future.

The National Partnership Agreements (NPA) for adult public dental services will provide additional funding to states and territories from July 2014 to expand services for adults in the public dental system. This also is a welcome initiative. It will be critical that in the introduction of this funding there are adequate transparency and accountability processes in place to ensure that the funding is effectively used by state and territory governments to deliver dental care and is an additional source of funding to their existing funding commitments.

In particular, the public need to be satisfied that the states and territories direct the NPA funding to the provision of clinical services through the most effective and efficient mechanism and that programmes developed are an adjunct to existing service provision, not a replacement.

The ADA sees current state and territory budgetary commitments for dental services as inadequate to meet demand for services. Notwithstanding the additional funding from the Australian Government, the ADA believes that available funding is still unlikely to have the capacity to meet all of the expected demand.

Federal dental funding under the NPA is unlikely to reach the level of funding that was expended under the CDDS in any given year. The growth of expenditure under the CDDS reflected the considerable level of unmet demand in the community which suggests that there will continue to be gaps in service delivery as a result of inadequate funding for public dental services overall.



The success of the additional investment in dental service delivery will be dependent on all governments recognising that, as the majority of dental practitioners in Australia work within the private sector, engagement and utilisation of the capacity of the dental profession is critical. Private practitioners already have the capacity and resources to provide services in many areas where there is limited or no public sector infrastructure and they need to be utilised to ensure the expenditure provided achieves the objectives of delivering care.

Leadership, coordination, communication and commitment from the Australian Government will be required to achieve this outcome. One of the main challenges will be to develop mechanisms within the NPA that enables the state and territories to work in partnership with private practitioners as an additional means to reduce the public dental waiting lists.



The House of Representatives Standing Committee on health and Ageing has identified a number of areas that it will consider in this inquiry. The ADA will respond to each in turn.

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

Most Australians pay for their own dental care and receive services promptly through the private sector, while others tend not to prioritise their dental health needs.

Some sections of the community rely on the public sector for dental services and it is important that the system is able to meet these needs in a timely and efficient manner.

Exact figures on public sector dental waiting lists are not available in every state and territory. Where waiting list information is available, it differs markedly from state to state and provides no accurate reflection of the true position across Australia. It is therefore difficult to obtain data about the extent and type of dental care across the community. In some circumstances, waiting lists have been exaggerated and used as a political tool to gain additional Commonwealth funding.

Historically, there has been considerable capacity within the private sector to address the unmet need which exists on public waiting lists.

In the 1990s the Commonwealth Dental Health Scheme (CDHS) provided access for public patients to a private dentist; this approach saw waiting lists disappear within six months.

Similarly, the Chronic Disease Dental Scheme (CDDS), while problematic because of the way it was implemented and the level of administrative requirements associated with it, had a dramatic impact on public sector waiting lists across Australia. Allowing eligible patients to access private dentists (who represent around 90% of the available dental workforce) resulted in many, who were waiting on public sector waiting lists, to receive more timely treatment.

The demand for public dental services currently far outweighs the resources in terms of infrastructure and workforce available in the public sector to provide services. The experience with the CDHS and CDDS demonstrates that private sector dentists are capable to assist with the delivery of services associated with any new public funding. It is important that strong relationships are established between governments and the private sector and that the ADA is engaged to participate in addressing the needs of Australians and in educating the profession of the requirements of any scheme.

Rather than utilise the NPA funding to provide for additional infrastructure to increase capacity of the public system, it would be more cost efficient to direct the money to the private sector by means such as a voucher system that will allow for patients to access a private dentist. This would enable the existing underutilised private sector dentist workforce to meet any unmet demand with its existing resources and would avoid the need for funding to be directed to development of infrastructure in the public sector when that infrastructure exists in the private sector.

The utilisation of private sector dentists in the delivery of care will ensure efficient use of the NPA funds and allow for accurate monitoring and measurement of service delivery.

2. Mix and coverage of dental services supported by state and territory governments, and the Australian Government

State and territory governments

There is no consistency in the eligibility criteria for those entitled to treatment in the public sectors. Some offer dental care to all children, some only to a subset of children. All state and territories provide dental care to those that hold a form of concession card. In some states/territories, patients are required to make a co-payment for services while in others there is no additional charge to the patient.

The type of services provided within the public sector also varies and treatment options are limited compared to private practice. This means an inferior range of treatment is provided. Most public health systems within states and territories broadly include dental services to children and adults according to criteria that target emergency situations; those in most need; dental education and oral health promotional services. The critical role of the public sector in the education and training of dentists should not be overlooked in the discussions on the NPA. There should ideally be some allocation of resources to education and training as well.

Funding limitations are such that in some jurisdictions care is mainly limited to treating emergency presentations with little or no capacity to provide routine care and prevention. This results in long delays for those patients on elective public waiting lists. These limitations result in a 'stop gap' approach and make it difficult to address dental disease before it gets out of hand.

However it should be recognised that there are a number of states and territories that have processes in place to utilise the available capacity within the private sector. For example, in South Australia, patients requiring emergency care, who cannot be accommodated within the public system, are authorised to receive care from a private dentist.

Another example is the use of the private sector to treat patients from rural and remote areas. Eligible patients may access private dentists where there is no public dental clinic under a fee for service arrangement between the state/territory health department and private practitioners.

The ADA is aware of a number of settings where public dental chairs are unused due to staffing restrictions and funding cut backs. The NPA should accordingly require state and territory health departments to undertake a cost benefit analysis of establishing additional public dental clinics versus the utilisation of already widespread and established private dental practices. It makes economic sense to utilise the private sector infrastructure resources already available, rather than duplicate these within the public system.

There is inconsistency in the per capita funding allocated within states and territories for public dental services. The NPA funding should seek to deliver an equal level of service to all



Australians. The NPA funds should not be used to “top-up” states that do not currently provide sufficient per capita funding.

Australian Government

The ADA understands that the Australian Government supports the provision of dental services by providing funding:

- Directly to the states and territories for public dental services; and
- For dental services provided by private dentists under targeted schemes; namely the Department of Veterans’ Affairs Schedule of Dental Services (DVA), the Cleft Lip and Cleft Palate Scheme (CLCLP) and the Medicare Teen Dental Plan (MTDP).

For many years there has been a widening gap between the cost of providing dental care and the fees paid by the Australian Government under these schemes. This growing gap is reaching the point whereby dentists are finding these schemes non-viable. Unless fees are brought in line with customary charges, or a system of co-payment is introduced, it will become increasingly difficult for private sector dentists to continue their participation in government schemes.

i) Department of Veteran Affairs Schedule of Dental Services

Dentists over recent years have achieved only modest increases in Department of Veteran Affairs (DVA) fees charged to patients for services.

In a comparative analysis undertaken by the ADA of the thirteen most common procedures undertaken by dentists (see Table 1), it was found that on average there is now a 19.5% difference between the mean ADA fees as detailed in the ADA National Dental Fees Survey (DFS) 2012 and the rebates offered by DVA as per the 2012 Fee Schedule of Dental Services for Dentists and Dental Specialist.

Annual Differences between ADA/DVA for 13 most common procedures					
Procedure		DVA \$	ADA \$	Difference \$	%
011	Oral Exam Comprehensive	52.65	60.49	\$7.84	14.89%
022	X-Ray-Per Film	37	41.67	\$4.67	12.62%
114	Calculus Removal	89.70	107.27	\$17.57	19.59%
161	Fissure Sealing-Per Tooth	46.05	54.04	\$7.99	17.35%
311	Removal of Tooth or Part(s)	131.30	167.46	\$36.16	27.54%
415	Chemo-Prep-1Canal	214.15	253.10	\$38.95	18.19%
416	Chemo-Prep Additional Canal	102.00	122.86	\$20.86	20.45%
521	Adhesive-1 Surface Anterior	115.45	140.26	\$24.81	21.49%
522	Adhesive-2 Surfaces Anterior	140.15	168.73	\$28.58	20.39%
531	Adhesive-1 Surface Posterior	123.30	148.21	\$24.91	20.20%
532	Adhesive-2 Surfaces Posterior	154.80	185.24	\$30.44	19.66%
615	Full Crown-Veneered Indirect	1263.70	1458.70	\$195.00	15.43%
711	Denture	954.25	1197.11	\$242.86	25.45%

Table 1: Annual Difference between ADA/DVA Fees

Source: ADA Dental Fees Survey 2012 & DVA Fee Schedule of Dental Services November 2012

Noting that Australian Tax Office statistics indicate that overhead levels in dental practices can be 80%, it is clear that with this level of overhead and a discrepancy of 19.5% between customary fees and those paid by government there is little, if any, return on provision of dental services. The dental profession has over recent years been able to keep fee increases to a minimum. Increases in dental fees are well below that measured by the Health Consumer Price Index. The dental profession remains committed to provide on-going dental treatment to the deserving DVA community but feels that with the lack of any realistic fee review the Australian Government is exploiting the goodwill and commitment of the dental profession to the veteran community. In order to ensure the continuation of services under the DVA scheme, its fees must be brought in line to reflect the current costs of providing services. Given that there has been no adjustment to the fees provided by DVA for some time, the ADA urges a review of the DVA fee schedule be undertaken immediately.

ii) Cleft Lip and Cleft Palate Scheme

Another area where rebates have not kept pace with the cost of treatment is for patients who require dental services under the Medicare Cleft Lip and Cleft Palate Scheme (Scheme). As part of the recent Australian Government Department of Health and Ageing review of eligibility and range of conditions that could be treated under the Scheme, the ADA asked for a detailed review of the Medicare Benefits Schedule fees under the Scheme, as this has not occurred for some time. While the ADA will soon make a formal submission to the Australian Government Department of Health and Ageing seeking a review of the fees, given the breadth of practitioners involved in delivering services under the Scheme and the range of government departments involved in the Scheme's administration, it may be more appropriate for such a review to be undertaken under the direction of the Australian Government Department of Treasury.

iii) Medicare Teen Dental Plan (MTDP)/ Grow up Smiling (GUS)

While noting that this Inquiry is about Adult Dental service, it is relevant to comment on these schemes as their creation is crucial to maximising the effects of adult schemes. Investment in children's dental care will have a favourable impact on adult schemes. Addressing dental problems in childhood will not only reduce dental problems carried into adulthood, it will also reduce the costs of addressing adult dental problems in the future.

The MTDP, administered under the *Dental Benefits Act 2008*, provides eligible teenagers between the ages of 12-17 with \$166.15 per calendar year to help with the cost of an annual preventative dental check. Patients can attend either a private dentist or a public dental clinic to receive services under the scheme.

Uptake of this scheme is around 30% only and this poor uptake is thought to be due to the fact that it only covers the cost of an oral examination, x-ray and scale and clean but not any treatment required. Such costs must be borne by the patient. The entitlement criteria are such that treatment requirements are often beyond their financial means.

It is anticipated that the new GUS will take effect in January 2014 and will address this problem to some extent but only if it provides for the delivery of a comprehensive suite of services by dentists.

The Department of Health and Ageing in its evidence to the Senate Committee recently stated that it anticipates that, as the Australian Government increases its service provision (through GUS) for children, the demand for children's dental services would, over time, be less. While the ADA hopes this situation occurs, it refers to the Department's own comments that it will be framing the NPAs to ensure that the states and territories maintain existing effort towards the state public dental services, and that any reallocation of resources does not diminish the level of dental care provided.

3. Availability and affordability of dental services for people with special dental health needs

There are a number of subpopulations within Australia who have special dental health needs. The ADA's 2013-14 Federal Budget Submission provided the following discussion. The ADA believes that if funding through the NPA needs to be directed to infrastructure then priority should be given to improving or creating the special facilities that are required to treat dental disease in people with special needs.

a. Indigenous Australians

The ADA's 2013-14 Federal Budget Submission outlined the special dental health needs of Indigenous Australians:

"Indigenous Australians have approximately five times the prevalence of dental disease than non-Indigenous Australians. Indigenous adults have substantially higher rates of periodontal disease (90% in comparison to 25% in non-Indigenous). Indigenous children suffer higher rates of dental decay than other Australian children. Dentist often require young children to go under general anaesthetic to be able to safely treat any cases of dental disease; this need similarly applies to Indigenous Australian children. "

"A fundamental step that can be taken to improve the oral health status of Indigenous Australians is improving the supply of fluoridated water to Indigenous communities. This single measure has been proven to effectively reduce the incidence of tooth decay.

There are significant programmes in place to try and address the gap in health status for Indigenous Australians but few of these programmes are directed toward dental care. There are opportunities to broaden these programmes at minimal additional cost to include oral health initiatives.

For example, the Australian Government currently funds the Australian Nurse-Family Partnership Program to support women pregnant with an Aboriginal and/or Torres Strait Islander child to improve their own health and the health of their baby. If adequately trained, (for example, by completing the oral health competencies available under the Health Training Package), these nurses could also provide advice on oral health care for the mother and baby and this advice can flow on to the extended family.

Aboriginal Health Workers with this training would be able to promote good oral health and also promptly identify and refer patients requiring urgent dental care within Indigenous communities. All initiatives should be further supported by the development of fully equipped mobile dental teams to ensure access to treatment when necessary and where a full time dental service is not available."

The NPA should include provision for further training of Aboriginal Health Workers, or staff at existing public clinics, to better assess and treat Indigenous patients.



b. Older Australians

The ADA's 2013-14 Federal Budget Submission outlined the special dental health needs of older Australians.

“Maintaining the dental health of this section of the community, especially those in residential aged care facilities, provides an additional challenge. Studies have shown that high levels of plaque accumulate on resident’s natural teeth and dentures which in turn place them at high risk for developing aspiration pneumonia, a commonly occurring event necessitating transfer to an acute care facility. Dislodgement of teeth, fillings and calculus as well as ill-fitting dentures contributes to this problem.

The importance of maintaining residents’ good oral health has the potential to minimise the risk of deterioration in the general health of residents and therefore reduce the demand on the health system.

The ADA recommends that assessment and care of the teeth and gums be made a core component in the education and training of all healthcare professionals working in aged and residential care.

In addition, measures to ensure appropriate care is provided should be incorporated into the standards by which aged care facilities are accredited. This must extend to the need for facilities to provide an environment within which professional dental examinations and treatment can be delivered. Lack of an appropriate type of dental chair, x-ray facilities and other relevant equipment available at residential aged care facilities are significant barriers to providing quality care but could be addressed if such facilities were incorporated into the design of residential aged care facilities. This will not occur without direction from governments or its support provided to existing facilities. The fitting out of a multi-purpose room that can be utilised by dentists and other visiting healthcare professionals will have significant cost benefits to the health system overall.

Alternatively, the Australian Government could encourage and financially support suitably equipped mobile dental units to provide subsidised services.”

The NPA should include provision for equipped mobile dental units to address the dental health needs of those in aged residential care – bringing the care to the patients, rather than the traditional public dental clinic model. In addition, dedicated treatment rooms in Residential Aged Care Facilities (RACF) could be funded. Nursing homes are settings in which dental equipment could be installed for use by visiting dentists. Equipment that is fully functional but no longer required by public and private dental practices (due to renovations or equipment upgrades etc.) could be serviced and installed in dedicated treatment rooms within nursing homes. This would allow for basic dental services to be available to residents on site and would ensure that the residents’ oral health needs are addressed on a regular basis. It would mean that residents are less likely to be required to leave the nursing home in order to access oral health care.

In the context of an increasing oversupply of dentists, an opportunity exists to make better use of this under-utilised resource to address these needs.

c. Disabled Australians

The special dental health needs of Disabled Australians were a feature of the ADA's 2013-14 Federal Budget Submission:

“A recent study by the Productivity Commission estimates that one in five Australians suffer from a disability.

People with a disability experience much higher levels of oral disease than the general population partly due to problems with their physical inability to maintain adequate levels of oral hygiene. Added to this is the difficulty in accessing appropriate facilities and practitioners with the expertise and experience to treat these individuals. Often the treatment they require is more complex because of the nature of their disability or because other health issues compound their oral health issues.

Because of these issues there is a greater dependence on the general health system for a suitable mode of care for delivery of dental services. There is a need for high use of in-patient care under general anaesthetic. This imposes a burden on an already stressed hospital system.

In addition to increasing dentists’ individual skills and competence, provision should also be made available to dentists for infrastructure costs associated with building renovations so that existing practices can be upgraded to accommodate wheelchair access etc. By accommodating the needs of these patients within the private practice setting, there will be substantial cost savings to the public sector and a subsequent reduction in waiting lists. This could easily be achieved by prioritising support to dentists under the Health and Hospital Funds programme overseen by the Department of Health and Ageing.

While the proposed investment in general practice will accommodate a greater percentage of patients with special needs, efforts to increase the number of ‘Special Needs’ dentists is also required. These specialist practitioners provide care to people with an intellectual disability, medical, physical or psychiatric conditions that require special methods or techniques to prevent or treat oral health problems or where such conditions necessitate special dental treatment plans. Currently, there are few dentists registered in this specialty field and efforts to increase workforce numbers in this area, such as through the use of incentives, are required.”

Access to general anaesthesia (GA) by dentists is extremely important as it allows those patients who are unable to undergo dental treatment in the usual dental practice setting due to their disability to receive safe, effective and suitable dental treatment. Currently there is limited access to general anaesthetic theatre time in public hospitals for dental procedures. This is in part due to the funding models used to reimburse hospitals for services provided which make it more attractive financially for hospitals to undertake other types of surgery.

Modifications to existing health fund arrangements are required. Health fund rebates are very low and are structured as a disincentive to hospitals and Day Procedure Centres (DPC) offering dental services, particularly if longer procedures are required.

For example, ADA has been advised by a private hospital representative in Victoria that every time the hospital conducts a dental treatment under GA, it incurs a loss of around \$1,300. Another DPC representative has advised that the health fund payment for a dental treatment under GA (of any length of time) is around \$300 and that this does not even cover the basic costs associated with the procedure. The banding of dental procedures is inequitable when compared with other medical procedures. Dental treatments administered under GA fall under the lowest private health insurance funding band.

The result is that in order to keep private operating facilities viable, hospitals are being forced to reduce or limit the number of operating lists available for dental care.

It is understood that the GUS scheme will not provide reimbursement for services provided under general anaesthesia. Therefore, in the absence of provision within the NPA for access

to general anaesthesia for dental procedures, the waiting lists for these patients are unlikely to be impacted upon and there will be a compounding of dental health problems in later life that will in turn impact upon the effectiveness of adult dental care programmes.

NPA funding should be directed to address this shortcoming.

4. Availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations

The ADA 2013-14 Federal Budget Submission also made comment on the disadvantage experienced by some rural and remote communities.

“In a country as vast as Australia, there will always be areas that are scarcely populated and as a result, the services that are available in that area, be it transport, shops or healthcare, are limited.

In dentistry, viability of a practice is dependent on having a large enough population to whom services can be delivered on a regular and reliable basis; so, it is not surprising that the distribution of dentists closely reflects population distribution.

That said if systems are established it may be possible to increase the ratio of dentists/population in remote and very remote areas and in areas where the socio-economic status of the population is such that private practice models are not viable. For example, a private dentist may be more willing to set up a practice if state based public dental services outsource services to them thereby ensuring adequate patient throughput. The Australian Government may wish to raise these service delivery models in its negotiations with the states and territory governments as a basis for providing additional funding for dental services through the National Partnership Agreements.

A second area for investment is to increase support for geographically disadvantaged Australians to travel to larger regional centres to access care that is not available locally. For example, assistance similar to that provided for patients to attend medical appointments should be provided by the government for travel costs in excess of 100 km each way to the nearest dentist.”

As already stated, there is a significant oversupply of dentists which could be utilised for the purpose of the development of flexible mobile service delivery models in the extremely remote areas.

5. The coordination of dental services between the two tiers of government and with privately funded dental services

The success of additional investment in dental service delivery is dependent on all governments recognising that, as the majority of dental practitioners in Australia work within the private sector, engagement with the dental profession is critical.

As indicated earlier, private practitioners have capacity to provide services in areas where there is limited or no public sector infrastructure.

Leadership, coordination, communication and commitment from the Australian Government will be required to achieve this outcome. One of the main challenges is to develop mechanisms within the NPA that enables the state and territories to work in partnership with private practitioners as an additional means to reduce the public dental waiting lists.



As indicated earlier, the ADA suggests that as the majority of the workforce practises in the private sector, then with the appropriate mobilisation of this capacity, it will be able to work as an adjunct to the public sector to supply targeted services. The ADA seeks the opportunity to work jointly with government to develop these systems.

6. Workforce issues relevant to the provision of dental services

There has been a substantial growth in the dental workforce over the last few years. Numbers of Australian graduates entering the workforce are expected to increase even more rapidly over the next two years with the first graduates coming from new dental schools expected this year.

There has also been a significant increase in the number of dentists entering the workforce through migration pathways.

The ADA is of the view that Australia has a critical oversupply of dentists. New graduates are experiencing increasing difficulty in finding full time employment, and at the same time, employers report record numbers of applicants for vacant positions even in traditionally hard-to-fill vacancies.

On the evidence available, it would appear there are only a small number of vacancies for dentists in the public sector. Further, the limitations in the range of services provided, the lack of mentoring for junior dentists makes public sector dental practice a difficult environment in which to consolidate skills and competencies upon graduation.

This needs to be considered in the light of the often significantly more complex treatment requirements of patients who are eligible for treatment within the public sector.

Public sector waiting lists are being used to justify arguments to support the notion of workforce shortages. This has been demonstrated to not be the case.

The waiting list in public sector exists for two reasons:

- 1) Budgetary i.e. insufficient funding for employment of dentists to provide services in the public clinics; and
- 2) Infrastructure inefficiencies in service delivery.

Conclusion

ADA looks forward to being able to engage with government to advise and assist in the development of the appropriate dental service delivery models for all Australians.

Dr Karin Alexander
President
28 March 2013.