AUSTRALIAN DENTAL and ORAL HEALTH THERAPISTS' ASSOC Inc.

26 October 2016

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

Re: Productivity Commission

Dear Hon. Scott Morrison,

ADOHTA is pleased that the preliminary report by the Commission has identified that improvement to public dental services is a high priority. We recognise that many low socioeconomic populations do not receive timely dental services as a result of the high costs of the private sector and the limited resources of the public sector. We would like to present our comments in relation to the preliminary findings of the Commission.

Scope to improve outcomes

Quality

ADOHTA has previously presented evidence that dental hygienists, dental therapists and oral health therapists (DHs, DTs and OHTs) provide high quality care consistent with national standards. We remain cautious that while there are very low rates of complaints to the Australian Health Practitioner Regulation Agency (AHPRA) and other local regulatory bodies, there have been recent concerns of significant infection control breaches that have put patients at high-risk healthcare induced infections with dental care provided by registered[1] and unregistered dentists in private practice.[2] ADOHTA advises that any consideration to provide public dental services through the private sector requires health and safety processes and/or accreditation, which to date is not a mandatory requirement in private practice.

[1] Australian Health Practitioner Regulation Agency, 'Regulation at work protecting patients', *Australian Health Practitioner Regulation Agency* [website],13th August 2015, Melbourne, <http://www.dentalboard.gov.au/documents/default.aspx?record=WD15%2f17252&dbid=AP&chksum=jySoOeYRtgB4KGvhdOhhvA%3d%3d>, accessed 14th October 206

[2] Australian Health Practitioner Regulation Agency, 'AHPRA: Court outcome shows regulation at work protecting patients', *Australian Health Practitioner Regulation Agency* [website],13th August 2015, Melbourne, <http://www.dentalboard.gov.au/documents/default.aspx?record=WD15%2f17252&dbid=AP&chksum=jySoOeYRtgB4KGvhdOhhvA%3d%3d>, accessed 14th October 206.

Equity

ADOHTA agrees that there are concerns of the equitable accessibility of public dental services within low socioeconomic populations. However, it is imperative to also acknowledge that improvement to population oral health necessitates expanding oral health promotion initiatives that are complementary to the provision of clinical service delivery. Standard care provision of dental services cannot solely address the undying causes of oral diseases, which are largely chronic diseases shaped by social determinants of health. Our profession recognises the unique role DHs, DTs and OHTs have to enhance access and utilisation of dental services as part of their training competencies in oral health promotion. In addition, there is value to the healthcare system as part of their preventive approach and focus to clinical dental services. The Commission identified that a smaller proportion of preventive care is provided to adults in the public sector.[3] ADOHTA notes that this trend may be rooted not only in funding mechanisms that favour surgical interventions, but also the limited competency of dentists to provide preventive focused dental services and/or whether patients who use public dental services currently have advanced established oral diseases requiring more costly dental treatment.

Efficiency and Accountability

ADOHTA is not surprised that the Commission has not found evidence on the efficiency of public dental services or evidence within the private sector. As noted in our previous submission, we have advocated for the provision of provider numbers for our profession to introduce greater transparency and accountability of dental service provision. Proposed options to outsource public dental care within the private sector should seek the experience of successful bids of private practices to provide public dental services for adolescents from Year 9 (13–14 year olds) until their 18th birthday, under the Combined Dental Agreement with District Health Boards in New Zealand,[4] where DTs and OHTs provides a majority of dental care to children adolescents through School Dental Services.

Currently, clinical services provided by DHs, DTs and OHTs are billed under the dentist provider number. This creates barriers for DHs, DTs and OHTs to become independent providers of dental services due to the reliance on dentists, who are traditionally their employers and may result in employers restricting their scope of practice. Expanded scope of practice and the utilisation of full autonomous scope 'could improve patient satisfaction, health outcomes, service quality and efficiency'.[5] Actions to improve efficiency are currently in progress through the development and training of the advanced practice role of DTs and OHTs to provide adult restorative dental services. Through expanded scope of practice, DTs and OHTs can now provide comprehensive preventive care to persons of all ages resulting in improve continuity of care, including the capacity to treat adult emergency dental care. The recognition for the advanced practice role of DTs and OHTs were presented at the recent Allied Health Forum

[3] Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform*, Preliminary Findings Report, Australian Government, Canberra, 2016, p. 113.
[4] Ministry of Health, *Our Oral Health - Key findings of the2009 New Zealand Oral Health Survey*, Ministry of Health, Wellington, New Zealand, 2010, p. 8.
[5] Young, G., Hulcombe, J., Hurwood, A. & Nancarrow, S., 'The Queensland Health Ministerial Taskforce on health practitioners' expanded scope of practice: consultation findings', *Australian Health Review*, vol. 39, no. 3, 2015, p. 54.

supported by the Department of Health and Human Services (Victoria).[6] Observed benefits have included increased capacity for those trained with expanded scope of practice working in rural and remote locations who can now provide adult restorative services within public and private dental clinics that operate without a dentist.

We note that workforce data provided by the Commission demonstrates a higher reliance on DTs and OHTs in the public sector compared to the private sector.[7] This trend is reflective of the changing community needs and demand for preventive focused care. Our profession is integral to public dental services and is associated with cost-effectiveness of publicly funded services, where goals of the public sector is to maintain service quality and maximise clinical and patient output. Accountability for dental practitioners is embedded within public dental services, where DHs, DTs and OHTs are able to charge for dental services. This is enabled by funding arrangements that do not require the use of provider numbers.

ADOHTA is disappointed the Commission has not acknowledged the constraints for DHs, DTs and OHTs of not having access to a provider number is clearly a significant impediment to improving efficiency and accountability in the delivery of clinical dental services.

Preliminary Findings

ADOHTA supports the recommendations of the Commission, and proposes options for the federal government to improve human services across the population.

> 'Users could benefit from having greater choice over the timing and location of treatment. Greater continuity of care may lead to fewer people delaying dental treatment until more painful and costly care becomes necessary'.[8]

The establishment for independent practitioner status for dental hygienists, dental therapists and oral health therapists alongside the provision of provider numbers creates greater informed user choice of the timing, location and continuity of care as part of the essential role of the dentist within the dental team environment.

> 'The uncontested provision of services in government-operated clinics results in limited responsiveness to user needs and preferences. Minimal public performance reporting limits accountability to those who fund services'.[9]

Where there are federal government dental programs currently in place, the provision of independent practitioner status and provider numbers for dental hygienists, dental therapists and oral health therapists will introduce greater transparency, accountability and continuity of care where dental services are funded under Medicare and private health insurance.

> 'Service provision could be made more contestable by inviting bids from non-government providers to operate public dental clinics. More competition and choice

[6] Nguyen, T., *Oral Health Therapy: Increasing access to dental care services*, *Sharing advanced practice in allied health forum*, Melbourne, 12th September 2016, Presentation.
[7] Productivity Commission, op. cit., p. 114.
[8] Productivity Commission, op. cit., p. 117.
[9] ibid.

could involve using delivery mechanisms that allow users to choose between competing private dental practices'.[10]

The provision of independent practitioner status and provision of provider numbers for DHs, DTs and OHTs will introduce more competition and user choice that are conducive to improving population oral health via preventive approaches to clinical dental services, particularly in the private sector. ADOHTA also recognises the significant government investment being made in digital health and e-health initiatives which seek to promote efficiencies within the health system. Should the independent practitioner status and provider numbers for DHs, DTs and OHTs be granted for dental services funded under Medicare and private health insurance schemes, as the case has been with general practice, we would actively engage with the government to support DHs, DTs and OHTs in the form of education and training and software development for the use of the My Health Record in their practice setting. This would ensure that DHs, DTs and OHTs could contribute to a patient's shared health record in a way that supports other arms of dental health, the impact of oral health on overall health status and a reduction in avoidable expensive hospital admissions for oral health related complications and problems.

ADOHTA supports the work of the Commission and welcomes inclusion in follow-up consultations to improve the oral health for all Australians.

Yours sincerely,

Hellene Platell
President
Australian Dental and Oral Health Therapists' Association Inc.

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[10] ibid.