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AUSTRALIAN DENTAL ASSOCIATION

14 July 2017

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

Sent by online form

Re: Draft Report – Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services

Dear Commissioner

The Australian Dental Association (ADA) thanks the Productivity Commission (Commission) for the opportunity to comment on the Draft Report *Introducing competition and Informed user choice into Human Services: Reforms to Human Services* (Draft Report).

The ADA is the peak national professional body representing the majority of Australia's 15,000 registered dentists as well as dentist students. ADA members work in both the public and private sectors.

The primary objectives of the ADA are to encourage the improvement of the oral and general health of the public; to advance and promote the ethics, art and science of dentistry; and to support members of the Association in enhancing their ability to provide safe, high quality professional oral healthcare.

The ADA supports the following Draft Recommendations for the State and Territory Governments to:

> 11.1: Report publicly against benchmark of clinically-acceptable waiting times; including at the public dental services' provider level; and
>
> 11.2: Establish outcomes frameworks for public dental services for both clinical outcomes and patient reported measures.

Draft Recommendation 11.3, suggesting the development of digital oral health records for public dental services to be incorporated into the My Health Record (MyHR) system, must recognise that the MyHR system is a health summary and a document recording system and does not constitute a set of medical records upon which health practitioners can rely. MyHRs are intended to supplement the overall medical record keeping practices practitioners must perform but does not replace them. Therefore, this Draft Recommendation should not be considered until a fully functioning and secure MyHR is operative for medical records. Furthermore, this work must be led by the Australian Digital Health Agency (ADHA) to ensure a consistent approach that is interoperable with the MyHR System. Before proceeding, further discussion is required to include dental records in MyHR.

The ADA does not support Draft Recommendations 12.1, 12.2 and 12.3 which refer to a consumer directed care approach to public dental services; particularly the use of a blended payment model comprising of risk weighted capitation payments, performance based outcome payments and activity based payments.

Also, the ADA does not support Draft Recommendation 12.4 requiring the use of a centrally managed allocation system to provide access to consumer directed care by state and territory governments. Similarly, the ADA does not support Draft Recommendation 12.5 requiring outcomes-based commissioning systems for public dental services from which greater contestability would be introduced (with the exception of remote locations and outreach services).

This submission elaborates on the ADA's view regarding the above Draft Recommendations.

The ADA warns against undertaking reforms based on models that have not been sufficiently scrutinised or assessed. The Commission's Draft Recommendations for dental services propose substantial changes to the public dental system. Any system wide change requires extensive consultation with those who access public dental care, the public dental sector, and the dental profession. Furthermore, any proposed model must undergo extensive testing to ensure the generation of intended outcomes, and any unintended consequences identified and appropriately managed. Most critically, governments must provide a concerted financial and capacity investment over a long period of time to achieve the goals outlined by the Draft Report.

First principles

Any discussion of oral health care policy must recognise at the outset that most oral disease can be prevented through good personal oral hygiene and diet, abstinence from tobacco use, community-based preventive activities such as water fluoridation and professional dental care. Accordingly, policy makers must provide investment and an ongoing commitment to support and promote these measures. In particular, ffluoridation of reticulated water supplies has been one of the major public health achievements of the 20th century. The Australian Government and states and territories governments must therefore commit to ensuring all localities with 1,000 or more residents with mains supplied (reticulated) water are fluoridated.

Improve transparency and reporting

The Draft Report's discussion about improving benchmarks and outcome frameworks (Draft Recommendations 11.1 and 11.2) must recognise that the current waiting time targets set in National Partnership Agreements (NPA), and state-wide targets, are considered to be a reasonable waiting time target with the available funding. The state-wide waiting time aggregates do not provide the public with a meaningful indicator of how long they can expect to wait to receive care at their local clinic. Therefore, the existing waiting time targets and reporting measures are arbitrary, and do not provide the public with a meaningful indicator of whether our public dental system is performing to an acceptable standard.

The ADA sees little value in the proposal of splitting waiting lists on a risk–based priority for fear of over burgeoning administrative procedures. This could have the effect of a minor dental issue being continually 'bumped' back until it becomes a more complex and costly treatment procedure.

Addressing these issues will require further development of data systems, and agreement on what should be the clinically-acceptable waiting time benchmarks. Therefore, the ADA urges the government to provide additional funding to support this process, and closely consult the dental profession.

Draft Recommendation 11.2 envisages establishing outcomes frameworks for public dental care, which include both clinical outcomes and patient reported measures. Introducing the necessary framework and process changes to achieve this will require the engagement of consumers, public dental sector employees, and the dental profession. Therefore, the ADA urges government to extensively consult all these groups. As the Draft Report states:

> *"Moving to a system that focuses on outcomes, rather than outputs, would require evaluation periods to be long enough for providers to have an incentive to invest in programs that may take time to pay off, such as a greater focus on preventive care. It would be difficult to establish sufficiently long timeframes for evaluation with recent policy and funding uncertainty" (page 365).*

Given the lack of credible evidence that the outcomes measures used in England provide greater value than

current surveys, combined with the lack of detail of the usefulness of outcome measures models such as those proposed in Victoria, the ADA cannot support such Draft Recommendation 11.2 in the short to medium term. The funds required for such surveys would far better be expended in preventive care.

Blended payment and care models

Within the Australian context, the blended payment model for public dental services which envisage a risk weighted capitation payment per enrolled patient and additional payments for clinical and patient outcomes is not appropriate.

From a consumer perspective, the ADA has no evidence that risk weighted capitation schemes used elsewhere have been successful. These encourage 'cherry picking' treatment priority and do not enhance consumer choice of provider. The Commission has tagged priority for consumer choice in the proposed reforms. However, capitation schemes lock consumers to certain providers whom they have capitation in place, and their ability to change provider becomes a complex process fraught with contractual restrictions binding the provider of the service. These complexities will be most pronounced in remote communities with mobile and itinerant populations. Also, capitation schemes undermine informed consent aspects of care which are fundamental to health care in Australia. The defined enrolment period is not transferable to different providers. This could be an issue within multiple provider practices.

Capitation dental schemes are not a suitable model for procedures where patients have complex or special needs. The model is unlikely to be effective as it ignores the reality that a large proportion of prioritised patients already require emergency treatment.

Civil liberties and privacy issues will impede the ability of public or private administrators of capitation dental schemes to attribute dental risk classifications to individual patients. Accordingly, capitation dental schemes should not be adopted for publicly or privately funded dental schemes.

The ADA challenges the Draft Report's characterisation that denture construction, under this model, is complex and hard to define. In fact, denture construction is remarkably easy to define and straight forward and is easy for public clinics to outsource to private practice to perform for patients. The outsourcing of such work by dental health services to private practice is commonplace South Australia and New South Wales.

The ADA is irrevocably opposed to capitation schemes and urges that dental care continue to be provided on a fee-for-service basis. Fee-for-service is the most competitive and efficient model that provides the most predictable outcome for the consumers. Furthermore, the fee-for-service model most effectively enables the provision of informed and financial consent for patients.

Also, the ADA does not support the proposed blended payment and care model considering the constraints of the public dental system. The Draft Report acknowledges that the reason public dental services do not focus on prevention and early intervention is that they usually receive patients with major complex problems – emergency and restorative treatments. Therefore, it is recommended that priority patients are still able to receive the next available appointment, irrespective of their dental symptoms, rather than go on a waiting list. Furthermore, there have been cases where patients who have received treatment are reinserted on the waiting list – raising more doubts about the usefulness of the current methodology of waiting lists. Instead, these patients should be put on a maintenance programme so their dental health does not deteriorate but this does not occur.

The ADA's Australian Dental Health Plan (ADHP), available from www.ada.org.au, outlines a framework for how a targeted approach can most effectively and efficiently service these populations.

Leveraging the already available dental workforce and infrastructure

Policy makers must take an agnostic approach when it comes to considering which sector, public or private, is better placed to provide essential services to the community. With respect to dental care, policy makers must make recommendations based on where the resources and dental workforce is available. In Australia,

the majority of the dental workforce and infrastructure is in private practice. Under 20% of practitioners work in public dental clinics.

State and territory governments have appropriately used voucher systems to ensure that patients have the choice to see the dental practitioner that is most appropriate for them. In other words, funding should follow the patient, rather than the health provider *per se*. Typically, public dental patients use their vouchers to attend a dentist from their local area, who would be in the best position to understand the profile of patients in that community and in turn provide the most appropriate treatment. The ADA's ADHP refers to use of private practice as an adjunct to public care. Examples are in the New South Wales and Western Australia where existing voucher systems have worked successfully.

The ADA strongly questions the basis on which the Draft Report asserts that *"Ad hoc use of fee-for-service vouchers has not resulted in a systemic improvement in user choice, and has done little to improve the effectiveness of public dental services over time."*

The ADA always supports a preventive approach to dental care. The Draft Report notes that the public dental system is not able to focus on this. Private practice, where the practitioners are more available in number to attend to public dental system patients, have more resources in which to engage in oral health promotion and education; increasing the likelihood that these patients adopt more positive oral health habits, lowering their risk of dental problems in the future and reducing the burden on the public health system.

Another example of a particularly effective national voucher system that has made inroads into the demand for low income people for health care, is the Child Dental Benefit Schedule (CDBS). Targeted to the children of families who receive Family Tax Benefit Part A, the CDBS enables these children to receive $1,000 of dental treatment every two years. This targeted scheme assists these children to access dental care when they otherwise would not. Two government reviews into the CDBS have found that this scheme has largely been effective; noting that the level of impact would be larger if the Australian Government improved promotion of the scheme.

Voucher schemes empower the consumer to choose services they see as appropriate for their needs, promoting competition and quality of care. Due to inconsistent and uncertain funding and resourcing of state public dental systems, understandably eligible patients would choose to see a dentist in private practice as they have all the required equipment, and are readily available to provide quality dental treatment. Payment models developed beyond voucher schemes in the name of promoting further competition between an already constrained public dental workforce is unlikely to result in better oral health outcomes for eligible patients.

Reforming federal-state funding arrangements for public dental services

The Draft Report recognises correctly policy and funding uncertainty:

> *"limits the long-term planning and evaluation needed to improve services. Short-term funding boosts in recent years have improved access to public dental care, but have done little to 'break the cycle' of treatment and repair. (Overview and Recommendations, page 31)*

The ADA has urged health ministers to adopt a more consistent and uniform approach to its dental care NPAs. NPAs must be reformed to provide guaranteed funding for the full three-year term, rather than recent practice that has seen funding commitments negotiated and signed annually. This would reduce the average reported 2-3 year waiting period to receive dental care.

Also, the NPAs need to ensure access to dental care to those deemed most in need and must be in addition to existing funding commitments by the states and territories, not a replacement of them. To further this end, current and future NPAs should include a requirement that state and territory governments are transparent and accountable in their delivery of public dental services, and:

- Maintain spending on public dental services at an agreed minimum amount per capita;
- Work towards achieving consistency in patient eligibility for accessing services and the type of services

available through the public dental system; and

- Make effective use of the existing workforce infrastructure and resources in the private sector where it is more economically feasible.

One of the main challenges will be to develop, maintain and improve mechanisms within the NPA that enable the states and territories to work in partnership with private practitioners as an additional means to reduce the public dental waiting lists. The NPA is the vehicle to forge these connections for instance by requiring consistent use of voucher systems across the states and territories.

Oral health outcomes frameworks of public dental sector service delivery should be further developed in the NPAs. Accordingly, they should have a commitment to providing corresponding funding and workforce capability improvement as well, alongside uniformly leveraging the existing dental workforce and infrastructure that already exist in private practice.

The ADA is greatly concerned in the way dental care is rated by the Independent Hospital Pricing Authority (IHPA) and the whole concept of pricing models based fundamentally with hospital care and hospital costing systems. The Diagnosis Related Groups (DRG) and National Efficient Cost (NEC) and National Efficient Price (NEP) do not allow reflective fees for dental care and is a primary reason dental care is not carried out under general anaesthetic (GA) in hospitals. A cohort of patients exists who need to have dental care under GA. The current system does not allow equitable dental care in hospital facilities. The ADA urges the Commission to encourage an alternative funding model for dental care in hospitals that includes the full range or dental procedures and not just the very restrictive current DRG's

Digital Oral Health Record

While the ADA recognises the possible advantages of developing digital oral health records for public dental services such a system is not appropriate to incorporate into the MyHR system because it is only a health summary and a document recording system. The MyHR system has been designed as a supplement to the medical record keeping health practitioners must practice, not as a replacement. Therefore, this recommendation regarding digital oral health records for dental services should not be considered until a fully functioning secure MyHR is operative for medical records.

Should you require further comment regarding the ADA's feedback, please contact, the ADA Chief Executive Officer, Damian Mitsch

Yours sincerely

Dr Hugo Sachs
President