Commissioner Stephen King

Human Services Inquiry

Productivity Commission

Dear Commissioner King

I have attached a number of documents in relation to the Commission's Report "Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform." My comments relate only to Public Dental Services. The attachments include:

- A short summary of my 40 year involvement in leadership and policy advisory roles in dental public health.
- A series of specific comments on aspects of the report.
- Supporting documents. It should be noted that since my retirement from my executive role within SA Health/SA Dental Service in 2013, I no longer have access to some more recent documents that would support my comments. However, SA Dental Service/SA Health should be able to provide these to the Commission if asked.

  Please note that I have included the full SA Dental Service Yearbook for 2011-12 (Attachment D) and an extract from 2013-14 (Attachment D). These are on the SA Health website and do not need to be included on the Commission website in full.

1. Making public dental services contestable

Key among the preliminary findings was that people receiving publicly funded dental treatment would benefit from being able to choose either a public or private provider. The report suggests that this could lead to greater continuity of care and, as a result, fewer people may delay treatment.

I am fully supportive of allowing people, who are eligible for publicly funded dental care, being able to freely access dental care and to choose their provider, either public or private. Indeed, this was highlighted by the National Advisory Council on Dental Health (of which I was a member) in its report.

SA Dental Service has worked successfully with the Child Dental Benefits Schedule (CDBS) which is fully contestable in this manner. Under the CDBS parents have to full freedom of choice of the provider of their children's dental treatment from the public or private sectors.

However, there are a number of consequences flowing from the adoption of a fully contestable model for eligible adults that would need to be managed.

1.1 The number of eligible adults seeking dental care

First, government funding levels for the treatment of eligible adults (concession card holders) currently only supports the treatment of around 20% of the eligible population in any one year. Furthermore, as pointed out in the Commission's Report, a significant proportion of this care is limited to emergency treatment rather than timely general dental treatment.

Around 50% of card holding adults (ie eligible for publicly funded treatment) receive dental care each year. However, very few people are aware that 60% of these eligible adults receiving treatment in any one year are receiving this treatment in the private sector and paying it themselves (with or without the support of private dental insurance). This is documented in the attachments (that include tables from the National Survey of Adult Oral Health).

Hence, if eligible adults were free to seek dental care at public expense on a desirably regular basis directly from private or public dental providers (as for most children under the CDBS) there are cost implications. The public funding for these services would need to increase significantly to cover the treatment of the eligible adults who are currently paying for their own treatment. Further increases in government dental funding would need to be found if the approach resulted in the desired increase in the number of adult eligible people receiving regular preventively focused dental care.

Cost increases flowing from this cause could be moderated but not eliminated. For example, the private sector frequently recommends check-ups every six months for everyone. Many dental authorities recognise that the frequency of dental check-ups should be varied based of the patient's risk of developing dental disease. This approach allows the frequency of dental check-ups (and other associated items of care) for low risk patients to be as low as every two years without negative health impacts. This targeted approach is promoted in both the National Oral Health Plans.

Alternatively, this contestable model could chose to impose barriers in order to control expenditure. The most common "barrier' would be the use of waiting lists. Patients would be free to select any provider under such a model but would need to wait until they were issued with an "authority" or voucher to receive public funding for their treatment. This may work against the aim of having more card holders seeking timely dental care.

1.2 The cost of a course of dental care for an eligible adult

A further factor in the implementation of a contestable model for adults relates to the relative costs of a course of publicly funded dental care in the public and private sectors. This is dealt with in some detail in the attachments. In summary, evidence shows that when eligible adults are treated by the private sector using current voucher schemes, the fee for service value of the care each person receives is, on average, at least 30% higher than the average course of care in the public sector. Likely reasons for this difference are discussed in the attachments. However, the private sector tends to provide more restorative care per person (fillings) than public dentists, probably reflecting different treatment philosophies and the different incentives in the public and private funding models.

The states/territories have attempted to control the delivery of more service items per patient in the private sector by limiting the list of items of care that are funded by the Voucher Scheme. These attempts have largely been unsuccessful.

The Commission may wish to seek advice from the Commonwealth about the relative treatment patterns (and costs) of treatment in the private and public sectors under the CDBS and/or explore the cost per patient under the Medicare Chronic Disease Dental Program. The Commonwealth would have these figures.

Hence, funding for the flexible and contestable services would need to be increased to cover this aspect of the cost of the implementing the model if the number of eligible adults treated is to be maintained even at current levels. Further increases in funding would be required if the desired increase in dental attendance was achieved.

2. Responsiveness to user needs and accountability

The attachments document evidence of the responsiveness of South Australian public dental services as well as providing a number of examples of the evaluation and reporting of the cost effectiveness and quality of publicly funded dental care. These documents may not have been made available to the Commission to date. SA Dental Service, and I expect other public dental service providers, would be able to provide many more such examples.

3. Opening up the management of public clinics to non-government providers

I would argue that it is rather dangerous to attempt to characterise the provision of dental services as a simple purchaser-providers model. The limited public dental funding has forced SA Dental Service to become highly innovative in the development of new approaches to the provision of dental care to eligible people that is based on dental public health principles and not on standard models of clinical dentistry.

For example, in the 1980s and 1990s, the SA Dental Service radically changed the approach to children's dentistry, leading to both better oral health outcomes and major financial savings. Changes included the targeting of preventive services to high risk children, withdrawing these preventive services from low risk children and extending the period between check-ups up to 2 years for low risk children. This freed up millions of dollars for the rapid expansion of services to eligible adults yet the oral health of children rapidly improved to be among the best in the world by the mid 1990s.

Similarly, in the 2000s the SA Dental Service worked with the University of Adelaide to develop and implement a highly effective computer based screening/triaging tool that more accurately identified patients with real dental emergencies. This tool allowed the public dental service to better manage the exploding demand for emergency dental treatment that resulted from the axing of the Commonwealth Dental Health Program funding in the late 1990s. As a result, the clinical time devoted to dental emergencies fell from over 60% to under 20% allowing clinical time available for preventively focused dental care to increase dramatically. Waiting lists dropped from nearly 5 years in 2002 to under a year by around 2011 and many more adults were able to receive more timely dental care. This program was widely publicised and won several awards for excellence in public sector management.

It is difficult to see how a private manager of public dental clinics simply providing traditional private approaches to clinical care could have shown such public health leadership.

Nevertheless, I would be supportive of a trial of a number of privately managed public clinics. There would need to be considerable work on developing a funding model with the incentives to provide treatment patterns to patients that are consistent with public dental health principles. There would also need to be an evaluation framework (that includes consideration of the balance of client choice, cost to government and oral health outcomes) established prior to the tender and implementation stages.

4. National Leadership

There is considerable variation between state/territory dental services in their approaches to service delivery, the accountability of their programs, their level of responsiveness and sophistication of their population oral health strategies. It is suggested that the Commonwealth should take a leadership role in oral health commencing with the appointment of a Chief Dental Officer to provide the leadership in line with the National Oral Health Plan endorsed by all the Nation's Health Ministers.

4. Further consultation

I would also suggest that the Commission holds a face to face consultation with a number of key representatives of the public dental and dental public health research sectors to explore these directions. I believe that is desirable because, as discussed in the attached specific comments, there does appear to be some misunderstandings in the Commission's report that could be clarified most efficiently in this way.

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