4

Adult Dental Services National Partnership Agreement framework

4.1 This chapter considers structural aspects of the Adult Dental Services National Partnership Agreement framework. In considering this the Committee has identified a number of key principles which it believes should form the foundation for negotiations between the Commonwealth, and states and territories. The chapter also examines the broader policy context and the importance of a coordinated and strategic approach to public dental health policy and service delivery.

Allocation of funding

4.2 The Commonwealth Government has committed $1.3 billion to state and territory governments to support additional dental services for adults. This funding will be provided through a National Partnership Agreement for adult dental services (the Adult Dental Services NPA). As noted earlier in the report, the Intergovernmental Agreement on Federal Financial Relations sets out a framework 'which will provide a robust foundation for collaboration on policy development and service delivery and facilitate the implementation of economic and social reforms in areas of national importance'.[1] The Adult Dental Services NPA, which will provide funds to the states and territories to provide public dental services based on mutually agreed outcomes, will sit under this framework.

4.3 Although the total funding for the Adult Dental Services NPA has been announced, the allocation of funding to individual states and territories is yet to be determined. It is anticipated that the allocation of funds will be

1 Intergovernmental Agreement on Federal Financial Relations, pp. 1–2.

determined on the basis of a formula that takes into account a number of factors.

4.4 An example of how funding allocation is determined is provided by the current Dental Waiting List NPA. The Dental Waiting List NPA provides Commonwealth Government funding to the states and territories based on the number of health care and pensioner concession card holders in each jurisdiction. In essence, this provides states and territories with a share of funding based on the population of people eligible for public dental services in each jurisdiction (concession card holders). An additional loading is provided to Tasmania, the ACT and the NT to account for their smaller populations.[2]

4.5 While basing funding on the concession card holder population is comparatively straightforward, evidence suggests that the cost of delivering services varies depending on location (based on the Australian Statistical Geography Standard (ASGS)), Indigenous status and individual needs.[3]

4.6 For example, the submission from the National Oral Health Steering Group observes:

> The cost and complexity of provision of care in rural and remote locations is far greater than in metropolitan areas. This should be reflected in any funding model.[4]

4.7 The Australian Healthcare and Hospitals Association (AHHA) have also advocated for the NPA to acknowledge the additional costs of providing treatment to patients in rural and remote locations and for a proportion of funding to be quarantined for services to Aboriginal and Torres Strait Islander people.[5] The National Aboriginal Community Controlled Health Organisation (NACCHO) estimates that a weighting of 30 per cent for Indigenous Australians is necessary to appropriately provide services to this group.[6]

Committee comment

4.8 Allocation of funding based on the total eligible population numbers in each jurisdiction ensures that the Commonwealth Government is

2 Department of Health and Ageing (DoHA), *Submission 34,* p. 2. See also: Ms Flanagan, *Official Committee Hansard*, Canberra, 12 March 2013, p. 10.

3 National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 29,* p. 2.

4 National Oral Health Promotion Steering Group, *Submission 22*, p 2.

5 Ms Prue Power, Australian Healthcare and Hospitals Association (AHHA), Canberra, 22 April 2013, *Official Committee Hansard*, p. 7.

6 Ms Lisa Briggs, NACCHO, Canberra, 22 April 2013, *Official Committee Hansard*, p. 15.

providing equal funding for each eligible individual. While being easy to manage administratively this may not represent the fairest way to allocate funds. Providing funding to states and territories in this way may unintentionally impose restrictions on providing services, as it does not take into account variations in state and territory priority groups that may require funding above average levels to receive appropriate dental treatment.

4.9 The Committee agrees that there is a need for further consideration of the formula used to allocate the proportion of funding to the states and territories under the Adult Dental Services NPA. While not necessarily an exhaustive list of factors that might be taken into account, the funding formula could include loadings to reflect differences in the size and distribution of priority population groups, including:

- concession card holder population;
- geographic spread of the population;
- the Indigenous population; and
- other priority population groups such as people with disabilities, people with chronic diseases, people on low incomes or people who are homeless.

4.10 As with the Dental Waiting List NPA, an additional loading for states and territories with smaller populations may also be appropriate.

Recommendation 6

The Australian Government, in negotiation with state and territory governments, develop a formula for the allocation of funding to state and territory governments under the Adult Dental Services National Partnership Agreement based on the size and distribution of priority population groups, including:

- **concession card holder population;**
- **geographic spread of the population;**
- **the Indigenous population; and**
- **other priority population groups such as people with disabilities, people with chronic diseases, people on low incomes or people who are homeless.**

Maintenance of effort

4.11 A key principle for the Adult Dental Services NPA is that it provides funding to state and territory governments to support additional adult dental services. The importance of maintaining current services in the lead up to implementing the Adult Dental Services NPA was emphasised by the Public Health Association of Australia (PHAA) which submitted:

> [The NPA] must require states and territories to maintain their current effort or the potential gains will be minimised by cost shifting.[7]

4.12 However, concern was raised that state and territory governments were scaling back efforts to support public dental services in anticipation of receiving additional Commonwealth support through the NPA. For example, the NSW Oral Health Alliance stated:

> Over the past five years, NSW governments' anticipation of Commonwealth oral health reform has in effect frozen state-level investment in public dental services.[8]

4.13 While maintenance of funding provides a simple measure to determine ongoing state and territory financial commitment to dental health services, it does not necessarily provide the most meaningful measure. This was

7 Public Health Association of Australia (PHAA), *Submission 12*, p. 5.

8 NSW Oral Health Alliance, *Submission 36*, p. 8. See also: Australian Dental Association (ADA) (NSW Branch), *Submission 40*, p. 9; Ms Julie Barker, Australian Dental and Oral Health Therapists' Association (ADOHTA), *Official Committee Hansard*, Canberra, 23 April 2013, p. 10.

explained further in the following testimony by a representative of the Department of Health and Ageing (DoHA), who observed:

> If [state and territory governments] are able to maintain their baseline activity and do the additional activity we want while spending less of their own money, then that is an efficiency saving, and that is probably a good thing.[9]

4.14 Adding to consideration of this issue, representatives of DoHA advised that Clause 5 of the Dental Waiting List NPA specifies that in order to achieve agreed outcomes states and territories must maintain existing efforts:[10]

> ... for this agreement to have the desired impact on public dental services it is essential that the States' clinical activity related to public dental services, child, adult and special needs patients, is maintained and not withdrawn and redirected away from dental services, and that investments under this agreement are additional to such effort.[11]

4.15 DoHA explained that 'effort' under the Dental Waiting List NPA is measured in terms of notional units of clinical activity known as Dental Weighted Activity Units (DWAUs). Assessment of DWAUs supplied to the Commonwealth prior to state and territory governments signing the NPA provides a baseline measure. Additional effort is assessed against this baseline.

4.16 Application of this assessment system to the Dental Waiting List NPA was described by DoHA in more detail as follows:

> The [Dental Waiting List] NPA is framed to allow an initial up-front payment of $69.2 million to assist the states and territories in building capacity for dental infrastructure and workforce. From June 2013 until 2015, the remaining funds of $274.8 million will be tied to performance targets measured against the 2011-12 baseline. States will need to achieve at least 65% of their target to receive a proportion of the total funds available for that period.
>
> All targets will be expressed in terms of Dental Weighted Activity Units (DWAU), calculated using the Australian Dental Association three digit item codes, and a weighting included as a Schedule to the Agreement. The performance indicators will measure the clinical activity of the states and territories to ensure that they use

9 Mr Charles Maskell-Knight, DoHA, *Official Committee Hansard*, Canberra, 12 March 2013, p. 6.

10 Mr Charles Maskell-Knight, DoHA, *Official Committee Hansard*, Canberra, 12 March 2013, p. 3.

11 Ms Kerry Flanagan, DoHA, *Official Committee Hansard*, Canberra, 23 April 2013, p. 49.

> the Commonwealth funds to provide services beyond their current levels.[12]

Committee comment

4.17 Funding provided under the Adult Dental Services NPA is intended to supplement existing state and territory effort. In providing this additional funding the aim is to increase access to public dental services for those who need it most.

4.18 To ensure that funding provided through the Adult Dental Services NPA is used to provide additional dental services the Committee believes that a baseline assessment of current effort is essential. Establishing agreed benchmarks for expansion of dental services and processes for monitoring progress thereafter is clearly critical to assessing whether additional services are in fact being provided.

4.19 The Committee believes that the Adult Dental Services NPA should include a 'maintenance of effort' clause, similar to the clause included in the Dental Waiting List NPA, that measures increased effort in terms of higher levels of dental activity and improved clinical outcomes against an established baseline.

Recommendation 7

The Australian Government include a 'maintenance of effort' clause in the Adult Dental Services National Partnership Agreement, similar to that included in the Dental Waiting List National Partnership Agreement. This clause should specify that state and territory governments must maintain public dental clinical activity for adults, so that additional funding provided under the Adult Dental Services National Partnership Agreement is used to increase current effort.

4.20 While acknowledging concerns expressed that state and territory governments might reduce their own expenditure on dental services, the Committee notes that equating effort to level of expenditure only will provide an overly simplistic representation of the public dental system. A more meaningful assessment of effort should take into account levels of service provision and clinical outcomes. As long as agreed service delivery and clinical activity benchmarks are being met, expenditure decreases may reflect efficiencies in service delivery.

12 DoHA, *Submission 34*, p. 3.

4.21 Accountability and reporting requirements are considered in more detail below. Further consideration will be given to DWAUs and how these units might be used to assess changes to the levels of clinical activity and types of dental services provided by states and territories.

Accountability and reporting

4.22 State and territory governments, and those responsible for delivery of adult dental services, have indicated that the NPA should not include 'onerous and difficult reporting'[13] and that there 'be a reduction in administrative burden'.[14] In relation to this, Ms Prue Power, Chief Executive, AHHA, stated:

> It is critical that the data collection and reporting of activity levels required by the Commonwealth are not excessive. That is a key principle of the National Health Reform Agreement—to reduce the burdens of administration.[15]

4.23 However, given the nature of the NPA framework and the financial requirements related to it, agreed benchmarks and key performance indicators (KPIs) are needed to measure progress and outcomes.

4.24 For example, performance and monitoring under the Dental Waiting List NPA requires states and territories to report on the following KPIs:

- Number of patients receiving dental services;
- Number of patients on dental waiting lists;
- Waiting time for patients on public dental waiting lists;
- Number of children and adults receiving specialist or general anaesthetic services;
- Number of dental occasions of service provided; and
- The number of additional Dental Weighted Activity Units (DWAUs).[16]

4.25 Clearly, specific benchmarks and KPIs for the Adult Dental Services NPA will need to be developed and negotiated. However, evidence to this

13 Dental Health Services Victoria (DHSV), *Submission 32*, p. 17.

14 ACT Health, *Submission 30*, p. 1.

15 Ms Prue Power, AHHA, *Official Committee Hansard*, Canberra, 22 April 2013, p. 8.

16 Ms Janet Anderson, DoHA, *Official Committee Hansard*, 22 April 2013, Canberra, p. 49.

inquiry has questioned the validity of one of the commonly used measures of dental need; that is, the number of patients on dental waiting lists.[17]

4.26 For example, the submission from Dental Health Services Victoria states:

> Public dental waiting lists in Victoria do not reflect the true or potential demand for care by the eligible population. Across Australia, waiting lists have been used as demand management tools and have assisted to suppress the true need for dental care of the eligible population.[18]

4.27 As explained further in the submission made by the NSW Ministry of Health:

> Waiting lists are poor measures of unmet demand for dental services as they do not include adults who for various reasons are not seeking access to dental care even when they need it. In NSW this includes adults with poor dental health, who are not eligible for public dental services and cannot afford private dental care.[19]

4.28 Additionally, the Loddon Mallee Region Oral Health Network states:

> The public dental waiting lists potentially do not account for those people who [are] unaware of the importance of dental care or their eligibility for public dental services or those that experience access barriers such as lack of public and private transport options, mobility issues, cultural reasons etc.[20]

4.29 Services for Rural and Remote Allied Health (SARRAH) provides the following perspective on dental waiting lists:

> SARRAH believes it is time that political parties of all persuasions realise that waiting lists are a political measure, not a measure of access to dental care. Waiting list times and lengths can be manipulable to suit political ends. For example, methods of creating a short waiting list may include instructing dental practitioners:
>
> - not to do full oral examinations and provide a very limited range of dental services;
> - not to inform patients that there is a waiting list;
> - to inform patients who become aware of a waiting list that it is many years long;

17 ADA, *Submission 37*, p. 4. See also: Australian and New Zealand Academy of Special Needs Dentistry (ANZSND) and the Australian Society of Special Care in Dentistry (ASSCD), *Submission 21*, p. 2; NSW Oral Health Alliance, *Submission 36*, p. 5.

18 DHSV, *Submission 32*, p. 6.

19 NSW Ministry of Health, *Submission 24*, p. 3.

20 Loddon Mallee Region Oral Health Network, *Submission 20*, p. 1.

- to audit the waiting list by contacting patients and removing those who do not respond within a short period of time from the list; and
- to redefine the waiting list into a number of lists such as placing those who have had treatment in the last year on a recall list, not a waiting list.[21]

4.30 An additional concern in relation to the use of waiting lists as a measure of demand is that those treated in the public dental system includes those individuals in need of emergency treatment.[22] These patients are generally triaged and provided an appointment in a short space of time.[23] These patients usually do not appear on waiting lists. Furthermore, triaging and responding to emergency cases also has effects on waiting times for those already on public dental waiting lists.[24]

4.31 However, and as illustrated by the Dental Waiting List NPA, it is usual practice to have a range of KPIs, rather than a single measure to assess outcomes.

4.32 The submission from Queensland's Minister for Health, Hon Lawrence Springborg MP, advocates for:

> … performance benchmarks based on improvements in service outcomes, not just increases in service activity for example, questioning if waiting times for routine dental care are reducing, or if access to emergency care has improved.[25]

4.33 The Consumer Health Forum (CHF) has proposed that a range of KPIs be developed for the Adult Dental Services NPA under the following items:

- community-wide oral health promotion and community education;
- planning for and provision of dental services for high-risk consumers according to need, including provision of general services, emergency care and more complex treatments;
- dental health service infrastructure and programs for hard to reach populations;
- water fluoridation, particularly in centres with populations of 1000 or above;

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21 Services for Rural and Remote Allied Health (SARRAH), *Submission 3*; p. 4, ADA, *Submission 37,* p. 4.

22 ADA, *Submission 40,* p. 4; Mr Andrew McAuliffe, AHHA, *Official Committee Hansard*, Canberra, 22 April 2013, p. 8.

23 Ms Emma Bridge, Oral Health Services Tasmania, *Official Committee Hansard*, Canberra, 22 April 2013, p. 33; Ms Jennifer Floyd, Western NSW Local Health District, *Proof Transcript of Evidence,* Dubbo, 17 May, 2013, p. 10.

24 DHSV, *Submission 32,* p. 6.

25 Hon Lawrence Springborg MP, *Submission 43*, p. 2.

- the elimination of co-payments for pensioner and Health Care Card holders; and
- reducing the number of emergency presentations by pensioner and health care card holders and increasing the percentage of card holders receiving regular check-ups and preventive care.[26]

4.34 Whatever the agreed benchmarks and KPIs, collection of dental data and statistics remains a fundamental challenge. As noted by DoHA:

> There are currently gaps in existing dental and oral health data sources. Specifically, there is a lack of data about adults accessing publicly-funded dental services and visits to private dental services.[27]

4.35 To address some of the concerns associated with dental waiting list data specifically, DoHA noted that the Australian Institute of Health and Welfare (AIHW) has developed the Public Dental Waiting Times National Minimum Data Set (PDWT NMDS). The PDWT NMDS will 'collect information on waiting times for people placed on public dental service waiting lists in all states and territories, measuring the time between placement on the list and the date an offer of care is made, or care received.' The PDWT NMDS will be implemented from 1 July 2013.[28]

4.36 Also, as noted earlier in this chapter, the Dental Waiting List NPA includes a KPI which measures progress toward clinical activity benchmarks in terms of DWAUs. Evidence suggests that the use of DWAUs as a measure to more accurately assess clinical activity and outcomes is subject to ongoing development:

> … we are still looking at the data set which is going to best inform the Commonwealth, as essentially funder or purchaser of services under the expanded package. This is the first time we have actually engaged with states and territories on this notional unit called DWAU. It would be fair to say that we are all learning how to use it and how it can be best applied to a monitoring regime. … That is something we are being very open about in our discussions with states and territories—that we are feeling our way into this space and look to do so collaboratively.[29]

26 Consumer Health Forum of Australia (CHF), *Submission 15*, p. 10.
27 DoHA, *Submission 34*, p. 8.
28 DoHA, *Submission 34*, p. 8.
29 Ms Janet Anderson, DoHA, *Official Committee Hansard*, Canberra, 22 April 2013, p. 50.

4.37 In order to maximise reporting efficiency, it was proposed that consideration be given to the use of existing data collection and reporting systems.[30]

Committee comment

4.38 To support the principle of accountability the Commonwealth Government must have appropriate oversight of the NPA and the services delivered under it. The Committee understands that this is achieved by placing reporting requirements on jurisdictions to monitor progress towards agreed outcomes. At the same time, the Committee is also aware of the need to ensure that reporting is not unnecessarily onerous.

4.39 With regard to the Dental Waiting List NPA, the Committee notes that the current KPIs are not solely based on public dental waiting list numbers. Given the concerns expressed in relation to limitations of this KPI as a measure of unmet demand for services, inclusion of a wider suite of KPIs would seem justified. The Committee is optimistic that work being undertaken by the AIHW to establish a PDWT NMDS will alleviate these concerns.

4.40 As the Dental Waiting List NPA and the Adult Dental Services NPA will overlap by 12 months, it will be important to ensure that any reporting requirements over this period are managed appropriately. In particular, consideration should be given to making use of dental data and statistics already collected by states and territories to streamline reporting for the two NPAs, maximising administrative efficiency and minimising reporting burden.

4.41 Establishing benchmarks and KPIs for the Adult Dental Services NPA will need to be negotiated between the Commonwealth and the states and territories. The Committee also recognises that to be effective, KPIs must be clearly defined, measurable and based on outcomes that are achievable.

4.42 While the KPIs used for the Dental Waiting List NPA could provide a starting point for negotiations, development of an altered or expanded range of KPIs that address the unique objectives of the Adult Dental Services NPA will be essential. In addition to assessing increases in clinical activity over baselines, the Committee would like to see the inclusion of KPIs that have the capacity to monitor agreed outcomes, including shifts in the type of service being delivered (e.g. from emergency to preventive) and delivery of services to specific population groups.

4.43 To monitor shifts in the type of services delivered or targeting of services it may be possible to adapt DWAUs by applying weighting to agreed

30 Hon Lawrence Springborg MP, *Submission 43*, p. 2.

priority outcomes. The Committee notes that work on the use of DWAUs as a tool to monitor clinical activity is still in progress. The Committee also supports the collaborative approach that has been adopted to progress this.

Recommendation 8

The Australian Government develop a performance and reporting framework for the Adult Dental Services National Partnership Agreement that will accurately and objectively assess progress towards achieving agreed benchmarks for service delivery and clinical outcomes.

In consultation with state and territory governments, and with private providers of dental services, consideration should be given to a range of key performance indicators that will allow for monitoring of:

- **changes to the levels of clinical activity;**
- **preventive services as a proportion of all services delivered; and**
- **targeting of services to specific population groups.**

In developing the performance and reporting framework, consideration must be given to making use of existing data collection and reporting systems to maximise administrative efficiency and minimise reporting burden.

Consistency across jurisdictions

4.44 A number of submissions have observed that the type of dental services, eligibility requirements for access, and co-payments for services differ between states and territories. As noted by SARRAH:

> There is also limited coordination of dental services between State and Territory Governments. The State and Territory Governments have different rules and systems for supplying dental care. A meeting between these government oral health administrators is needed to develop a consistent set of rules for supplying public dental care across Australia.[31]

4.45 The submission from the Australian Dental Association (ADA) observes:

31 SARRAH, *Submission 3,* p. 8. See also: Dental Hygienists Association of Australia (DHAA), *Submission 2*; Mr Thomas Higgins, *Submission No 31.*

> 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.[32]

4.46 Also noting that co-payment practices vary considerably between states and territories, a representative of DoHA provided the following testimony:

> Queensland do not have any co-payments—that might be why they have the longest waiting lists; New South Wales have co-payments for some specialist dental services and some dentures; Victoria has a range from $25 for emergency, $100 for general course of care, up to $120 for dentures; Tasmania hits everybody for $25 up to maximum of $366 for course of care … [t]he Northern Territory does not have any; WA has a sliding scale; ACT has an annual maximum …[33]

4.47 Differences between states and territories in relation to scope of practice limitations that apply particularly to dental and oral therapists were also raised. Inconsistency in scope of practice restrictions means workforce limitations are more significant in some jurisdictions than in others. As submitted by the Australian Dental and Oral Health Therapists' Association (ADOHTA):

> Currently, limits are placed on dental and oral health therapists based upon the level of tertiary training in the state they work in. In Victoria a dental therapist is allowed to treat patients up to the age of 25, whereas dental and oral health therapists in Queensland are restricted to working on patients from between four and 18 years of age.[34]

4.48 While there was general support for greater cross-jurisdictional consistency, the context of the Dental Reform Package as part of the Federal Financial Relations Framework provides flexibility for state and territory governments to determine priorities for services and service delivery. In relation to this, DoHA provides the following advice:

32 ADA, *Submission 37*, p. 5.

33 Mr Charles Maskell-Knight, DoHA, *Official Committee Hansard*, Canberra, 12 March 2013, p. 10.

34 ADOHTA, *Submission 19*, p. 3.

> The [adult dental services] NPA's deliverables will be customised for each state and territory depending on the demonstrated local needs and progress under the 2012-13 Dental Waiting List NPA.[35]

4.49 Similarly the submission from ACT Health emphasises that in order to comply with the principles of the Intergovernmental Agreement on Federal Financial Relations, the Commonwealth Government should focus more on agreed outcomes and be less prescriptive in relation to service delivery, stating:

> The ACT Health Directorate expects the Commonwealth uphold its commitment to move away from prescriptions on service delivery in the form of financial or other input controls, which inhibit state service delivery and priority setting, and instead, focus on the achievement of mutually agreed outcomes, providing the states and territories with increased flexibility in the way services are delivered.[36]

Committee comment

4.50 While acknowledging that variations to the type of dental services, eligibility requirements for access, and co-payments between jurisdictions exist, the Committee believes that the most important consideration is to increase availability and access to public dental services for those who need it most. Although national consistency would ensure that all Australians have access to the same public dental services wherever they are and whatever their age, the Adult Dental Services NPA is being developed in a framework which aims to provide states and territories with maximum flexibility for delivering services.

4.51 In the context of this framework, the Committee understands that there is some scope, albeit rather limited, for the Adult Dental Services NPA to promote a degree of national consistency for adult dental services. For example, this may be achieved through an NPA which includes benchmarks and KPIs to promote the delivery of particular service types or prioritises access for particular population groups. However, the benefits of national consistency need to be offset against the basic principle that supports the rights and responsibilities for states and territories to prioritise and shape services to meet particular and localised needs.

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35 Department of Health and Ageing website, 'Dental Health: Dental Reform', <www.health.gov.au/internet/main/publishing.nsf/Content/dentalreform> viewed 8 May 2013.

36 ACT Health, *Submission 30*, p. 1.

Sustainable funding

4.52 Although the Dental Waiting List NPA and the Adult Dental Services NPA provide substantial additional funding to extend state and territory public dental services, concerns have been raised about the sustainability of the funding. This is particularly significant given that NPAs have defined end-dates, while the dental and oral health needs of the population will be ongoing.[37]

4.53 With regard to this issue, the NSW Ministry for Health observed:

> … a long term sustainable funding mechanism needs to be put in place to ensure that those who cannot afford private health insurance have access to basic preventive and treatment dental services.
>
> Unfortunately National Partnership Agreements may not provide a secure funding mechanism. The current arrangement is time limited and like the Commonwealth Chronic Disease Dental Scheme (CDDS), creates a situation where service activity is increased with no certainty of that capacity being able to be sustained.[38]

4.54 Similarly, the Tasmanian Department of Health and Human Services emphasised the importance of sustained funding, explaining:

> In terms of structure of future programs, states and territories always have problems with national partnership agreements basically because they are there for limited terms, probably three years, and especially where your investment is going to be in recurrent expenditure. If you are going to employ more dental staff, what happens at the end of three years if the funding ceases? … National partnership agreement: while we commend the investment, in the longer term it actually needs to move into something like a national agreement so that there is ongoing commitment of funding.[39]

4.55 The ADA (NSW Branch) expressed concern about longer-term funding, saying:

> Furthermore, the funding that has been announced under the National Partnership Agreement for adult public dental services is

37 See for example: NSW Ministry of Health, *Submission 24*, p. 6; ACT Health, *Submission 30*, p. 2; DHSV, *Submission 32*, p. 16.

38 NSW Ministry of Health, *Submission 24*, p. 6.

39 Mr Paul Geeves, Department of Health and Human Services Tasmania, *Official Committee Hansard,* Canberra, 22 April 2013, p. 34.

> only committed up to the end of 2017-18. As noted, there is already a level of uncertainty around this funding given the impending election later this year. This uncertainty makes it very difficult for state and territory public dental services to efficiently and effectively plan dental programs around this funding, particularly in the medium to long term.[40]

4.56 Also acknowledging the time and expense involved in establishing public dental services, the submission from Mr Lawrence Springborg MP states:

> … an NPA that does not provide certainty of funding, both within and beyond the NPA period, risks the development of short-term, temporary 'band-aid' strategies, that ultimately do not address the oral health needs of adults requiring public dental services in Queensland.[41]

4.57 To address this concern Mr Springborg MP suggests:

> The [Adult Dental Services] NPA should have provisions for State and Federal Governments, and private dental providers, to discuss ongoing funding for dental services at least 12 months prior to the expiry of the NPA.[42]

Committee Comment

4.58 The issue of funding sustainability is clearly an important one and is likely to affect all states and territories, particularly when undertaking infrastructure or workforce planning. The Committee recognises that in order to build on improvements in dental and oral health arising from the Dental Waiting List NPA and the Adult Dental Services NPA, an approach that supports a commitment to ongoing funding is necessary.

4.59 To alleviate concerns about sustained funding, and assist state and territory governments and private sector partners to make longer-term planning decisions, the Committee recommends the inclusion of a provision in the Adult Dental Services NPA which requires negotiations about continued funding for adult dental services to commence at least 12 months prior to the NPA's expiration.

40 ADA (NSW Branch), *Submission 40*, p. 9.

41 Hon Lawrence Springborg MP, *Submission 43*, p. 2.

42 Hon Lawrence Springborg MP, *Submission 43*, p. 2.

Recommendation 9

The Australian Government include provision in the Adult Dental Services National Partnership Agreement that requires all signatories to commence negotiations for a new National Partnership Agreement (or alternative funding model) at least 12 months prior to its expiration.

4.60 The Committee comments further on the need for sustainability in the context of a strategic approach to dental and oral health policy.

A coordinated approach

4.61 As outlined in Chapter 2, responsibility for dental services is shared by Commonwealth, state and territory governments, and the private sector. Funding for dental services is also shared, with the majority of services being paid for by individuals with or without assistance from private health insurance. However, evidence to the inquiry suggests that coordination is a significant area of weakness.

4.62 Several submissions indicate that coordination between the two tiers of government in relation to dental policy and service delivery is inadequate. Some have noted in particular that a lack of clarity around roles and responsibilities has resulted in 'buck passing' between the Commonwealth, and states and territories. Furthermore, evidence indicates that inadequate coordination extends to government engagement with private dental services.[43]

4.63 As noted in the submission from the Tasmanian Department of Health and Human Services:

> Dental services funded or provided by state/territory governments, the Australian Government and by the private sector tend to operate independently from each other with no linkages to an overall national dental care strategy. Given that fund holders for dental services are both tiers of government, individuals through out-of-pocket expenses and private health insurance companies, it is not surprising that there is very little coordination of services. Improved coordination of dental services may lead to more cost effective dental programs and better

43 See for example: DHAA, *Submission 2*; Association for the Promotion of Oral Health (APOH), *Submission 4*, pp.11–12.

> targeting of government funded services to people who would most benefit from dental treatment.[44]

4.64 The NSW Oral Health Alliance observed:

> [t]he Alliance is concerned about on-going fragmented policy and funding responsibility for dental services between the two tiers of government, and the scope and coverage of services funded under the package.
>
> The Alliance is concerned about the lack of a clear, comprehensive national framework for oral health policy and funding. The current shared approach between the states and the Commonwealth is piecemeal and fragmented. Blurred responsibilities between the two tiers of government in the absence of a comprehensive framework leave the system exposed to gaming and perverse incentives.[45]

4.65 The AHHA also expressed concern about inefficiencies and the potential for duplication, observing:

> 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.

4.66 Some contributors to the inquiry have recommended appointing a Commonwealth Chief Dental Officer or an independent oral health advisory body to improve coordination across the two tiers of government, increase engagement with the private providers of dental services and to provide independent policy advice.[46]

4.67 DoHA already has a Chief Medical Officer, a Chief Nursing Officer and, as noted by the AHHA, has recently appointed a Chief Allied Health Officer.[47] The AHHA also notes that DoHA currently has independent advisory bodies to cover areas such as mental health, aged care funding, influenza, suicide prevention, dementia, pathology, pharmaceuticals, preventive health and marketing of infant formula.[48]

4.68 Responding to these proposals, DoHA commented:

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44 Tasmanian Department of Health and Human Services, *Submission 26*, p 3.

45 NSW Oral Health Alliance, *Submission 36*, p. 8.

46 APOH, *Submission 4*, p. 12; AHHA, *Submission 5*, p. 7; ADA (NSW Branch), *Submission 40,* p.11.

47 AHHA, *Submission 5,* p. 7.

48 AHHA, *Submission 5,* p. 7.

> I suppose for me it would be about what value [a Commonwealth Chief Dental Officer] might add. There is already a lot of engagement with the industry that occurs anyway. You do not necessarily need a specialist in the Department of Health and Ageing—you can get advice from many sources, as we do. For example, on dental issues, the Department of Veterans' Affairs runs a dental scheme for veterans, and they have a panel of dental experts that we use. We think that is probably a cheaper and more efficient way of accessing expertise. Also, I am sure that the Australian Dental Association, if we asked them, would be more than happy to give us advice for free. So it would be up to government to decide whether it wanted to do something like that. We have quite a lot in place already which allows us to get expert advice on dental policy.[49]

Committee comment

4.69 The Committee understands concerns regarding a lack of coordination between the two tiers of government, and the private sector, in relation to dental health policy and services. The Committee has commented elsewhere in this report on the importance of increasing engagement with the providers of private dental services, particularly in areas where public services are not available or are oversubscribed.

4.70 With regard to improving coordination, the Committee considers that the Adult Dental Services NPA provides an opportunity for significant progress. Clearly defining roles and responsibilities for the Commonwealth, and for states and territories, is a fundamental element of any NPA, and as such will be integral to dialogue and negotiations.

4.71 While acknowledging the views expressed by DoHA, there is precedence for appointments such as a Chief Dental Officer or an independent advisory body to improve coordination across the tiers of government and the private sector, and to provide policy advice. On this basis, the Committee believes that suggestions to appoint a Commonwealth Chief Dental Officer or an independent advisory body for oral health warrant further consideration.

49 Ms Kerry Flanagan, DoHA, *Official Committee Hansard,* Canberra, 22 April 2013, p. 51.

Recommendation 10

The Department of Health and Ageing, in consultation with state and territory governments and other key stakeholders, examine the case to appoint a Commonwealth Chief Dental Officer or establish an independent advisory body to:

- **improve coordination between the Australian Government, and state and territory governments;**
- **increase engagement with the private sector, particularly private providers of dental services; and**
- **provide independent policy advice on dental and oral health.**

A strategic approach

4.72 Evidence notes inconsistent government approaches over the years to dental policy and to responsibility for funding and provision of dental services. This has resulted in a history of dental policy and services characterised by changing priorities and sporadic, short-term funding.[50]

4.73 History has shown that there is a need for a national strategic approach to dental health service provision.

4.74 In the following testimony Dental Health Services Victoria outlined the effect of the changing policy frameworks on waiting lists for public dental services:

> The Government needs to consider long term sustainability. Oral Health has suffered over the years with on-off funding. Over a decade ago the Commonwealth Dental Health Program was axed resulting in a number of people unable to access care. This has been repeated with the closure of the Chronic Dental Disease scheme. Both of these events resulted in significant increases in waiting lists as the resultant increase in demand through the success of these Commonwealth schemes led to additional eligible people, who might not previously had accessed public dental care, now demanding care with no other options than already lengthy public dental waiting lists.[51]

4.75 Commenting on the consequences of closing the CDDS, Dr Kerrilee Punshon of the Australian Society of Special Care in Dentistry and the

50 See for example: CHF, *Submission 15*, p. 5.

51 DHSV, *Submission 32*, p. 16. See also: NSW Oral Health Alliance, *Submission 36*.

Australian and New Zealand Academy of Special Needs Dentistry described the implications on continuing of care for dental patients:

> … I have a pool of patients at the moment that have just finished the Chronic Disease Dental Scheme. Some of them had come to me with very poor oral health several years ago. We have cleaned them up and got them tidied up. We now have a lot of them under control and they are ticking along nicely, but there is a lack of continuity. Some of them are staying on in the practice but I do not know how long for, even though their costs are less now because they are coming in more for check-up and cleaning rather than comprehensive work, because that was done. Others are going back to the private sector and others are saying it is all too hard and they have just given up. What concerns me is that you have spent this basket of money on getting these people's oral health better and sorting out the backlog of problems they had, and now we have just dropped them and things are just going to break down again for a lot of them.[52]

4.76 The implications for individual patients is also illustrated in personal testimony from a patient with long-term and ongoing dental care issues:

> My name is Sally and I received the dental health plan when it was up and running and now am in desperate need of this again. I have suffered from anorexia for the past 28 years and never anticipated that it would result in my losing most of my teeth which now leaves me five up top. I am in need of having two of them pulled and a denture so that I can at least feel more normal. It is difficult trying to emotionally cope with the loss of my teeth and not being able to afford private dental care. I am in chronic pain because of my teeth and am on a two year waiting list for public dental care but by that stage I don't know what will happen.[53]

4.77 With regard to strategic planning for dental and oral health, DoHA advised that the process of developing an updated National Oral Health Plan has started. The National Oral Health Plan 2014-2023 will replace the National Oral Health Plan 2004-2013. The updated plan is expected to be finalised by the by the end of 2013.

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52 Dr Kerrilee Punshon, ANZSND and ASSCD, *Official Committee Hansard*, Canberra, 23 April 2013, p. 20.

53 Ms Sally Stamm, *Submission 41*, p. [1].

4.78 While evidence was generally supportive of updating the National Oral Health Plan, CHF expressed concern that implementation of the first plan had been poor, observing:

> The patchiness of funding, coupled with the lack of coordination, has contributed to the lack of progress under the National Oral Health Plan 2004-2013. The document was ratified by the Australian Health Ministers' Advisory Council in 2004, and in the decade since, minimal progress has been made under several of its key indicators.[54]

4.79 A longer-term strategy that was strongly supported in evidence was for implementation of a universal dental care scheme funded by Medicare.[55]

4.80 For example, Dr Thomas Higgins, a Tasmanian-based periodontist, suggested:

> The answer to ensuring better access [for] all adult Australians to better dental health is to transfer the provision of general dental services to the private sector insisting upon quality guidelines, standards and practice accreditation. The financing of these services would be via taxation arrangements and an increase in the Medicare levy by a realistic percentage, with built-in 3 year reviews.[56]

4.81 Testimony indicated that a universal dental care system would make best use of services available through the private sector and public system. As explained by the Association for the Promotion of Oral Health (APOH):

> Were Medicare to fund dental treatment in a similar way to medical service, then most people currently unable to access timely treatment in the public dental service could receive near immediate treatment by private dentists. This would greatly reduce demand for public dental services, and provide opportunity for the public dental service to improve the quality of treatment delivered.[57]

4.82 Several submissions noted that the issue of universal dental care has been gaining momentum recently, referring to the National Health and Hospitals Reform Commission (NHHRC), which put forward an option of

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54 CHF, Submission 15, p. 6.

55 See for example: SARRAH, *Submission 3,* p. 5, APOH, *Submission 4,* p. 4, AHHA, *Submission 5,* p. 3, Combined Pensioners and Superannuants Association of New South Wales, *Submission 6,* p. 3, Public Health Association of Australian, *Submission 12,* p. 4, Australian Research Centre for Population Oral Health, *Submission 18,* p. 4, NSW Oral Health Alliance, *Submission 36,* p. 8.

56 Mr Thomas Higgins, *Submission 31*, p. 9.

57 APOH, *Submission 4,* p. 6. See also: SARRAH, *Submission 3*, p. 5.

a universal dental scheme 'Denticare', in its 2009 report to Government.[58] In responding to the NHHRC's recommendation for 'Denticare', the Government advised only that it was committed to the aim of increasing access to dental services by proving a package of dental reforms to better target services to those Australian most in need.[59]

4.83 Recognising the financial implications of introducing a universal dental care scheme, the majority of proponents supported a phased approach to implementation. The Dental Reform Package and the Commonwealth Government's commitment to fund an extension to adult dental services under the NPA were viewed as an opportunity to progress toward the goal of a universal dental care scheme.[60]

Committee comment

4.84 It is clear that the approach of successive governments to dental policy has been inconsistent. This has resulted in a changeable policy environment that has not been compatible with a sustained commitment to improving the dental and oral health for all Australians.

4.85 The Committee notes evidence relating to the CDHP and the CDDS which illustrates the impact of the 'stop-start' funding on patients. Patients impacted by closure of these schemes have had few options available to them. While some who can afford to do so have sought treatment through the private system, others have had to join lengthy waiting lists to access public dental services. Some patients, unable to afford private treatment and discouraged by lengthy waiting times to access public services, have discontinued treatment altogether. For governments responsible for the provision of public dental services, the changeable policy environment compromises their ability to plan services and support the necessary workforce to deliver services in the longer term.

4.86 Notwithstanding the policy decisions to close these schemes, there are some key lessons to be learned which should inform the development of future policy. The Committee believes that many of these issues could have been avoided if both tiers of governments adopted a longer-term strategic approach to dental policy and funding of dental care.

4.87 To achieve the best possible outcome and level of commitment necessary, the Committee recognises the need for the Commonwealth to work closely with state and territory governments and other key stakeholders to

58 *National Health and Hospitals Reform Commission Final Report*, June 2009, p. 26.

59 *A National Health and Hospitals Network for Australia's Future 2010*, p. 152.

60 See for example: AHHA, *Submission 5*, p. 2.

develop a strategic plan to underpin longer-term dental policy endeavours.

4.88 Although the Committee is encouraged to note that develop of the updated National Oral Health Plan for 2014-2023 has involved stakeholder consultation, it also notes evidence which suggests that implementation of the National Oral Health Plan 2004-2013 was disappointing. Therefore, to complement development of the National Oral Health Plan for 2014-2023, the Committee recommends a process of negotiation with state and territory governments and other key stakeholders, to establish and commit to an implementation strategy.

Recommendation 11

The Australian Government commit to a robust dental policy framework that guarantees the long-term sustainability of the public dental sector as a provider of dental services through ongoing funding support.

Recommendation 12

The Australian Government, in consultation with state and territory governments and other key stakeholders, establish and commit to an implementation strategy for the National Oral Health Plan 2014-2023.

4.89 In considering the evidence, the Committee notes the general enthusiasm for the introduction of a universal dental scheme delivered through a combination of public and private dental services. While a universal dental scheme is a worthy goal to work toward in the longer-term, the Committee understands the substantial cost that a universal scheme would present.

4.90 The current public dental system provides important and necessary services to the eligible population, and its contribution to the oral health of Australians should not be undervalued. However, there are evidently issues in providing access to the eligible population as illustrated to some degree by long waiting lists and delays in accessing public dental services.

4.91 In the shorter-term, the Committee agrees that effort should be focussed on how to prioritise access to publicly funded dental services to ensure that those most in need are able to access care. However, in the longer-

term the Committee is keen to support a strategic policy approach for phased implementation of a universal dental care scheme.

Recommendation 13

The Australian Government adopt a strategic policy approach which supports deliberate and phased progress toward a universal access to dental services scheme for Australia.

Ms Jill Hall MP
Chair

4 June 2013