REFORMS TO HUMAN SERVICES 2016

PUBLIC DENTAL SERVICE - DHSV RESPONSE

dental health
services victoria
oral health for better health

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Contents

Acknowledgement

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Contact for this submission

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Glossary

AIHW	Australian Institute of Health and Welfare
CDA	community dental agencies
CDBS	Child Dental Benefits Schedule
CDDP	Chronic Disease Dental Program
DHSV	Dental Health Services Victoria
ICHOM	International Consortium for Health Outcomes Measurement
NSQHS	National Safety and Quality Health Service
PROMs	patient-reported outcome measures
RDHM	Royal Dental Hospital of Melbourne
SDS	School Dental Services
VAGO	Victorian Auditor-General's Office

Executive summary

Dental Health Services Victoria (DHSV) welcomes the opportunity to provide input into the second stage of the Productivity Commission's inquiry into introducing competition and informed user choice into human services. Particularly, as public dental services are one of the areas that have been identified for further investigation.

The purpose of this submission is to discuss the potential implications of the Report's findings and provide advice to the Productivity Commission on how to implement the recommendations if this course of action is chosen.

Improving health outcomes

Public dental services need to be designed to drive improvements in health outcomes using cost-effective interventions.

The current fee-for-service model provides perverse incentives to service providers. Under this model, service providers are incentivised to increase the quantity of services without any incentive to improve quality of health outcomes. This is because performance is measured based on outputs and activity levels rather than how an intervention has improved the patient's health. If greater competition and contestability were to be encouraged under the fee-for-service model, it would risk high costs for dental procedures. Regardless of whether the government implements greater competition and contestability in the dental industry, the payment system should be focused on providing performance based reimbursement.

The introduction of patient-reported outcome measures (PROMs) amongst other outcome measures could be used to measure the outcomes from health interventions. The International Consortium for Health Outcomes Measurement (ICHOM) is in the process of developing standard sets of measures for different conditions. DHSV is working with ICHOM along with other international partners to develop a consistent and well-accepted standard for measuring health outcomes within oral health, which will be completed by the end of 2017.

Prioritising prevention

Most oral problems can be prevented. Increasing the focus on early detection and preventive interventions can help people to have better oral health and to avoid costly treatment interventions and to reduce the reliance on emergency care. For example, DHSV found that oral health promotion interventions incorporating a wide variety of health promotion strategies were successful in preventing dental caries and gingival and periodontal disease among children from birth to 18 years of age (de Silva et al 2012). The model for public dental services needs to prioritise prevention, and ensure financial incentives are aligned with this objective.

A tailored funding model

Public dental services are not provided through a universal access system. The current level of funding is not even sufficient to cover all eligible people.

Dr Martin Dooland in his submission to the first stage of the inquiry explained that the current funding levels only allow for 20% of eligible adults to receive treatment in one year. In one year around 50% of eligible

adults will access dental services, with 60% of these people accessing services through the private sector and paying for it themselves. Due to cost, many often choose sub-optimal outcomes like tooth extraction rather than a course of treatment than may improve their health outcomes. Thus, if all eligible adults were able to access more appropriate services from the public or private sector, without having to wait, as is currently the method used to ration services, there would need to be a significant increase in government funding.

Hence, the amount of funding available from governments needs to be considered in designing changes to the funding and delivery models.

Recommendations

1. Apply a values based health care model that aims to achieve the best health outcomes, cost effectively, by relying on evidence based outcome indicators, rather than output or activity indicators
2. Establish a bundled payment system that drives health outcomes and moves away from a fee-for-service approach
3. Place a greater emphasis on evidence-based prevention and health promotion instead of treatment
4. Funding and service delivery models need to take into account the amount of public funding available

1 Introduction

The Productivity Commission has been requested to examine the application of competition and informed user choice to services within the human services sector and develop policy options to improve outcomes. This inquiry is being conducted in two stages; the first is an initial study of the human services sector identifying areas within the sector that may benefit from greater contestability, user choice and competition. The second stage is a more extensive examination of the selected services aiming to provide recommendations on how to introduce greater competition, contestability and user choice.

In November 2016, the Productivity Commission released their Report, *Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform* (the Report), which marks the end of the first stage of the inquiry. One area the Report identified as having potential benefits through an increase in contestability and competition was public dental health. Specifically, the Report noted three outcomes if greater competition, contestability and user choice were introduced for public dental health services:

- *Public dental services act as a safety net by providing access to basic dental care, but there is scope to improve outcomes. Access to services is a concern for certain populations and the uncontested provision of services in government-operated clinics limits responsiveness to user preferences. While governments regularly publish information on public dental activity levels, overall expenditure and waiting lists, accountability could be improved through greater public reporting on patient outcomes and cost effectiveness.*
- *Users could benefit from having greater choice over the timing and location of treatment, and their dental professional. Greater choice may lead to fewer people delaying dental treatment until more painful and costly care becomes necessary. In addition to initiatives already implemented by governments, encouraging more innovative and flexible public dental services could improve oral health in communities not well serviced by the private sector.*
- *The approach to greater competition, contestability and user choice should reflect the characteristics of users, availability of dental professionals, and cost-effectiveness of alternative models. Service provision could be made more contestable in areas where there may be limited capacity to sustain multiple providers. More competition and choice could involve using delivery mechanisms that allow users to choose between competing dental practices.*

The inquiry is now entering the second stage and The Productivity Commission has released an issues paper requesting information from the industry. DHSV has some concerns with the Report's findings in the first stage; primarily that increasing contestability, competition and user choice will not necessarily improve health outcomes. As such, the purpose of this submission is to discuss the potential implications of the Report's findings, respond to the request for information and provide advice to the Productivity Commission on how to implement the recommendations if this course of action is chosen. Responses to the specific questions asked by the Productivity Commission are included as an Attachment.

1.1 Public dental health services context in Victoria

The Victorian public dental service is funded through Dental Health Services Victoria (DHSV) and provided through 53 agencies located in public hospitals, community health organisations and DHSV's provider arm, The Royal Dental Hospital of Melbourne (RDHM). Emergency, general and specialist services are provided with specialist services predominantly being in a post graduate teaching environment. DHSV also supports clinical placements for all oral health entry level professional training, health promotion activities and clinical translational research.

Public dental services are not covered in Australia's universal health care system; instead, only those who meet certain eligibility criteria are able to receive public dental care. The two primary groups who are eligible for public dental care are children, and economically and socially disadvantaged people. Specifically, the following groups are eligible to receive public dental services:

- children aged 0 to 12 years;
- anyone who holds a health care or pensioner concession card;
- dependents of concession card holders;
- all children in out-of-home care;
- youth justice clients in custodial care under the age of 18 years;
- all refugees and asylum seekers; and
- Aboriginal and Torres Strait Islander people who are treated at The Royal Dental Hospital of Melbourne (RDHM) (DHSV, 2016).

A public dental program offered by the Commonwealth Government is the Child Dental Benefits Schedule (CDBS). Under this program, eligible children are able to access up to $1,000 per child worth of benefits for basic dental services over 2 consecutive years. The recipient is able to attend either a public dental clinic or a private dental clinic. To be eligible a child must be aged between 2 and 17 years, eligible for Medicare and already be receiving certain government benefits (Department of Human Services, 2017).

There have been a number of changes to public dental funding over the past few years resulting in unstable Government support to the sector. Prior to the CDBS there were a number of programs provided by the Commonwealth Government. The Chronic Disease Dental Program (CDDP) provided up to $4,250 in Medicare benefits over a two year period to people with a chronic medical condition; however, this program was ended in 2012 due to escalating costs. Another program commenced in 2008-09 called the Medicare Teen Dental Plan was the predecessor to the CDBS but provided predominantly preventive services to those aged between 12 and 17 years. This was replaced by the more comprehensive CDBS in 2014. In addition to these changes, the CDBS has also experienced proposed reduced funding over time. In 2016, the Health Minister changed the benefits cap entitlement, prior to this announcement eligible children could receive up to $1,000 instead of the current $700. In February 2017, this decision was reversed.

Despite the broad dental health coverage where approximately 41% of the Victorian population is eligible to receive public dental services (approximately 2.46 million people), only 31% of the eligible population seek access to the public dental system (Victorian Auditor-General's Office (VAGO), 2016).

2 Scope to improve outcomes

Public dental services need to be designed to drive improvements in health outcomes using cost-effective interventions

2.1 Quality

The Report noted there was no evidence of any quality disparity between public and private providers of dental services. All dental practitioners must register with the Dental Board of Australia. In addition to these restrictions, public dental clinics are required to be accredited against the National Safety and Quality Health Service (NSQHS) Standards 1-6 that were endorsed by Australian Health Ministers in 2011.

On the other hand, private dental providers are not required to be accredited under these standards and accreditation is voluntary. In the Report, the Australian Dental Association noted that the NSQHS Standards duplicate other standards and regulations and that the NSQHS Standards are based on hospital models of health care delivery that are not appropriate for clinics in other settings. While this could be the case, the advantage of accreditation is that an organisation or business has proven to independent authorities that those standards and regulations have been met. The public dental sector has worked with the NSQHS and adapted the Standards to an office based environment.

2.2 Equity

There are a number of barriers to accessing dental services; financial, cultural, pyscho-social and geographical. The Report noted that a high number of the population fail to seek dental treatment due to the high cost. The *National Dental Telephone Survey 2010* also found that 28% of people avoided or delayed visiting a dentist due to cost (VAGO, 2016). Another publication analysed data from 2008 and found that 46.7% of concession card holders delayed dental treatment due to cost, while 30.2% of non-card holders delayed treatment due to cost (Harford et al, 2011).

Similarly, there is a significant proportion of ineligible people who would have difficulty paying for basic dental care. According to the Australian Institute of Health and Welfare (AIHW), around 65% of people aged 15 to 44 years with annual household income between $30,000 and $90,000 do not have private health insurance cover for dental care (AIHW, 2015). Due to the cut-off for a health care card being an annual income of $48,256 for a couple with no children, this would leave many people in this population without any affordable access to dental care.

A second barrier to accessing dental services is geography. The Report correctly highlighted the difficulty of accessing dental services in rural and remote areas. The public sector is better equipped to provide services to these populations as it has economies of scale and is well distributed. (Tennant & Kruger) This allows the public sector to provide services at a

lower cost than the private sector. Increasing competition might result in fewer public clinics which would diminish the gains made by economies of scale and potentially result in higher average costs per service provision.

DHSV has been working with the Victorian Department of Health and Human Services and the community dental agencies (CDAs) to address the likely barriers to accessing treatment, the barriers and actions to address them include:

- **financial barriers**: public dental co-payments (fees) are capped and significantly lower than those charged by the private sector;
- **cultural barriers:** supporting Indigenous people to become dentists, recruiting an Aboriginal community development officer and the development of the Refugee Oral Health Targeted Education Program, waiving all co-payments for Aboriginal people, refugees and asylum seekers;
- **psycho-social barriers:** DHSV and the CDAs are undertaking pilot programs and research to improve oral health of people with disability and mental illness; and
- **geographical barriers:** DHSV has introduced outreach services, outpost services and oral health screening and referral (VAGO, 2016).

The current fee-for-service model incentivises providers to favour more highly remunerated restorative cases rather than complex chronic problems more prevalent among disadvantaged sub-populations. Treating more complex chronic cases requires additional time commitments to induce behavioural change and apply preventive intervention, which are lowly remunerated.

The fee-for-service model incentivises providers to favour more highly remunerated restorative cases rather than complex chronic problems more prevalent among disadvantaged sub-populations.

Thus, for people with complex chronic cases, such ‘cherry-picking’ choices may mean their access to dental services remains limited and greater competition may not lead to equitable outcomes. It is thus important to consider how market failures might occur that would impact on the Productivity Commission’s desirable objective of achieving timely, affordable, appropriate, high quality and cost-effective services.

2.3 Accountability

The public dental sector is required to report certain data to state and territory governments, some of which is made publicly available. Reporting in the public sector at a minimum includes: level of service, patient satisfaction survey findings, and information on service improvements (DHSV, 2015). On the other hand, there are no formal reporting requirements that the private sector must abide by and as a result, the private sector does not report as extensively as the public sector.

It has been recognised that although DHSV collects data and reports to the Department of Health and Human Services, the information collected focuses on outputs and cannot be used to assess changes in health outcomes. However, DHSV has already taken steps to ensure the collection of appropriate data that can be used to measure changes in health outcomes (VAGO, 2016).

DHSV has undertaken the Victorian Child Oral Health Survey 2013-14 and the Victorian Pre-schoolers Survey 2015. By recording information about tooth decay and sociodemographic indicators these surveys provide a baseline of measuring health outcomes for children.

There is still more work that can be done to ensure better accountability across the dental industry. A number of state governments issue vouchers for dental services that may be used in either a public or private clinic. The services that these vouchers cover are based on a percentage of the fee schedules from the Department of Veterans' Affairs. Under these schemes, invoices are sent from the service providers to account for the voucher. No other information is collected that can be used to analyse the efficiency and appropriateness of the service. This issue is prevalent across both the private and public clinics in the dental industry and should be addressed to ensure appropriate service provision and use of government funding.

This is of great importance as there is a move towards value based health care – where the value of services is ranked using the metric of the highest health outcome per dollar spent. Unlike publicly subsidised medical services which must undergo a cost-effectiveness analysis through the Medical Services Advisory Committee, dental services are not required to prove their cost-effectiveness.

VAGO (2016) reports on a number of commonly used performance indicators in the literature and research that could be used by the dental sector to report on their outcomes. The indicators are typically for potentially preventable hospitalisations for dental conditions and tooth decay, which can be measured in the number of decayed, missing and filled baby teeth and permanent teeth.

In addition to clinical indicators, measuring health outcomes from dental services from the patient's perspective is an important area where further work is underway. The use of patient-reported outcome measures (PROMs) to measure the outcomes from health interventions is an important area of current focus. The International Consortium for Health Outcomes Measurement (ICHOM) is in the process of developing standard sets of measures for different conditions. DHSV is working with ICHOM along with partners from the Harvard School of Dental Medicine and HCF Australia to develop a consistent and well-accepted standard for measuring health outcomes within oral health, which will be completed by the end of 2017.

The Australian Commission on Safety and Quality in Health Care commissioned the Centre for Health Service Development (2016) to undertake a literature review on the use of PROMs. The literature review found that the three main benefits or PROMs are:

- patients can be most accurate in describing their own symptoms, pain, function and quality of life and clinical outcomes alone cannot capture all relevant information about treatment effectiveness;
- PROMs can be used in clinical settings to support patient-centred care and ensure that care takes into account the things that matter most for patients; and
- PROMs generate data on the relative effectiveness of treatment which can be used for funding decisions and can used to measure the value of interventions.

As the health care industry moves to implement value based health care principles, health outcomes need to be readily available to analyse the effectiveness of services and hold providers accountable. Using PROMs and standards set internationally will improve accountability for the health sector, as well as driving efficiency (as discussed further in the next section), and should be incorporated into any reforms in the public dental sector.

2.4 Efficiency

DHVS agrees with the findings from the Report with regards to the efficiency of the dental industry in Australia. The Report references the submissions from DHSV and Dr Martin Dooland, both submissions argue that the current fee-for-service model is not appropriate and encourages over-servicing with no benefits to patients' health outcomes. Evidence of this claim was found in both submissions. Dr Dooland reported that the private sector is 30% more costly than the public sector for a course of general dental care for adults. While DHSV found through analysis of Dental Weighted Activity Units provided during a course of care that public patients treated in a private clinic received 51% more general dental services and 17% more emergency services compared to those treated in a public clinic.

These issues were also prevalent in the CDDP. The Report noted that after the cap for the program was increased ninefold to $4,250 per patient in 2008 the cost of the CDDP increased significantly. Two-thirds of the increase of expenditure on this program was found to be attributed to a service that had limited evidence of disease-control benefits.

A solution to this problem is to change the funding model to a bundled payment system that drives health outcomes and moves away from a fee-for-service approach. Efficiency in healthcare is best measured using health outcomes rather than health service outputs, since activity based measures may result in perverse incentives (Porter and Lee, 2013). Using indicators such as the standards being developed by ICHOM will enable the measurement of health outcomes and the assessment of true cost effectiveness for accountability and benchmarking purposes.

DHSV stresses the importance of moving away from a fee-for-service model, which appears to encourage supplier induced demand and subsequently increase costs, to a different funding model which focuses on health outcomes. If greater contestability is implemented without outcomes measures we could end up with a more costly, less effective system. Hence great care is needed in designing the next steps for reform.

If greater contestability is implemented without outcomes measures we could end up with a more costly, less effective system.

2.5 Responsiveness

The Report suggests that the ability for public patients to be seen in private dental clinics would provide greater access and consumer choice. However, increasing consumer choice will come at a price. Private clinics' decision of location is based on market forces and economic forces. Although the number of private clinics and dentists far outnumber the number of public ones, they are less socio-demographically accessible.

Private clinics in the traditional single-person practice, do not have the economies of scale that the public sector has which results in more costs for the private sector to service these markets. If the government wanted to encourage the private sector to service these the government would have to provide incentives for private clinics to open which would result in a substantial cost. Even if private clinics were to service these patients, there is a lack of evidence that increasing the choice for consumers will result in better care. Therefore, allowing private providers to service public patients might result in a significant cost and not improve health outcomes.

Despite the waiting lists for public dental services, many public dental patients are satisfied with their experience. DHSV report that overall patient satisfaction levels at the RDHM were at 88%, while 95% of day surgery patients at the RDHM rated their experience as "good or very good".

"Access to poor care is not the objective"
Porter and Lee (2013)

The Report also noted that although it is preferable for a client to see the same professional every visit, this is not necessarily optimal or possible in the public sector. Health care is increasingly being provided by a team of health providers, particularly for people with chronic diseases. When considering the value proposition, it is expected that professionals work to the top of their scope of practice. A team of providers with different levels of training should provide the services that improve health outcomes to the patient.

The public sector also provides training to undergraduate dental students. To ensure their training is as diverse and comprehensive as possible, these students are required to work with a variety of clients.

The Report also expressed concerns over the length of public dental waiting lists. Specifically that some patients who have been escalated from the waiting list to emergency care could have had their problems been addressed by preventive or restorative treatment if the list had not been so long.

DHSV suggests the use of different triage categories. Triaging is already done for emergency public dental services with targets to treat within defined times. However, risk is not currently categorised when people go onto the waiting list – so their condition may deteriorate over time, rather than preventing the worsening of the most serious conditions. As is done in other parts of the health system (notably, for elective surgery patients) dental patients – both hospitalised and in the community – should be prioritised in accordance with risk triage categories and with guidelines for such prioritisation and triaging. This would enable assessment and monitoring of waiting time targets, together with relative funding levels between jurisdictions, per risk-weighted patient. This would provide far better understanding of responsiveness in the system, and help enable timely access and favourable visiting patterns.

2.6 Recommendations

Recommendation 1:

Apply a values based health care model that aims to achieve the best health outcomes, cost effectively, by relying on evidence based outcome indicators, rather than output or activity indicators.

Through more appropriate reporting of outcomes, better understanding of cost effective services can be gained. This can then enable a values based health care model to be developed which will result in better health outcomes for lower cost. This would also support a team based approach with all team members working towards the top of their scope of practice or training. For example, a dentist would not be providing tooth brushing advice.

Recommendation 2:

Establish a bundled payment system that drives health outcomes and moves away from a fee-for-service approach

A fee-for-service model provides perverse incentives to service providers. Under this model, service providers are incentivised to increase the quantity of services without any incentive to improve quality of health outcomes. There is evidence that this is a problem in the private sector as the cost of providing services in the private sector is greater than in the public sectors. If greater competition and contestability were to be encouraged under the fee-for-service model, it would risk high costs for dental procedures. Regardless of whether the government implements greater competition and contestability in the dental industry, the payment system should be focused on providing performance based reimbursement.

3 Factors influencing the potential benefits of reform

Public dental services need to focus on reducing barriers to access and prioritising prevention over treatment

3.1 User characteristics

The eligible population for public dental services comprises two main groups, children and economically and socially disadvantaged people.

For children, there is a key role for the public sector in health promotion activities and setting up good habits for life for children. In relation to treatment, the CDBS means that eligible children can access services from the private and public sector. In Victoria, about 80% of all outputs delivered for the CDBS in 2014–15 were from the private sector (VAGO, 2016). The Report concludes that this suggests eligible families are able to make decisions about accessing dental care.

However, this does not consider how the use of private dental services have improved health outcomes. In South Australia, where there is well developed school dental program, it has been shown that children who receive care from public School Dental Services (SDS) have more favourable oral health outcomes than children seen by a private dentist alone (Gaughwin A et al, 1999). Children who receive care from their SDS or from both the SDS and private dentists (mixed care) have significantly lower rates of caries or "decayed, missing and filled surfaces" than children who receive care solely from private dentists or who had not received any care for two years. They also had less untreated disease, fewer fillings and a greater rate of fissure sealant placement than their privately seen counterparts.

Access to public dental services for treatment is important for people who are economically and socially disadvantaged. DHSV (2016a) has highlighted that people who access public dental care in Victoria:

- have more disease and fewer teeth than the general population;
- are less likely to access services than the general population;
- have to wait on average a year to get routine care with no recall arrangements (but this varies across the state); and
- receive care that is not always focused on achieving better health outcomes.

The report acknowledges many of the problems faced by these groups – lower oral health literacy, a greater prevalence of high dental fear than other groups, and certain populations not well serviced by the private sector, such as people with special care needs, residents of regional and remote areas, Indigenous Australians, the frail and elderly and the

homeless. The issues paper also highlights that these groups are likely to need additional support if they were required to select their own provider.

As discussed in section 2.2, the likely barriers to accessing services for these groups are financial, cultural, psycho-social and geographical. It is unclear that introducing user choice and competition would be an effective solution to addressing these barriers to access, and it is likely that additional funding and requirements would need to be placed on the private sector in order to meet the needs of these groups.

3.2 Supply characteristics

The public sector plays a major role in prevention and early intervention through a range of active and effective health promotion programs as opposed to private sector, which is predominantly treatment focused.

In Victoria, dentists make up 61% of the total effective full-time Victorian public dental workforce (VAGO, 2016) – consistent with the data presented in Figure 6.3 in the report – whereas the report shows approximately 80% of the private dental workforce is dentists. The Victorian Auditor-General's Report highlighted that:

> *The cost-effectiveness of the public dental workforce is a key consideration in a public health system with competing needs and limited resources. To achieve a cost-effective system, the most resource-intensive staff (dentists) should focus on the most complex and difficult types of services, such as treatment. The least expensive staff should carry out other services that they can be trained to deliver safely and competently, such as oral health education.*
>
> *It is not cost-effective for dentists to carry out preventive activities that other members of the dental care team can do. However, according to self-reported data from CDAs, dentists make up about 61 per cent of the total effective full-time Victorian public dental workforce. This is a barrier to the cost-effective delivery of the elements of a preventive approach, such as risk assessments of patient behaviours that lead to tooth decay, oral health education, and support to help patients better manage their oral health (VAGO, 2016 p.36).*

"It is not cost-effective for dentists to carry out preventive activities that other members of the dental care team can do."
Victorian Auditor-General's Office (2016)

Given the proportion of the private dental workforce that is dentists, it appears that there would need to be a change to the workforce mix in the private sector to enable prevention services to be delivered as cost effectively as in the public sector.

DHSV is currently working on implementing models of care that change the workforce mix to achieve the most efficient health outcomes. DHSV is actively promoting preventive models of care in public dentistry, integrating a population health and life course approach that incorporates components of prevention, minimal and early intervention, risk assessments and team-based workforce mix to deliver the right intervention by the right staff at the right time and place.

DHSV published an extensive systematic review that provides strong evidence on the effectiveness of these types of oral health promotion strategies (de Silva et al, 2012). The systematic review tested a diverse range of multi-component and multi-setting oral health promotion interventions incorporating a wide variety of health promotion strategies (e.g. policy, educational activities, professional oral health care, supervised tooth brushing programs, motivational interviewing) in preventing dental

caries and gingival and periodontal disease among children from birth to 18 years of age. The review found that oral health promotion interventions that included supervised tooth brushing with fluoridated tooth paste were generally effective in reducing tooth decay in children's deciduous teeth. Oral health education interventions provided in an educational setting combined with professional preventive oral care in a dental clinic were effective in reducing caries in children's permanent teeth. Other positive interventions included improving access to fluoride in its various forms and reducing sugar consumption.

DHSV would also reiterate that the shares of the respective patient populations that receive a teeth cleaning do not imply that the public sector is less focused on prevention than the private sector, which the Report claims. There remains debate on the optimally cost-effective amount of oral prophylaxis provided in a dental care setting, particularly one where supplier induced demand may exist. In addition, the Report needs to recognise that the public dental sector is still seeing a significantly higher number of emergency patients due to insufficient funding to provide a comprehensive course of care including preventive interventions.

3.3 Recommendation

Recommendation 3:

Place a greater emphasis on evidence-based prevention and health promotion instead of treatment

Most oral problems can be prevented. Increasing the focus on early detection and preventive interventions can help people to have better oral health and to avoid costly treatment interventions and reduce the reliance on emergency care. The model for public dental services needs to prioritise prevention, and ensure financial incentives are aligned with this objective.

4 The potential costs of reform

Increasing access to public dental services would require a large increase in government funding

4.1 Supporting users

Introducing more competition into a market strewn with information asymmetry and prone to supplier induced demand may lead to expensive unfavourable health outcomes for users. Any reforms would need to include additional support to users to make decisions, especially as the population that access public dental services are relatively more disadvantaged, and ensure that care is focused on health outcomes.

4.2 Government stewardship

4.2.1 Cost of increasing access

The current level of government funding is not sufficient to fund dental services for all adults eligible to receive public dental services. Dr Dooland in his submission to the first stage of the inquiry explained that the current funding levels only allow for 20% of eligible adults to receive treatment in one year. In one year around 50% of eligible adults will access dental services, with 60% of these people accessing services through the private sector and paying for it themselves. Thus, if all eligible adults were able to access services from the public or private sector, without having to wait as is currently the method used to ration services, there would need to be a significant increase in government funding.

This is without taking into account that the private sector tends to provide higher dentistry per individual than the public sector resulting in a higher per person cost, as was discussed in section 2.4.

Public dental services are not a universal health system. The current funding is not even sufficient to cover all eligible people.

4.2.2 Monitoring and evaluation of health outcomes

Government stewardship would also require an increase in the data collected and a shift toward collecting data on the basis of health outcomes. As discussed in section 2.3, the current reporting systems for public dental services focus on outputs rather than measuring health outcomes and there is little information collected in private dental services.

4.2.3 Oral health within the broader health system

Oral health is not separate from other health issues, and often patients will have a number of interlinked health issues. It is also possible to leverage other parts of the health system to support oral health outcomes. There is a role for government stewardship in linking oral health services in with the broader health system.

In Victoria, for example, most CDAs are part of community health centres or hospitals and the government provides funding to coordinate services locally and to use standardised tools and processes for referrals and information sharing. For example, through the Maternal and Child Health Service, nurses provide a full oral assessment at the eight-month, 18-month and 3.5-year consultations as part of the standard framework and

the Birthing Outcomes System. This service also collects data on pregnant women which, since 2015, includes two questions on oral health (VAGO, 2016).

4.3 Costs to providers

Private dental providers may face additional costs to adhere with the required quality standards, reporting requirements and potentially contracting costs, depending on the method used to introduce competition into the sector. In the private sector, most of this cost would likely be passed on into pricing and thus recovered, given relative price inelasticity in the private sector.

DHSV recommends that all service delivery organisations (not just those in the public sector) should be accredited against the National Safety and Quality Health Service Standards and, in particular, any private clinics wanting to provide services to publicly funded patients should gain this accreditation. As discussed in section 2.1, if private and public clinics are required to meet different standards this places additional costs on the public sector that is inequitable.

The other component of good governance and care is reporting data and outcomes, especially when spending public money. The public sector is already well developed in this space but the private sector will need adjustments to its data collection methods, which may require new processes and related computer software. Patient reported and other health outcome indicators will be very important to collect, including some clinical indicators, in order to drive evidence for value based care models, efficiency, equity and quality going forward. Greater access to information is also a key component of introducing greater choice, as described in the issues paper.

The issues paper identifies a number of models that could be used for public dental services, which may involve tender processes. Responding to tenders and ongoing contract management would create additional costs for providers. However, without proper oversight and safeguards there are risks about the quality and effectiveness of the services provided. The reforms made to the vocational education and training sector in 2009 and the consequential problems, described by the Productivity Commission in the Report, demonstrate that competition and user choice will not necessarily lead to more efficient outcomes in human services.

4.4 Recommendation

Recommendation 4:

Funding and service delivery models need to take into account the amount of public funding available

Public dental services are not a universal health system, and the funding is not even sufficient to cover all eligible people. The amount of funding available needs to be considered in designing changes to the funding and delivery models.

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