AUSTRALIAN DENTAL ASSOCIATION NSW SUBMISSION

Human Services Inquiry

Productivity Commission
Locked Bag 2, Collins Street
East Melbourne VIC 8003

6 February 2017

Dear Commissioner,

Re: PRODUCTIVITY COMMISSION REFORM TO HUMAN SERVICES – ISSUES PAPER (DECEMBER 2016).

The Australian Dental Association New South Wales Branch (ADA NSW) is the peak professional body representing dentistry in NSW and the ACT. Our vision is to achieve the best standard of oral health for our community and promoting oral health is a key part of our mission.

Thank you for the opportunity to provide feedback on the Productivity Commission Reform to Human Services. The comments below are a general response to the Productivity Commission's Issues Paper on Public Dental Services.

ADA NSW welcomes the Productivity Commission's recognition and inclusion of reforming public dental services in the second phase of the review. In particular, ADA NSW supports the Issues Paper findings:

- The preferred approach to reform public dental service to vary between urban, regional and remote regions
- Provision of dental services in remote Indigenous communities warrants additional consideration
- Improve accountability to those who fund public dental services (governments and users through co-payments)
- Greater public reporting, on a consistent basis, of clinical and other patient outcomes, releasing more detailed expenditure data including cost effectiveness of public dental services.

ADA NSW will provide information in response to some of the questions the Productivity Commission is seeking. It will also reiterate points and recommendations made in the ADA NSW submission to the Preliminary Findings Report.

Question: Whether existing eligibility criteria and the level of assistance for public dental services enable equitable access to care, including for people living in remote areas

Given the considerable variation between state/territory dental services delivery, eligibility criteria, and the accountability and reporting of their programs, data provided here focuses on NSW.

NSW has a predominantly private practice, fee-for-service delivery system with a limited public dental service only. The State provides a safety net for emergency and general dental care services through their 18 Local Health Districts.

Approximately 47% of the NSW population is eligible for public oral health services[1]. However only 17% (approximately 746) of the 4252 dentists in NSW are working in the public dental sector[2].

Only 6% of NSW residents receive care in the public sector, often only related to acute dental emergencies.

Disparities in oral health and access to oral health are well documented in NSW. Epidemiological surveys in NSW[3, 4] reaffirm that an average NSW resident has good oral health. However concession card holders (those eligible for public dental care), the indigenous population, and those living in rural and remote areas have significantly poorer oral health and inequitable access to oral health care. These findings have been translated to NSW state policy documents, Oral Health 2020[5]: A Strategic Framework for Dental Health in NSW and the NSW Aboriginal Oral health Plan[6]. These policy documents call for urgent action to reduce inequalities in access to oral health and improve oral health outcomes in these population subgroups.

A survey conducted by the New South Wales Council of Social Services (NCOSS)[7] on people experiencing poverty and disadvantage in NSW indicates:

- Respondents nominated timely, affordable dental care as the number one priority that would make a difference in their life and the life of their families. Access to oral health was highlighted as an issue especially among the elderly, residents in rural and remote areas and in the corrective setting.
- Respondents rated oral health a higher priority than reduced waiting time for specialist services/surgery or even emergency care.
- Dental treatment was the household item or activity identified by the largest proportion of respondents as being out of reach, with 38% of respondents saying they could not afford it.
- Approximately half of all people receiving the Disability Support Pension, a parenting payment or Newstart Allowance said they could not afford treatment.

As at June 2016 there were 80,942 adults waiting for dental treatment in NSW[8]. Of those adults waiting for general dental treatment, just over 30% are not seen within clinically acceptable benchmark times.

NSW is one of the most expensive states for dental care, with the average cost of a dental visit comprising a dental examination, two Bitewing X-rays and a scale and clean service sitting at just over $200[9]. NCOSS recommends that the NSW Government invest an additional $25 million into oral health services to improve access to timely dental services and reduce oral health inequities[7]. ADA NSW urges the Commission to address accessibility and affordability issues as a priority in reforming public dental services.

Question: The extent to which the current emphasis on government provision of public dental services limits the responsiveness of services to user preferences over the timing and location of treatment, and the type of services provided.

Public dental care, as a means tested residual program, is characterised by institutionalised scarcity and rationing of person focused dental treatment with restriction in the scope of activities delivered. Many public patients start on public dental waiting lists seeking preventive or restorative treatment but become emergency cases by the time they receive treatment. There is a limited focus on prevention and minimal intervention/restorative work due to a shortfall in dental workforce versus the demand for acute services.

Individuals who have difficulty accessing dental care seek relief from pain and infection through other health services. The end result of delays in treatment can be admission to hospital to treat serious infections. This puts pressure on the broader health system through dental treatment sought from hospitals (public and private), non-admitted clinics (outpatient treatment) and general practitioners. There is a risk that the overall cost of delivering dental services increases as medical management is used as the alternative for emergency dental problems.

Consumers of public dental services have less choice on the preference and location of their dental practitioner, continuity of care, frequency of visits and type of treatment received.

ADA NSW 's submission to the Preliminary Findings Report provided evidence that NSW private practitioners have played a significant role in improving access and providing care for eligible public patients under government funded dental programs.

A comprehensive range of services are provided in the private sector, including emergency and general dental as well as more complex and costly treatments such as orthodontic and endodontic services.

With the introduction of the NSW Oral Health Fee for Service Scheme in 2000, private practitioners have played a significant role in improving access and providing care for eligible public patients. This Scheme offers an alternative way for those who are eligible for public oral health care to receive dental treatment by a private practitioner who is registered with this Scheme[10].

Funding through the National Partnership Agreement on treating more public dental patients has reduced waiting times significantly in recent years[8]. Utilisation of private dentists and private infrastructure makes economic sense and has proven very successful in reducing the number of patients on public dental waiting lists.

A recent Australian study[11]was conducted to gauge the potential for reducing the national dental waiting list through geographical advantage, through subcontracting the delivery of subsidised dental care to the existing network of private dental clinics across Australia. This study reported that 96% (weighted average) coverage of the eligible population, and 168 000 people that are on the waiting list, can be achieved for most states and territories when the service area radius of both government and private dental clinics located outside metropolitan areas is increased to 50 km. The authors of the study, Dudko, Kruger and Tennant (2017) conclude:

> A framework with appropriate safeguards in place that would allow for subsidised dental services delivery at private clinics has the potential to reduce waiting lists, improve access for greater eligible population and increase service availability in rural and remote areas for entire communities where existing socioeconomic dynamics do not otherwise foster private practice set-up.

The model of care developed by Dudko et. al. may be a framework that the Commission could consider using in private practice to provide subsidised care[11].

ADA NSW would like to reiterate that providing timely, affordable and appropriate oral health care to all Australians requires an appropriate public/private partnership mix.

Question: Whether increased choice would lead to better outcomes for users, and how this would differ between patient populations and regions

Data collected in the public sector and through the Oral Health Fee for Service Scheme reports items of service provided. The health outcomes of the patient are not known. The appropriateness of the services provided in terms of meeting needs is not known. For these reasons, ADA NSW cannot comment on whether increased choice would lead to better outcomes. However ADA NSW supports the mandatory collection of standardised national data on oral health outcomes as outlined on page 5 of this submission.

However, introduction of increased choice is unlikely to achieve better outcomes for some population groups and regions. ADA NSW's submission to the Preliminary Findings Report stated that some subgroups of the Australian population do not have choice, because they need special services that are not readily accommodated in the fee for service remuneration private system.

More time and resources are required to provide dental services for those with special needs, multiple complex social/health issues, chronic disease and the elderly/frail. The report 'Improving Oral Health and Dental Care for Australians' highlights that the fee-for-service payment struggles to accommodate such demands on the private dentist, leaving such patients less attractive to private dentists[12]. The report also noted that maldistribution combined with travel costs or limitations, hours of practice, language and cultural or social hegemony discourage some people from visiting private practices. For some subgroups of the Australian population, the public dental sector remains the only choice in which they can access the right care in the right setting.

The scope for user choice and competition is likely to be limited in remote areas of Australia.
In remote areas, where there are fewer dental professionals, the local private dentists are overwhelmed by demand from private patients and are unwilling to treat public patients who have been issued with vouchers. Evidence also indicates that private dental services cannot be sustained in many rural and remote areas due to lack of dentists, high costs and low population density[13].

The elderly or dependant older people comprise one of the groups "at risk" from oral disease, particularly those residents in aged care facilities. As a population sector, the elderly comprise one of the highest groups of Australians being admitted to hospital due to dental issues.

ADA NSW welcomes the Commission's finding that in examining potential reform options, the Commission will consider the need to tailor reforms based on the characteristics of users and providers (Issues Paper p.39).

ADA NSW recommends that additional consideration is warranted for the provision of dental services in all Indigenous communities, for the elderly and some high risk groups.

Dental diseases share a number of risk factors in common with the major national health priority areas (e.g. obesity, diabetes and cardiovascular disease). Not only are there common risk factors, such factors tend to cluster in population groups with a lower socio-economic status.

Implementing initiatives that prevent and treat oral disease will support efforts to address chronic disease. Public dental care offers a primary care opportunity for a point of intervention service that can reduce the risk of oral and possibly general health problems. Therefore integrating oral health care into the broader health system will gain synergies and reinforce preventive interventions' improving oral and general health. When prevention and health promotion is supported with a strong primary care system, it potentiates reduced disease in society and reduced future costs and demand for care[14 15]. By incorporating oral health into the primary care system standard of patient care, the oral health needs of those communities and populations most in need can be addressed. To this end, ADA NSW would like the Commission to advocate for an expert oral health provider to be a member of every Primary Health Network.

ADA NSW 's submission to the Preliminary Findings Report provided further evidence as to why a parallel emphasis must also be placed in investing and building the capacity of the public dental services for vulnerable groups within the population. 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.

A well-supported public sector dental service is required to deliver oral health population strategies with strong emphasis on the social determinants of health, research, education and teaching. The major role of the NSW Government in oral health population has been the strong, bipartisan support for water fluoridation. Over 96% of the NSW population on town water supply receive fluoridated water as a primary preventive measure.

Question: The scope to improve accountability through more public reporting, including on patient outcomes and cost effectiveness

Traditional reporting measures have used the length of dental waiting lists for benchmarking. However, waiting lists are a measure of current dental service demand, rather than the performance, quality and efficiency of the organisation.

In NSW and Australia there is a paucity of published data on efficiency, effectiveness and cost effectiveness of dental treatment provided in the public and private sector.

There is no information on the efficiency of current public dental services relative to private services. The Competition Policy Review (2015) investigated the effectiveness of voucher schemes in reducing waiting lists for public dental services. However the investigation did not measure effectiveness in terms of health outcomes, overall appropriateness of treatment, or cost-effectiveness.

The current public dental service system in Australia is output and activity driven. One way to determine the value of dollars spent for dental care is to measure the outcomes associated with such treatment. Efficiency in healthcare is best measured using health outcomes rather than health service outputs, since activity based measures may result in incentive to provide inappropriate care.

ADA NSW recommends:

- The collection of standardised and meaningful data be made compulsory, and in particular, with health outcome indicators including clinical indicators.
- Have an agreed set of oral health outcome indicators and the necessary data collection processes to support assessment against this framework.
- Develop an evidence based model of oral health care that delivers beneficial and measurable health outcomes using agreed definitions and methods for data collection and analysis.
  For example, an agreed set of indicators would enable comparison of the relative treatment patterns (and costs) of treatment provided in the private and public sectors under the Child Dental Benefit Scheme (CDBS).

ADA NSW believes that the ultimate goal would be to develop:

- An oral health care model for both the public and private sector to achieve the best evidence based outcomes cost effectively, using oral health rather than output or activity indicators.
- A funding model that would shift service provision away from less clinically and cost effective services towards those that are most clinically and cost effective, incentivising preventive intervention at the individual and community level.

ADA NSW welcomes the Productivity Commission's next stage of work in this important inquiry. The following recommendations have been provided for the Commission to consider in their analysis of reforming public dental services and improving oral health for all Australians:

1. Reinstate and maintain funding of the National Partnership Agreement to ensure significant achievements gained in improving access and care to public patients through public and private partnership continues.

2. Explore options for new models of care utilising private practitioners to improve access and continuity of care to public patients through public and private partnership.
   The Commission may like to consider the Dudko et. al. model utilising the existing network of private dental clinics with appropriate safeguards in place to deliver subsidised dental care to improve access for eligible population.

3. Develop an oral health care model for both the public and private sector to achieve the best evidence based outcomes cost effectively, using oral health rather than output or activity indicators.

4. Develop a funding model for both the public and private sector that would encourage clinically and cost effective services and incentivise preventive intervention at the individual and community level.

5. Explore options for new models of care given the increasing recognition that oral health is a risk factor to general health and quality of life.
   a. Integrate oral health into primary care networks for a common risk factor approach
      to oral health
   b. An expert oral health provider to be a member of every Primary Health Network.
   c. A model similar to the Chronic Disease Dental Scheme (CDDS) with safeguards in place to minimise the risk of fraudulent claims by health providers and taking into account other criticisms attributed to the closure of the program.

6. Increase funding and invest in public sector dentistry for population health initiatives, research, education and teaching.

ADA NSW looks forward to continued involvement in this Inquiry. We would welcome the opportunity to meet with the Inquiry to further discuss the Productivity Commission's Issues Paper on Public Dental Services.

Regards,

Australian Dental Association (NSW Branch) Limited

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