Comments on the COMMISSION Report

Comments in relation to 6.1-Public Dental Services in Australia

- The report documents the use of voucher scheme in other States. However, there has also been extensive and successful use of vouchers in SA for the treatment of eligible adults since the early 1980s. Patients receiving vouchers are free to use them with any private provider who is willing to provide the treatment under the schemes. In the most recent analysis, approximately 80% of general dental practitioners in the private sector provided treatment to public patients with vouchers (internal SA Dental Service data).

  Vouchers are issued to patients with a range of treatment needs including both emergency, general and some specialist dental care. I have attached the relevant page from the SA Dental Service Yearbook for 2013-14 that shows the scale of expenditure on such fee-for service programs in the private sector (Attachment B). This document is on the SA Health website.

- It should also be noted that the Australia Government's Child Dental Benefits Schedule (CDBS) allows patients (ie parents) to select private or public dental providers in a completely contestable way. In 2014-15, 74% of CDBS treatment in South Australia was provided by public clinics of the School Dental Service (Report on the Third Review of the Dental Benefits Act 2008, not attached). Verbal advice from the Office of the Federal Minister for Health indicates that there was some abuse of the Scheme by private providers and this was the reason the Commonwealth had planned to replace the scheme with a state managed program under a National Partnership Agreement. I understand this change has been blocked by Parliament. I support the continuance of the CDBS as it does provide contestable services from the provider of the parents' choice. However, the program does require more effective promotion in some state/territories.

- The report recorded that public dental services are mostly provided in state/territory dental clinics in contrast to optometry that is almost wholly provided in the private sector. Optometry is an open ended scheme with Medicare funding driven by demand. Public dental services for adults, by way of contrast, have fixed budgets. Hence, state/territory dental services use the controlled issuing of vouchers for private treatment to supplement their public clinics' care within the available fixed funding. The reasons for giving priority to treatment by public clinics is explored later in this submission.

Comments in relation to 6.2- Scope to improve outcomes

- The report states that "the current emphasis on providing services in government-operated clinics limits responsiveness to user needs and preferences". However, I suggest that this statement ignores the South Australian experience.

  South Australia allocates dental funding to geographic areas based on the numbers of eligible adults in the area. If public dental facilities are not available or reasonably accessible in an area, the appropriate number of vouchers are issued to patients in that area for eligible patients to receive their treatment privately to ensure consistency of access to dental care for eligible adults.

However, remote areas commonly do not have sufficient private dentists, providing a challenge for both the public and private dental sectors. Approaches to address this challenge are covered later in the submission.

- The suggestion that public dental services are not responsive to user needs is not accepted.

  In South Australia, a range of programs, targeted at sub-groups of the eligible population with high needs, have been developed and implemented. These programs have been developed in consultation with the relevant communities, the private dental sector and the SA Dental Service's consumer advisory panel. Examples of these programs in the last decade include:

  - A statewide Nursing Home Program. (This program was adopted by the Commonwealth for National roll out and uses private providers for most of the treatment.)
  - A program for older people living in Residential Care (This program won a Premier's Award for excellence in public sector management and was adopted by the Commonwealth for national roll out).
  - The Aboriginal Liaison Program (This program has dramatically increased the number of Aboriginal people receiving dental care)
  - A Program for people living in supported residential care and a separate dental program for the homeless
  - A Special Needs Dental Program for people with complicating health issues and
  - Fly-in-fly-out dental programs for rural and remote areas where there are no private providers available and no public clinics.

  Some further information about these programs is included in the SA Dental Service Yearbook 2011-12 (Attachment D). This document is on the SA Health website.

- The report claims that there is scope to improve accountability because public performance reporting is currently minimal. South Australia has a long history of the ongoing evaluation and reporting of its performance. I have attached a routine internal report that I have in my home files (Attachment C), but SA Dental Service could provide many more examples to the Commission if needed. I have also attached a copy of the SA Dental Service Yearbook for 2011/12 that is on the SA Health Internet (Attachment D) that also includes process and outcome performance indicators.

  The SA Dental Service capability in the planning, implementation and evaluation of dental services has been recognised internationally. For example, the service has undertaken oral health projects in Seychelles, Qatar and Brunei at these country's request as well as interstate consultations.

  Most states and territory public dental services collect data on dental treatment and dental health status for the patients they see. These data are used internally for decision making and shared with the Australian Research Centre for Population Oral Health which undertakes analysis and publishes widely.

I have also attached the Report developed by the Australian Research Centre for Population Oral Health (ARCPOH) from a range of data sources (Attachment E) This report aimed monitoring and reporting the process and outcome indicators included in the first National Oral Health Plan 2014-2013. This demonstrates a high level of accountability.

Equity

- It is claimed in the report that "adults receiving public dental services are disproportionally from disadvantaged areas." This bias is the direct result of state dental policy limiting public dental care for adults to holders of Health Care and Pensioner Concession Cards issued by the Commonwealth. In this light is it not clear why this the bias is considered "disproportionate" rather than successful targeting of services.

- The report points out that 30% of people receiving public dental care resided in areas with the higher incomes. The only conclusion that can be drawn from this observation (and Figure 6.1) is that many low income earners live in wealthy areas. It does not mean that public dental services are treating higher income adults.

- The report correctly points to the importance of receiving preventively focused dental care rather than rely on emergency treatment for problems.

  It is true that Aboriginal people have been less likely to seek and receive preventively focused dental care and have tended to receive emergency treatment.

  In the 2000s South Australia has implemented major initiatives to address these issues with considerable success. In cooperation with Aboriginal controlled health services, a program of priority access for Aboriginal people (the Aboriginal Liaison Program) has been implemented resulting proportion of Aboriginal eligible adults receiving preventively focussed dental care in SA each year now actually exceeds the figure of non-Aboriginal eligible adults. Attachment C and D .

  In addition, for the wider group of eligible adults, a computer based screening and demand management program (The Relative Needs Index) was designed with Adelaide University and implemented. The program aimed to assist public dental services for adults to focus more on the provision of preventively focused dental care rather than simply responding to dental emergencies. As a result of this program, the proportion of clinical time spent on treating emergencies in SA fell from around 60% in the 2004 to under 20% in 2012. This program won a Premier's Award for Excellence in public sector management and was a finalist in the Prime minister's similar award. SA Dental Service could provide the formal report of this program that was widely distributed.

Efficiency and accountability

- The Commission reported that it has not found any published evidence on the efficiency of public dental services and suggests that a lack of published information is symptomatic of a broader problem with accountability.
- Since the 1980s the South Australian Dental Service, and some other state/territory public dental services, have routinely measured the cost effectiveness of their services when compared with the cost of delivering those services through the private sector using a range of fee schedules.

  I have attached my reconstruction of these analyses from 2011/12 using information in my files (Attachment F). SA Dental Service would be able to provide more examples of these analyses.

  These reviews of cost effectiveness consistently show that, for adults, it costs around 30% more to provide a course of general dental care in the private sector than providing a general course of dental care in the public sector. This is despite the fact that public dental clinics prioritise their treatment to a number of higher need, and therefore higher cost, groups such as the homeless, Aboriginal people and people in residential care etc .

  I would be happy to provide further explanation of these tables if required.

  The overwhelming reason for this large cost difference is the fact that private dentists, paid on a fee for service basis, consistently provide more treatment per eligible adult patient than public dentist would. Private dentists primarily provide more restorative treatment (fillings) per patient (Attachment G).

- The provision of more treatment per patient provided by the private sector for public patients could be considered to be simple over-servicing.

  However, there are alternative explanations. For example, public dentists operate on the basis of public dental health principles. In an environment where demand exceeds supply (with limited fixed budgets), they will consider whether their clinical time is best spent providing additional items of care with very marginal benefit to the patient in the chair when they could provide highly beneficial treatment to the next patient. A private dentist may well regard the voucher as an opportunity to provide dental care of any marginal value to the patient up to the dollar value limit commonly used in these schemes.

  This higher cost of general dental care through the private dental sector is central to public dental services providing as much of their dental treatment in their own public clinics as possible. If all general dental care was contracted openly on a fee for service basis to the private sector to increase patient choice, the current limited public dental budgets would fund the treatment around 25% fewer patients with dramatic deterioration of oral health outcomes for the eligible population. The result for the eligible population would be more

choice for the individual but far less access to publicly funded care for the population group and far poorer oral health outcomes.

This behaviour of private dentists operating under a publicly funded dental program was also evident in the Medicare Chronic Disease Dental Program. This Program was closed by the Commonwealth as a result of rapidly escalating costs. It was also the South Australian experience that many private providers "cherry picked" complex and lucrative treatment items of care up to the Scheme's $4,250 cap. They then referred the patient back to the public dental sector for the more basic general dental care. The Commission may wish to confirm this experience with the relevant Commonwealth Government Department.

The Commission may also wish to seek advice from the Commonwealth about the relative comparative treatment patterns of the private dental public dental sectors under the CDBS.

These problems highlight the need to explore mechanisms of funding dental care that provide incentives for appropriate dental care that gives the desired oral health outcomes for the funding available rather than rewarding more treatment per person when some of this treatment is of little value to the patient.

SA Dental Service attempted an alternative funding model for children in the 1990s and 1990s. Rather than pay private dentists on a fee for service basis to treat children in some country areas, the dentists were paid on a fix fee per course of care. This "Capitation Fee" was set at a level that would fund the type of treatment being provided by the School Dental Service in the rest of the State. This experiment was not successful, with the private dentists on average providing significantly less treatment per patient than was considered desirable.

- The Report also claims there is an "evident lack of reporting of public dental service quality and patient outcomes."

The Commission may not be aware that School Dental Services do provide oral health outcome data for the children they treat to the Australian Research for population Oral Health (ARCPOH) which regularly publishes these results. Many of these reports are available on the ARCPOH website. As indicated previously, oral health outcomes are also included in the SA Dental Service Yearbook (Attachment D).

There is also research published in the 1990's comparing the oral health outcomes for SA children receiving private and public dental care (Oral Health of children in South Australia by socio-demographic characteristics and choice of provider. Community Dent Oral Epidemiol 1999; 27; 93-102 Anne Gaughwin, A. John Spencer) . This research paper reported that children treated in the SA School Dental Service had slightly better oral health outcomes than children treated in the private sector.

Similarly for adults, most states/territories provide oral health outcome data for the adults they treat and this data is provided to ARCPH which analyses it and regularly publishes the material.

The quality of care provided in public and private settings can be inferred using the oral health outcome. For example, the prevalence of unsatisfactory restorations at dental

examination is a standard index routinely reported. However, an even more powerful tool is the analysis of dental service provision by item of care. This tool allows public dental services to review each operator's service mix and provide counselling when deemed necessary. The service mix of publicly funded dental services (both in public clinics and when contracted privately) is published every year in the SA Dental Service Yearbook (Attachment D).

- The report also indicates that the Commission is not aware of "any broader evaluations within Australia of how vouchers have affected the quality and cost effectiveness of care". In the 1980s and 1990s studies have been undertaken in South Australia of the quality of dental treatment contracted privately as well as treatment provided by the public dental clinics. I am aware that similar work was undertaken by Dental Health Services Victoria in the 1990s.

  Apart from the greater volume of services per patient provided by private providers, no significant differences in quality were found.

- The Commission may not be aware that public dental services around Australia are required to receive quality accreditation under the National Safety and Quality processes. Quality accreditation is voluntary in the private dental sector.

  The public dental quality review processes report a wide range of quality indicators for dental treatment for comparison between clinics, regions and states/territories. I have attached an extract of a report flowing from this process (Attachment H). I do not have the detailed tables from this report in my home files but SA Dental Service may be able to provide them.

Responsiveness

- As noted earlier, South Australia uses vouchers to ensure that dental services are accessible when public dental clinics are not well located or cannot meet demand for treatment. However, it should be noted that frequently in rural areas, the local private dentists are overwhelmed by demand from private patients and are unwilling to treat public patients who have been issued with vouchers.

- It is agreed that continuity of dental provider is valuable. However, it should be noted that there are limitations on the degree to which this can be achieved. For instance, undergraduate dental students need to be provided with a large number of patients whose treatment needs match the range of needs of student for clinical experience. To achieve this outcome, all patients cannot be given the right to select their provider. It would be difficult for most private dentists to provide this service to the dental education sector.

Comments in relation to 6.3 –Factors Influencing the potential benefits of reform

User Characteristics

- The statement that "the most relevant user characteristic is probably the disproportionate share of adult users from disadvantaged areas." is confusing. When the State/Territory policies limit public dental treatment of adults almost exclusively to holders of Health Care and Pensioner Concession Cards it is difficult to conceive that any other outcome would be expected.
- The report points to research that shows poor health literacy and fear are causes of low income earners not seeking dental care and with the result that they experience more untreated dental decay and periodontal disease. This leads to a suggestion programs of information promoting the importance of dental care as a response. However, in the section under "Responsiveness" the report had recognised the impact of long waiting lists on the ability of low income earners to receive timely preventive and restorative care. State/territory dental budgets are only sufficient to treat around 20% of eligible adults in any one year (Attachment J). Hence, when low income earners cannot afford self-funded private dental care, they go without treatment and no amount of information about the importance of timely dental care will make any difference.

  It should also be noted that the National Survey of Adult Oral Health showed that the index of underlying rates of dental decay (DMFT) is little different between high and low income earners. The largest oral health inequalities between eligible and non-eligible adults are the number of teeth with untreated dental decay (D) and the number of extracted teeth(M). Both of these items relate to lack of access to early dental treatment (fillings) flowing from limited fixed dental budgets and the long waiting lists that flow from them.

  I have attached (Attachment I) extracts from the National Survey of Adult Oral Health 2004-06 that document these oral health outcomes and I would be happy to discuss these tables with the Commission.

Supply Characteristics

- The report points to the fact that emergency care comprises a greater share of services provided to public dental patients and there is proportionately less preventive and restorative care provided by public clinics. It must be understood that this mix of services results from public dental services responding to demand for emergency treatment (for condition such as infection, trauma and pain) from eligible patients. Meeting this pressing demand within clinically appropriate times leaves insufficient resources left to meet the broader needs of non-emergency patients and these patients languish on long waiting lists. This is similar to the problem faced by the wider public hospital sector when attempting to balance emergency care and elective surgery.

As mentioned earlier in the submission, South Australia has implemented innovative programs to manage demand for emergency care to maximise the provision of timely and preventively focused general dental care for adults. However, budget limitations still affect the balance between preventive and restorative dental care.

- When non-emergency patients eventually receive treatment they do receive a balanced mix of preventive and restorative care. However, the private sector is inclined to provide baskets of preventive services to its clients irrespective of the patients' disease risk profile. Frequently, these service are of little marginal value to the patient's oral health outcome.

  By way of contrast, the public dental sector uses of public health approach to provide these services in a more targeted way to match the individual patients risk profile. The use of public health models aims to maximise the oral health outcome for the whole population of eligible people within the funding available rather than focusing on solely on the patient in the chair.

  In this way, more patients receive care with little or no loss of effectiveness.

- The issue of dental workforce mix is raised by the Commission in its report. The public dental sector has made maximum use of dental therapists and oral health therapists to significant effect for many years. As a result, treatment provided by the public dental services under the Child Dental Benefits Schedule costs around two thirds of the fee level being paid by the Commonwealth. Benefits of this scale in the private sector for adult public patients would see a major increase in the affordability and accessibility of dental care and the Commission may wish to encourage the wider use of oral health therapists and to pass on the savings to their patients.

- The report claims that "Greater contestability of government-funded dental care could assist in the development of more flexible and responsive service models." This statement should not stand alone without recognition of the higher cost of contracting a course of publicly funded dental care to the private sector. Achieving greater choice without additional funding would result in fewer eligible patients being treated and far poorer population oral health outcomes.

Comments in relation to 6.4 The potential costs of reform

- One issue raised only in passing by the report may be a barrier to more effective workforce reform. Currently, dental therapists, dental hygienists and oral health therapists do not have their own provider number and must rely on dentists' provider numbers. Dentists have opposed provider numbers for these other clinicians. It is suggested that allocating provider numbers to all clinicians may contribute to a greater use of the skills of the full dental workforce.

- As explained earlier allowing eligible adults to select either a public or private provider for their publicly funded dental care, while highly desirable, has costs that flow from

    - More treatment being provided per patient in the private sector environment
    - The program having to fund very large numbers of eligible adults who currently pay for their own dental care in the private sector. I have attached the relevant pages from the National Survey of Adult Oral Health 2004-6 that documents scale of this issue (Attachment J). In summary, 50.6% of adults eligible for public dental care did attend a dentist in the previous 12 months but 62.7% of these eligible adults had their last visit at a private dentist and the majority of these paid for their own dental treatment.
    - Hence, public dental services were able to treat less than 20% of eligible adults each year.