ADOHTA

AUSTRALIAN DENTAL and ORAL HEALTH THERAPISTS' ASSOC Inc.

14 July 2017

Human Services Inquiry
Productivity Commission
Locked Bag 2, Collins Street East
Melbourne Vic 8003

Re: Productivity Commission Consultation Draft Report

Dear Hon. Scott Morrison

On behalf of The Australian Dental and Oral Health Therapists' Association (ADOHTA), the peak body that represents Oral Health Professionals (OHPs), which include dental therapists, oral health therapists and dental hygienists, we wish to provide our comments on the Productivity Commission's draft report on Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, in relation to public dental services.

OHPs work in multidisciplinary teams with a range of different providers in all sectors of healthcare. They provide education and information, prevention and restorative care cost effectively. Our organisation is dedicated to expanding access to cost-effective oral health services for all Australians. We believe that developing policies and funding mechanisms to ensure that all Australians have direct access to OHP services is a critical part of the solution to expanding access to preventive oral health care, improving oral health promotion and disease prevention, and contributing to a reduction in the number of avoidable hospital admissions for dental conditions amongst the Australian population.

DRAFT RECOMMENDATION 11.1

State and Territory Governments should report publicly against a consistent benchmark of clinically acceptable waiting times, split by risk based priority levels.

Once data systems are developed, provider level reporting should be published monthly and aggregate measures included in public dental services' annual reporting processes

ADOHTA supports the need to develop a consistent and appropriate benchmarking of waiting times, which are aligned with the objectives of Australia's National Oral Health Plan 2015-2024. Whilst, this type of public reporting would increase accountability, it should be noted that addressing the consumer driven demand for both emergency and general dental care in the public sector would be difficult without significant federal and State/Territory government funding to provide services. Investment by governments in oral health have continued to remain

inadequate as is evident by barriers faced by individuals and families, who often delay seeking dental care particularly due to cost.

The draft report identified non-urgent waiting times for public dental service can be up to 2-3 years. A recognition towards prevention, maximal utilisation, and increased in the number of OHPs would improve the cost-effectiveness on the healthcare system. This is largely due to the fact that salaried dentists are costlier to employ in comparison to salaried OHPs, who could provide a large majority of general dental services delivered in the public sector to achieve population health outcomes. This would enable dentists to focus on more complex dental care needs of the population.

Prioritising individuals using a risk based approach with access to dental care is an appropriate approach to address oral health inequities. However, it should be noted that many oral diseases are largely preventable. ADOHTA supports a public dental system that offers all eligible populations access to preventive oral health services at the earliest possible, which would increase self-determination for all individuals to prevent oral disease progression. A focus on prevention is likely to create more a sustainable and fiscally fundable provision of dental services by reducing the need for more complex dental care.

DRAFT RECOMMENDATION 11.2

State and Territory Governments should establish outcomes frameworks for public dental services that focus on patient outcomes and include both clinical outcomes and patient reported measures.

State and Territory Governments should assess Dental Health Services Victoria's work to date on outcome measures, once implemented, with a view to identifying and commencing implementation of a nationally consistent outcomes framework.

ADOHTA supports the recommendation on establishing appropriate clinical and patient reported measures, in which the funding mechanism for dental services are tangibly linked to patient outcomes. These outcomes should also include benchmarking on the provision of preventive dental services and any dental treatment provided should be subjected to a performance monitoring framework to ensure the services rendered is appropriate to the individuals' dental treatment needs and expectations. This would increase service provider accountability.

DRAFT RECOMMENDATION 11.3

State and Territory Governments should develop comprehensive digital oral health records for public dental services. Once developed, these systems should be incorporated within the My Health Record system.

ADOHTA supports the need to develop a digital oral health records system for public dental services which can then be potentially be linked to the My Health Record system. These systems are essential to integrate public dental services into the broader health care system. Not only will it provide opportunity for inter-professional collaboration, it would enable a more person-centred management pathway.

DRAFT RECOMMENDATION 12.1

State and Territory Governments should introduce a consumer directed care approach to public dental services. Under the new approach, participating providers should be paid based on a blended payment model that incorporates:

- *risk weighted capitation payments for preventive and restorative services for enrolled patients that incentivises the provision of clinically and cost-effective treatments. Governments should weight capitation payments based on the treatment needs of different population groups (including adults and children)*

- *performance based outcome payments, incorporating payments for clinical and patient outcomes*

- *activity based payments for complex and hard to define procedures (such as dentures). The dental treatments that would be eligible for activity based payments should be determined by governments based on available evidence on the clinical and cost effectiveness of treatments.*

State and Territory Governments should ensure that under the scheme:

- *patients are offered choice of provider (public or private clinic) who will care for them for a defined enrolment period*

- *the enrolment period aligns with the time required to effectively measure outcomes*

- users are able to change provider in certain circumstances (such as, when moving city).

ADOHTA supports a consumer directed care approach to public dental services and recognises that more work is required to determine what is clinically and cost-effective treatment. A risk weighted capitation payment for an enrolled patient would need to be based on different population groups and individuals. Medicare data evaluated by ADOHTA suggests the average cost per individual under the Child Dental Benefits Scheme (CDBS) is $206 for the 0-4 age group, $538 for the 5-14 age group, and $642 for the 15-17 age group. However, the dental treatment provided under the scheme is subjected to a consumer driven model, which is not established on evidence-based researched CDBS item schedule. Currently, billing arrangements does not accurately reflect who was the provider of the service because treatment provided by OHPs are required to be billed under a dentist provider number. An example of a poor cost-effective dental treatment is a dental restoration or root canal treatment, which largely does not address the biological management of dental caries (tooth decay). ADOHTA supports the direction to have a funding mechanism that rewards performance on improving clinical and patient outcomes and activity based remuneration for more complex care.

ADOHTA has reservations providing a choice for the consumer to choose the public or private sector for a defined enrolment period as this will lead to less cost-effectiveness in the health care system. It is more likely that consumers will choose a private provider, largely for the perceived higher quality of care provided. Private providers may not necessarily be able to support population health goals due to their fundamental aim of profit. Although there are many private providers who do provide person-centred care, there are real risks there may be over-servicing of higher end costly dental treatment, which is evident from the outcomes of the Chronic Disease

Dental Scheme. Dentists were providing dental crowns, which are generally not cost-effective. There is a need to create relevant and minimally intrusive performance monitoring systems to ensure services provided in the private sector are appropriate.

A defined enrolment period could potentially limit consumers provider choice, and may not necessarily be in the best interest of the patient. It is common for consumers to change their dental provider because they felt that he/she did not deliver the best care for them. Dental practitioner choice is also limited in many private practices if they only have employed dentists. ADOHTA advocates the government to facilitate provider numbers for OHPs to enable all consumers to have access to a preventive approach to dental services provided by OHPs. For example, some community dental agencies in Victoria utilise only OHPs to develop dental treatment plans with clients at the first point of contact, provide general dental services within their scope of practice and refer the client for more complex dental care, if required, to the dentist, or other health professionals.

DRAFT RECOMMENDATION 12.2

The Independent Hospital Pricing Authority, in consultation with State and Territory Governments and the dental profession, should be funded by the Australian Government to determine the efficient prices for consumer directed care payments.

ADOHTA is willing to work with the Independent Hospital Pricing Authority to determine efficient prices for consumer directed care payments. OHPs have a strong history of working in the public dental sector providing cost-effective dental services to the community. Our profession recognises that dentistry in Australia, is largely considered expensive for populations who are the most likely to need dental services.

DRAFT RECOMMENDATION 12.3

State and Territory Governments should transition to a consumer directed care approach by first establishing initial test sites to evaluate new blended payment models and allocation systems, before a staged roll out.

ADOHTA is supportive of setting up rigorous trials, monitoring and evaluating their impact of a consumer directed care approach that utilises OHPs. We emphasise from our previous submissions that running a trial of OHPs in independent practice settings and under different payment systems such as, vouchers and OHP specific Medicare Item Numbers, which would additionally need to be evidence reviewed, would be beneficial to addressing the issues within the current model of public dental services being delivery nationally, and provide an evidence-base for future policy decision making.

DRAFT RECOMMENDATION 12.4

State and Territory Governments should provide access to consumer directed care through a centrally managed allocation system. Under the allocation system, governments should triage patients for both general and urgent care through an initial assessment. The initial assessment should identify and prioritise access for eligible users most at risk of developing, or worsening, oral disease.

Governments should ensure that, when allocated funding, a patient has access to:

- *clinically- and cost-effective treatments that are necessary for the patient to have a disease free mouth*

- *payment arrangements where patients can choose to pay extra to the provider to access a range of clinically effective treatments beyond the basic treatments*

- *consumer oriented information on participating providers including, for example, clinic locations and published outcome measures, to enable their choice of provider.*

ADOHTA is pleased the proposal identified in the Productivity Commission's draft report articulated the need to utilise the oral health therapist as one of the OHP providers to deliver a preventive focused model of dental care. An OHP would also able to triage patients for both general and urgent care through an initial assessment. This would create sustainability providing oral health care that aims to prevent the worsening of oral disease for eligible users of public dental services, via appropriate resource allocation.

ADOHTA supports a funding mechanism that incentivises prevention services as fully funded rather than restorative or extraction services, which does not address the root cause of dental caries and periodontal disease (gum disease). Those treatments could be covered under payment arrangements where patients can choose to pay extra to the provider to access a range of clinically effective treatments beyond the basic treatments. This mechanism would create incentives for a prevention focus while maintaining a disincentive for the user to choose elective non-urgent restorative or extraction services that could have been prevented through informed consumer self-care. It also shifts the dependence away from dental practitioners to 'fix' a dental problem, and move towards a collaborative provider-user approach towards health.

ADOHTA is unclear how consumer oriented information on participating providers regarding location and outcome measures would contribute to achieve population health outcomes. A publicly available rating system may contravene the Australian Health Practitioner Regulation Agency's 'Guidelines for advertising regulated health services'.

DRAFT RECOMMENDATION 12.5

State and Territory Governments should establish outcomes based commissioning systems for public dental services. Once systems are established, State and Territory Governments should examine opportunities for introducing greater contestability in public dental services.

At first, greater contestability should be introduced in those settings where it is clear that competition is not feasible, including remote provision and other outreach services.

ADOHTA supports the establishment of an outcomes based commissioning systems for public dental services and utilising the resources of the private sector more effectively. This would require an appropriate performance monitoring to ensure accountability is created. Greater contestability can be introduced including remote provision and outreach services firstly by ensuring OHPs who already work in these areas have access to provider numbers. Workforce data reported by the Australian Institute of Health and Welfare have consistently reported dental and oral health therapists are more evenly distributed by geographic location compared to

dentists. Enabling access to provider numbers for OHPs would free the market more cost-effectively and enable more informed user choice to a preventive focus of dental care by OHPs.

ADOHTA would like to reiterate the important significance to approve independent practitioner status and the provision of provider numbers for OHPs to introduce more competition and user choice. This would enhance access to all consumers a preventive model of dental care cost-effectively, particularly in the private sector.

ADOHTA looks forward to contributing to the work of the Productivity Commission in the future, and anticipates the outcomes of the report will shift public dental services towards a prevention focus, which is facilitated by maximal and greater utilisation of OHPs.

Yours sincerely,

Tan Nguyen
President
Australian Dental and Oral Health Therapists' Association Inc.