

Health *Voices*

Journal of the
Consumers Health Forum
of Australia

Representing consumers on national health issues



**Putting money
where the mouth
is: solutions
for Australia's
dental crisis**



Health Voices

Health Voices is published twice each year. Each issue has a theme that promotes debate on issues of interest to health consumers, government and industry.

Readers are encouraged to write letters to CHF in response to journal articles or other issues in Australian healthcare.

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The Consumers Health Forum of Australia

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers.

CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF does this by:

1. advocating for appropriate and equitable healthcare
2. undertaking consumer-based research and developing a strong consumer knowledge base
3. identifying key issues in safety and quality of health services for consumers
4. raising the health literacy of consumers, health professionals and stakeholders
5. providing a strong national voice for health consumers and supporting consumer participation in health policy and program decision making

CHF values:

- our members' knowledge, experience and involvement
- development of an integrated healthcare system that values the consumer experience
- early intervention, prevention and early diagnosis
- collaborative integrated healthcare
- working in partnership

CHF member organisations reach Australian health consumers across a wide range of health interests and health system experiences. CHF policy is developed through consultation with members, ensuring that CHF maintains a broad, representative, health consumer perspective.

CHF is committed to being an active advocate in the ongoing development of Australian health policy and practice.

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Editorial



It is estimated in the past two years, close to two million Australians who needed dental care weren't able to access treatment because they couldn't afford

it¹. More than 12 million Australians have to look after their dental care themselves and over 50,000 people a year²— enough to fill a big country town — are being hospitalised for preventable oral conditions. Dental admissions are the largest category of acute preventable hospital admissions.

CHF believes that something has gone badly wrong when you have nearly three quarters of a million Australians on a public waiting list. A massive number of Australians — particularly people on lower incomes — simply cannot access basic dental care at all. Australia clearly faces a hidden epidemic when it comes to accessing the public dental health system.

This issue of *Health Voices* addresses these issues. We have contributions from all sides of politics and are extremely grateful to the Minister for Health, the Hon Tanya Plibersek MP; Shadow Minister for Health and Ageing, the Hon Peter Dutton MP and Greens Health Spokesperson Senator Richard Di Natale for sharing with us their thoughts on dental reform. Clearly there is a measure of bi-partisanship on this issue which gives us hope that change is possible.

The most appealing part of putting this issue of *Health Voices* together has been to collect ideas about how we can impact change. In the following pages you will find thoughts on how dental can link to broader health delivery such as through Medicare Locals; workforce initiatives that focus on utilising broader scope of practice, training and use of overseas practitioners; and different models of targeting valuable health dollars — some already in practice such as the Chronic Disease Dental Scheme, Medicare or a new form of social insurance such as the National Health and Hospital Reform Commission's 'Denticare' scheme.

We hear from members of the National Advisory Council on Dental Health including Deputy Chair, John Spencer. John lays out the Council's focus on care provision for children and those who can least afford dental care. Tony McBride looks at how Medicare Locals can co-ordinate and target care provision and Cassandra Goldie tackles the need to address cost barriers to care.

Professor Hans Zoellner focuses on the imbalance between public and private dentistry and examines ways to shift public dental services from emergency and basic dentistry to high quality services for complex and difficult patients; and in doing so, create a public dental service attractive for the very best dental clinicians to exercise their skills.

Mark Cormack, Chief Executive at Health Workforce Australia tells us about national oral health workforce planning to tackle the maldistribution of dental professionals and unmet need. He talks about greater flexibility and a team approach to care provision which we applaud.

The Australian Dental Association's President Dr Shane Fryer provides a useful summary of how Australian dental care has reached breaking point. He looks at Commonwealth dental schemes, past and present, and the opportunities to develop a new national dental scheme.

Former Chair of the National Health and Hospital Reform Council, Dr Christine Bennett, talks about some of the innovation that was considered under the Council's remit to look at health reform in this country and suggests a targeted social insurance model for those in greatest financial and clinical need.

Dr Deborah Cole, CEO of Dental Health Services Victoria, spells out her multi-strategy approach that can make a real difference to the lives of disadvantaged Australians. She highlights how States have been forced to focus on emergency treatment rather than on regular routine care which has led to poor long-term dental health outcomes for many Australians.

And finally we hear from the Brotherhood of St Laurence and the work they have been doing with consumers. They show us it is not just the disadvantaged that have difficulties getting access to affordable dental treatment and we hear personal stories from Pat, Michelle and Rhonda about their experiences accessing affordable dental care.

This is just a snapshot of the stories and views that we know are out there and we are grateful to everyone who has contributed to this issue of *Health Voices*.

The cost of putting all dental items on Medicare would cost billions every year. There are real answers spelled out over the following pages. Some people think that issues with teeth are some sort of cosmetic matter - that is a nonsense. The most common health condition in Australia is actually tooth decay. It's time we recognised the mouth as part of the body.

Carol Bennett, Chief Executive Officer, *Consumers Health Forum of Australia*

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1 Stewart JF & Ellershaw AC 2012. Oral health and use of dental services 2008: findings from the National Dental Telephone Interview Survey 2008. Dental statistics and research series no. 58. Cat. no. DEN 216. Canberra: AIHW.

2 *ibid*

Dental investment has to reach those who need it the most

The Hon Tanya Plibersek MP, Minister for Health



Whether it's been improving how our hospitals are run, addressing the shortages of doctors, nurses and health professionals in regional areas,

or making the largest ever investment in mental health services, we have taken the same, methodical and sound approach.

The starting point has been by speaking to the people who use and need the services, the consumers. Listening to their stories of how things could be better is a powerful way of understanding the impact of health services on ordinary Australians' lives.

In working out what to do and how to make a real difference, we have also carefully considered how we can make the system fairer. It's important that health services are targeted to those that need them most, and, as our recent reforms of the private health insurance

rebate show, we are determined to deliver greater fairness.

So, having made major reforms in the hospital, primary care and mental health systems, we are now beginning the process of reforming dental health services.

The Government has long been committed to publicly funded dental care that is targeted at Australians who can least afford to pay.

We have taken a number of actions to improve our dental health system.

We've already committed to spending \$165 million on dental services in the upcoming budget.

We've delivered practical improvements to dental care, including subsidising around 1.5 million dental check-ups so far for teenagers, through the Medicare Teen Dental Plan.

Through the Health and Hospitals Fund we have provided \$125 million for eight dental projects, delivering 220 new dental chairs across the country.

The recently opened \$2.1 million, 10-chair teaching dental clinic at the

Adelaide Dental Hospital will mean an extra 52,500 hours of clinical training over the next five years for undergraduate dental and oral health students.

'The Chronic Disease Dental Scheme isn't means tested, which means millionaires can get \$4,250 free dental care but a pensioner without a chronic disease cannot.'

Investments in the dental workforce will be a key part of our plans and we will invest \$52.6 million over four years to support the dental workforce through a voluntary dental intern program.

We've also made significant investments in programs to address workforce shortages in rural and regional areas.

\$11 million is being spent to improve dental health for indigenous people in rural and regional communities.



In addition to this, \$6.1 million is being provided to six Australian dental faculties to improve rural access to dental services by expanding dental training in regional settings. These faculties are at the Universities of Melbourne, Western Australia, Sydney, Queensland, Griffith and Adelaide.

But of course more needs to be done.

We want to make sure that our investments in dental health reach those who need it most.

Working families are struggling to get basic dental care and we need to make changes to improve the system; however, extra investment is not

possible without closing the Chronic Disease Dental Scheme (CDDS).

While state governments have traditionally had responsibility for providing public dental services, the Commonwealth government is the largest funder of public dental services in the country with much of this expenditure coming from CDDS.

The CDDS, while providing services for some parts of the population, is not well targeted and does not provide assistance to access dental services to those Australians in most financial need.

The scheme isn't means tested, which means millionaires can get \$4,250 free

dental care but a pensioner without a chronic disease cannot.

When Tony Abbott introduced the Chronic Disease Dental Scheme in the lead up to the 2007 election, it was projected to cost \$375 million in administered funds over four years. In 2010, more than \$660 million was claimed under the scheme.

For a scheme that does not target those most in need, this isn't a good use of health dollars.

The Government's reforms to dental health will be underpinned by fairness because that's what we stand for and that's what consumers expect.

Dentists shouldn't be pawns in politics of care

The Hon Peter Dutton MP, Shadow Minister for Health and Ageing



A great satisfaction of my job is meeting people who have had their quality of life immeasurably improved through successful

policies. That has been especially evident with the Medicare Chronic Disease Dental Scheme (CDDS). Some eligible patients have not seen a dentist in years. They have severe dental health issues. They are suffering, in great pain and the situation is making their underlying medical condition even more difficult to manage. One girl in particular comes to mind. She is wheelchair bound and has severe chronic health conditions. I was visiting a dental practice in Melbourne late last year and she and her mother made a special trip, a fair distance from memory, just so I could hear first-hand of the enormous benefit of the program for her health and general wellbeing.

These stories of relief and appreciation, from patients who otherwise would have languished for years on public dental waiting lists, are many and spread right across the country. The program has been successful and yes, as a result,

expensive. Last financial year, 5.7 million services were provided under the CDDS and about one million Australians have received dental treatment since 2007.

Despite strong public sentiment to improve access to affordable dental services, Labor is trying to abolish the only successful Medicare dental program in place. Since coming to office, Labor has twice tried to close the CDDS, but was disallowed in the Senate.

In last year's Budget and the Mid-Year Economic and Fiscal Outlook (MYEFO), Labor has reiterated its intention to close the scheme. Fortunately, they still don't have the numbers to do so.

It appears now that they have gone to 'plan B'. That is, to try to completely discredit the program and intimidate dentists from providing services through it.

Medicare has been directed to undertake a rigorous process of audits. As at the end of last year, 933 audits of dentists were under consideration or active and 89 had been completed. Of the audits completed, over 70 percent of dentists were found to be 'non-compliant'. On the face of it, the issue of perceived 'rorts' is convenient for a government desperate to close a scheme started by their Opposition.

Scratching below the surface though, there is something very ugly in the way dentists have been treated through this process. This is not about 'rorts'. This is

a political strategy with dentists as the pawns. Support within the profession for future government dental programs is quickly and seriously being eroded.

The Coalition does support an appropriate audit process to ensure the integrity of publicly financed programs. Any practitioner claiming for services that haven't been provided or who has been involved in substandard care should be held to account. However, the breaches we are talking about aren't for fraudulent claiming. Claiming under the scheme isn't even close to being maximised. The scheme allows for \$4,250 in treatment per patient, but the average being claimed is only \$1,716 per patient. To suggest that 70 percent of dentists are rorting the scheme is wrong and offensive. Dentists are in fact being pursued to the full extent of the law for technical oversights, such as failing to send a letter to a GP on time. For such a minor error, even if rectified, the dentists are being given letters of demand for full reimbursement of Medicare benefits, despite all services having been provided, all costs already having been incurred and patients being satisfied with the treatment. One practice with eight dentists who have provided treatment over a number of years is being made to pay back \$700,000. It is facing bankruptcy and closure. Again, the services claimed were provided,

but there was a timing issue with the paperwork which was rectified before the audit was even completed.

It is important to remember that this is the first time dentists have worked under Medicare. It defies common sense that resources would be deployed to target such minor, technical issues that do not have a substantial impact on patient care.

Whilst the Government may have some success in scaring dentists away from using the CDDS, there are serious implications for patients in the short and longer term. Abrupt cessation of treatment will be devastating for the many people whose health and lives have benefited greatly through access to affordable dental care under the scheme. There will be fewer practitioners participating for future patients to access. Dr Johnson from Tasmania, who has to pay back \$24,000 (three times more than she received as she is an employee) spoke for many in the profession when she said, "There

is now no chance of getting a public dental scheme off the ground because dentists as a whole will no longer trust the Government."

This is an intolerable situation. The Government's claim that Medicare is just enforcing the law doesn't wash. If there is such a perverse public policy outcome to legislation, the responsible Minister can easily act to rectify the situation. Successive Labor Ministers for Health and Human Services have refused to do so.

In the final week of the March 2012 sittings I introduced the *Health Insurance (Dental Services) Bill 2012* to address the situation. The Bill requires the Minister to provide alternative options for dentists who merely didn't comply with paperwork requirements. This may include the Commonwealth waiving its right for the repayment of debts in such circumstances. Trying to push a private member's bill through the Parliamentary process is complicated, time consuming and will require cross-

party and independent support. It is astounding the Government still refuses to act.

The Coalition takes dental health seriously. While the Government's dire fiscal situation at present might prevent a full universal system, we do have the capacity to refine and build on what is already in place. Labor's interest bill, around \$7 billion per annum in coming years, would in itself fund a full dental program. In the meantime though, we have offered to work with the Government to improve the CDDS and ensure it is better targeted to the patients most in need. This was refused, but we remain committed.

Dental health is an area where huge gains can be made in health outcomes and quality of life. It will require the participation and, importantly, the trust of dentists in public policy. The Coalition is the only side of politics working to achieve such an end and with a successful record delivering on policy in this important area of health.

Case Study: Pat's story



Pat, 68, was married at seventeen and had three children. Her husband was a heavy drinker and became a violent man. It was a terrifying time for Pat until her husband left. To cope with the pain, she drank. Then drinking took over her life. Fortunately, Pat was able to turn her life around with support from the Brotherhood's Coolibah Centre.

In her mid 50s, Pat was dealt another blow. Large amounts of decay caused

her teeth to rot and break. She believes this was a result of poor oral health as a child. When Pat visited her local Community Dental Clinic she was told she would have to wait two years to have dentures fitted.

During this waiting period, Pat experienced pain and discomfort, as well as becoming increasingly self conscience and anxious about her appearance. She was reluctant to smile or let anyone see her teeth.

'If your teeth aren't right you don't want to go out. You don't want to socialise, you don't want to see people and you just stay indoors. It was creating mental health problems for me. It was isolating and that's what's happening to people now. I was afraid to go out because of my teeth,' she said.

Pat eventually had her dentures fitted but when they broke last year, and she returned to the clinic to have them replaced, she was told she would again have to join the waiting list for an extended period.

Pat says her condition was affecting her ability to do everyday tasks and

believes everyone should have access to proper dental care. 'This is your teeth I'm talking about! It should be everyone's basic right in this country; to have somewhere to sleep, to have enough food to eat and to have decent teeth. It interfered with everything in my life.'

Pat knew she wouldn't be able to afford the cost of treatment so had planned to take out a loan for over \$1,000, but luckily the Brotherhood of St Laurence stepped in and she was able to get the treatment she needed at no cost.

'It shouldn't be the case that you have to find the money upfront for something as important as your teeth. Some people might go without paying their rent, or food or heating to make their payments. That's not right is it?'

'If I didn't have the Brotherhood I don't think I'd be able to work out who I should go and see about my teeth. And if you're one of the migrants coming here and you don't have the language skills either, how are you supposed to find out where to go to get help?'

The road to universal dental care

Senator Richard Di Natale, Greens Spokesperson on Health



Australia's oral health is a disgrace, and it is getting worse. The omission of the mouth from the health system is an increasingly glaring

anomaly. While Medicare has its problems, it can only be regarded as a popular success. It's time that the last gap was filled and Medicare covered the whole body. Universal dental care is an idea whose time has come.

Less than half the country is considered to have good oral health visiting patterns.¹ This has led to a crisis in poor dental health among large segments of the Australian community that has ramifications for the rest of the health system. Untreated dental issues account for up to one in ten visits to the GP for treatment of infections and pain.² Over 60,000 people a year are hospitalised for preventable oral conditions.³ This includes admissions to the emergency department; an infection due to untreated dental or periodontal disease can be fatal. By some accounts, gum disease and dental caries account for two of the five main public health issues in Australia.⁴

As well as the burden placed on the rest of the health system, untreated dental issues are estimated to cause about \$2 billion in lost productivity.⁵

As a former GP, I know that doctors make terrible dentists. As the statistics indicate, I saw many people with dental issues. The painkillers and antibiotics, which were all I could offer, were not sufficient. A doctor can't really help people suffering from dental issues – they need to see a dentist. As the saying goes, an ounce of prevention is worth a pound of cure, and this is nowhere truer than in dental health. But for some people visiting a dentist simply isn't an option. The reason is cost.

We have consistent data that a cost of even \$100 can put basic dental care, especially the preventative visits that save so much pain and money down the road, out of reach of many people. According to the most recent figures released by the Australian Institute of Health and Welfare, one in three people have reported avoiding going to the dentist because of the cost and one in five were unable to afford the recommended treatment following a check-up.⁶

This is a sorry state of affairs indeed in a country as prosperous as Australia. The relationship between oral health and overall health is well understood. The gums are a highway to the rest of the body and untreated dental decay can cause or complicate serious chronic illness including heart disease.

It is also an issue of basic social justice. The lack of public investment in dental health disproportionately affects low income earners, Indigenous Australians and those in rural and remote areas. The misery this causes affected people is very real. Apart from chronic pain, lack of sleep and poor nutrition, your chances of success in a job interview or rental application could be jeopardised by bad teeth. Dental care is not a luxury or an optional extra.

For all these reasons, there is ample scope for a major shift in government policy, but little time to waste.

The Greens believe that going to your dentist should be just like going to your doctor. There really is no fundamental reason to treat the mouth any differently to the rest of the body and that is why our vision is to bring dental into Medicare. We have a plan to phase in Denticare over five years, beginning with children and people with low incomes and expanding coverage until it is fully universal.

After the 2010 election, the Greens agreed to support the Labor Government. A crucial part of the agreement for us was a firm commitment for a significant investment

in dental health. The Government flagged in last year's Budget that it would be a priority in this 2012-13 Budget and we will hold them to that commitment. As part of our agreement, the Government set up the National Advisory Council on Dental Health, which was composed of dental experts, academics, educators and representatives from social service organisations. The purpose of the Council was to advise the Government on how to best invest and reform the dental system, and earlier this year it reported back with some very clear recommendations.

'One in three people have reported avoiding going to the dentist because of the cost and one in five were unable to afford the recommended treatment following a check-up.'

The Council was clear in its support for a universal scheme, agreeing that "that the long-term goal for dental health in Australia should be a system that allows universal access to dental care."⁷ Similar to our policy, in the short term, the Council advocated focusing on children and low-income earners, while slowly bringing in additional groups of consumers each year.

The Council has presented several options for reaching out to the neediest groups. This includes major investment in the public system, administered by the States, to achieve universal coverage for all children. Low-income adults, on the other hand, could receive an annual capped entitlement to receive services delivered either in private or public practice that would cover basic preventative and restorative dental work, and more complex items in cases of genuine clinical need. Eligibility for this entitlement could be expanded over time until the scheme was universal.

A Denticare scheme would be expensive. The burden of disease is high. The Council recommends investing at least \$7 billion over the forward estimates. This is undoubtedly a lot of money, but fairly proportionate to the overall health budget.

This is an issue of priorities. I am of the belief that Denticare is one of the most crucial and necessary health reforms of this decade. I believe ensuring that every person has access to a good standard of healthcare (including dental care) is one

of the key tasks of good government. It is easy for Wayne Swan to talk the talk about 'a fair go' but it's time to put the money where the mouth is.

At the time of writing, we are in negotiations over what sort of investment we will see in the next and future Budgets. I hope that this is the year that sets us on the road to universal dental care.

1 AIHW, Oral health and dental care in Australia, 2011.

2 *Dental and Oral Health Policy Issue Paper: Policy Issue Paper*, Menzies Centre for Health Policy, 2007.

3 AIHW, *op. cit.*

4 South Australian Dept of Human Services 2001: *Oral Health of Australians – National Planning for Oral Health Improvement: Final Report*

5 Menzies, *op. cit.*

6 AIHW, Oral health and use of dental services 2008: findings from the National Dental Telephone Interview Survey 2008, March 2012

7 Report of the National Advisory Council on Dental Health, February 2012, p. 55.

Providing dental care to those who need it most

Dr Christine Bennett, Dean of the School of Medicine, University of Sydney



Australians have a lot to smile about. A beautiful country, a strong currency, weather that's as good as it gets and a dynamic multicultural

society are all testament to our national good fortune. When it comes to health we enjoy long life expectancy, consumer choice through Medicare and private health insurance (PHI), and a health system ranked third in the world by the Commonwealth Fund. But when it comes to dental care the smile disappears – Australia has a health system 'without teeth'. Public dental services can't meet demand: it's time to ask what role the private sector might play in filling the gaps in dental provision that leave many people without access to even the most basic services.

Dental health is not included in our universal health system and access to dental care comes at great cost to low income families. Many Australians live with poor oral health, sometimes waiting years to receive basic dental care through public dental services as they cannot afford, or do not have access to, private dentists. Over 650,000 adults are on public dental waiting lists; the average waiting time is over two years.¹

Common oral disease such as tooth decay, gum disease and oral cancers are preventable with early detection and treatment. But early intervention often doesn't occur – there are around 50,000 avoidable hospital admissions every year arising from preventable dental conditions.² And there is still not adequate investment in oral health promotion and school based dental services, both low cost and high impact investments for the whole community.³ Poor oral health is clearly a problem for our community and in particular for people on lower incomes who avoid seeking timely treatment because of the cost. But for the individual living with poor oral health, the impact goes beyond pain and discomfort.

As Chair of the National Health and Hospitals Reform Commission (NHHRC), I had the privilege of talking to thousands of Australians about their health and healthcare. The story one older lady told has always stuck with me. She said that her teeth and mouth were in such a bad state that she didn't feel confident kissing her grandchildren because she was ashamed of her halitosis. What a powerful reminder that a healthy mouth is so important to our everyday living: eating, talking, smiling or showing affection with a kiss. Many people are trapped in a situation where their poor oral health is robbing them of confidence, self-esteem and dignity, and indeed the things that make life

enjoyable. And they have no possibility of accessing the treatment they need. Additionally the association of poor oral health with other conditions such as cardiovascular disease, malnutrition and hepatitis C compounds the problem.

How can we right this national wrong and in particular address the needs of people who lack access to dental care because they can't afford it? In a country where dental services are largely privately delivered, how can we make best use of our strong private dental resources?

In our final report in 2009, *A Healthier Future for all Australians*, the NHHRC set out a proposed solution called 'Denticare Australia' to deliver a publicly funded scheme of universal entitlement to dental care.⁴ This proposal was effectively a form of social insurance underpinned by public funding delivered by an increase in the Medicare Levy of 0.75 percent of taxable income. Every Australian would be entitled to a defined scope of dental services, but would have choice over who managed and provided their care. Every Australian could choose either a complying dental health plan offered by a private health insurer or rely on expanded public dental services; either way their personal choice would be funded through 'Denticare Australia'. A risk adjusted payment would follow the individual to their choice of public or private dental plan. That is, payments into the plan

would be higher for people more likely to require more dental services, thus ensuring that in this shared risk pool arrangement, health funds would seek to attract people at all levels of risk. Unfortunately this reform has failed to become reality, perhaps because of its ambitious scope and the tight state of public finances. So in the absence of a universal national solution, what other options could deliver improved access for people in greatest need through access to private dentistry? And what value can private health insurers add? Australia currently spends at least \$6.7 billion a year on dental care – the majority of this out of pocket expenditure by consumers.⁵ This spending is neither equitably distributed nor effective in delivering good dental health across the board. Dental care accounts for over eight percent of spending in the lowest income households⁶ – and that’s just those who choose to pay for it, with many other low income households simply going without. This means that simply accessing basic dental care is impoverishing for some of the poorest families in Australia. So there is clearly a need to target scarce resources more effectively towards those in greatest need.

There has been some attempt to increase access for those in greatest health need through Medicare, where the Chronic Disease Dental Scheme (CDDS) offers a number of MBS item numbers for provision of dental services for people with chronic disease. General Practitioners can refer patients with chronic disease to a dentist where the patient has a dental problem that is affecting their general health, or has the potential to in the future. While the rules on eligibility are clear, there is unfortunately ample opportunity for rorting of the system. The scheme, while well intentioned, has been at significant cost without clear evidence that it has done much to improve overall general or dental health. The Government has acknowledged that it is ‘very poorly targeted’, both in terms of the people who access the scheme and the services available through it. This warns against an ‘open cheque book’ approach with few cost controls associated with any potential future expansion in coverage.

There are two further options that could improve access to dental care: an expansion in dental services

capacity through dental internships; and the creation of a targeted social insurance approach (Denticare Priority as a working title) for those in greatest financial and possibly clinical need.

A one-year internship scheme prior to full registration for oral health practitioners (dentists, dental therapists and hygienists) was proposed by the NHHRC at an estimated annual cost of approximately \$200 million per annum.⁷ It would extend experience for new dental graduates and increase public and private dental service capacity. Intern placements in the private sector could be linked to providing care to lower income and high need groups. The training of dentists and oral health professionals would be improved, and there would be an increase in the supply of care to communities who currently lack access. The exposure to a broader range of practice would also perhaps expand the career horizons of young dentists.

Along with improved supply, there must also be a fresh focus on providing a sustainable solution to the challenge of providing dental care for low income people and families. A modification of the Denticare Australia concept could be developed – ‘Denticare Priority’ – with public investment focused on lower income groups where the problem of poor oral health is most entrenched – less than half of people in this group get the dental care they need.⁸

‘Denticare Priority’ would see a risk adjusted payment for a defined scope of entitlement to preventive and core dental care for those on or below a set income threshold. People could choose whether to direct their risk adjusted payment entitlement into a public dental service or enrol in a health fund that would cover them for the defined set of benefits. This has the virtue of providing greater consumer choice, as well as introducing competitive pressures amongst funds and providers to deliver the best service and value for patients.

For some advocates of reform, the involvement of private insurers in any solution is a bridge too far. But the private sector has unparalleled experience and expertise in purchasing or ‘brokering’ access to services with a strong customer service ethos and a value for money approach; this has already been demonstrated in some

funds’ dental network arrangements. It is likely that the use of private health insurers in delivering a social insurance approach would ensure better value is achieved from public investment than directly reimbursing private dental practitioners.

Provider interests need to be constructively challenged, and ‘Denticare Priority’ would go some way to achieving this by creating competitive tension and innovation through developing a model in which funding follows the consumer’s choice.

‘Denticare Priority’ also recognises that in tight fiscal circumstances, it is necessary to target public funds effectively, hence the focus on low income groups rather than the population as a whole. And while the separation of oral health from general health is not compatible with the principles of a comprehensive health system for the ‘whole person’, this would be a significant step in the right direction by providing better coverage for dental care to the people who need it most.

That might be enough to put a smile back on some faces.

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- 1 *A Healthier Future for All Australians: NHHRC Interim Report (2008) p264 - figures from Australian Dental Association (2008)*
 - 2 *A Healthier Future for All Australians: NHHRC Interim Report (2008) p262 – figures from Australian Dental Association (2008)*
 - 3 *A Healthier Future for all Australians: NHHRC Final Report (2009) Recommendations 85 & 86*
 - 4 *A Healthier Future for all Australians: NHHRC Final Report (2009) Recommendation 83*
 - 5 Armstrong and Campbell, NHHRC: *Costing a Social Insurance Scheme for Dental Care: Supplementary Report (2008), p7-8*
 - 6 National Centre for Social and Economic Modelling, *Distribution of expenditure on health goods and services by Australian households, discussion paper commissioned by the NHHRC (2008)*
 - 7 *A Healthier Future for all Australians: NHHRC Final Report (2009), p274*
 - 8 National Centre for Social and Economic Modelling, *Distribution of expenditure on health goods and services by Australian households, discussion paper commissioned by the NHHRC (2008)*

Building up the public sector dental workforce

Mark Cormack, CEO Health Workforce Australia



Access to appropriate and timely dental care and improving dental health for all Australians are two important topics that have been explored in a

recently released report by the National Advisory Council on Dental Health, which is now being considered in more detail by the Australian Government.

The report presents a range of options to improve dental health in relation to service delivery and future workforce planning which is critical for groups of people who have unmet dental needs.

This particularly affects socially disadvantaged adults, government health care cardholders, migrants, especially non-English speakers and particularly Indigenous Australians.

There is also a growing need amongst the aged population and people living in rural and remote areas, but existing programs do not currently meet demand for general dental care and there is inconsistent access through a maldistribution of dental practitioners.

Health Workforce Australia's (HWA) interest in oral health is through its role as the national health workforce agency. Its brief is national workforce planning and driving reforms in clinical training, workforce roles/models and recruitment and support for international health professionals.

National oral health workforce planning is currently being undertaken by HWA. Particular attention has been paid to examining the supply and demand requirements for all sectors of the oral health workforce up to 2025 – that is, dentists, dental hygienists, dental therapists, oral health therapists and technicians. We are also examining the

range of roles performed by oral health practitioners.

While the issue of a maldistribution of dental professionals and unmet need is generally agreed, there are widely differing views about the potential solutions to this problem.

One of the most obvious is to provide more support for clinical training programs for oral health practitioners, which the Commonwealth is doing through HWA's Clinical Training Funding Program. This has already provided funding agreements totalling more than \$30.5 million in capital and establishment costs, with recurrent funding of \$19.7 million for dentist training and approximately \$730,000 for oral health and oral hygiene training programs (see breakout story: The Common Ground Model).

'The focus is now on how to achieve a greater team approach within dental practice, involving general and specialists dentists and other oral health practitioners—hygienists, therapists, prosthetists and others as appropriate.'

A more recent initiative is the Commonwealth's new voluntary internship program for dentists. This approach will support the growing cohort of dentists in training.

Another option is through health workforce migration. Between 2005 and 2010 approximately 600 dentists migrated to Australia. These dentists are a critical source for Australia's oral health workforce and they could help ease rural and regional dental service shortages.

A third option is increasing the Scope of Practice (SoP) for dental hygienists, dental therapists and oral health therapists – that is, enabling them to practice safely up to their level of training, or at "the top of their license".

Scope of Practice is a term used to describe the range of tasks and clinical roles a health professional is permitted to practice, typically defined by the extent of that individual's education and competence.

I believe a more flexible workforce with a broader scope of practice and working within a supportive team environment is one means of better responding to the needs of all Australians, especially those from rural, remote and Aboriginal communities, older people and those living in institutions.

Australia has a higher proportion of dentists to oral health practitioners compared to other countries. There is a need to determine the best workforce model to deliver safe and cost effective care to the Australian public and then determine the mix of the workforce.

There is also evidence that a more preventive model will reduce the burden of oral health care compared to the traditional model. This may impact on the future numbers and mix of oral health practitioners and dentists being trained.

The focus is now on how to achieve a greater team approach within dental practice, involving general and specialists dentists and other oral health practitioners—hygienists, therapists, prosthetists and others as appropriate.



The Common Ground model

Nearly 40 per cent of Australians cannot access basic dental care when they need it, with many of the worst affected coming from low-income or homeless communities, where poor oral health is widespread and waiting lists are often measured in years.

In response to this need, Adelaide University's School of Dentistry has established a Community Outreach Program that has been able to fit out a new one-chair dental clinic at the Common Ground Project's newly-opened facility in Adelaide's CBD.

Supervised by dentists, medical practitioners and other qualified allied

health providers, the clinic's services will be provided largely by undergraduate dentistry, oral health, medicine and nursing students.

"The intention of the clinic is to provide increased clinical training capacity for dental and medical students and at the same time to provide a service for a grossly underserved group in our community," said Health Workforce Australia CEO Mark Cormack.

"This is a reflection of how we see the dental service delivery model in Australia changing to meet community needs more efficiently – and how we see HWA assisting this change."

HWA has largely funded the new clinic with a \$250,000 grant from its Clinical Training Fund, which has been established to underpin growth in dental and oral health training around Australia.

Current funding agreements include capital and establishment spending of more than \$53 million, with recurrent funding of more than \$17 million going to dental training and around \$760,000 going to oral health and hygiene training, which has resulted in a total of more than 220,000 clinical placement days.

Bringing dental care in from the cold

Tony McBride, consultant and Chair of the Australian Health Care Reform Alliance



Health reform is a long-term enterprise and progress towards a more equitable consumer-friendly system is frustratingly slow, despite a few worthwhile

changes in the last few years. Moving towards universal access to dental care would be a major step forward however and is long overdue.¹ Other articles in this edition will have covered this well. Exactly how future oral health care is organised is also important and this article argues for bringing dental care more into the mainstream of primary health care. As (or whenever) reform is undertaken, learning from the mistakes of the current primary health care system is essential so that we do not reinforce silos but move towards consumer-friendly integrated oral health care. And Medicare Locals, with the right levers, could be crucial vehicles in driving and facilitating such reforms.

Not only is there inadequate and inequitable access to oral health care, but such care in Australia often sits very much in a silo at the margins of the health system. There are several indicators of its outlier status.

- Dental care is much more expensive than almost any other health care: out-of-pocket expenses are on average 61 percent of the cost (compared to only 12 percent for all other health care).²
- The vast majority of dental care is provided in the private sector (predominantly in separate dental facilities in locations chosen by dentists, not population health planning).
- Public staff in most states are employed by a separate entity or stream of the health department, although in Victoria staff are often

employed in community health services and part of the primary health care team.

Therefore there has also been a historically low level of connection between dentists/oral health staff and other health practitioners in system or services. For not entirely rational reasons, much of the health system (and politicians) appears to see the mouth as separate from the rest of the body.

This is starting to change slowly. The Medicare Chronic Disease Dental Scheme itself is a recognition that oral health is closely linked to physical health more generally, especially chronic disease. Dentists state that they can sometimes identify early signs of some chronic diseases and alert their consumers. However, this is less likely to occur if oral health practitioners are not closely linked with such consumers' other primary health professionals.

Further, the oral health field is increasingly recognising the potential of other health professionals in improving oral health status. There is much dental need that could be identified by others and referrals made, encouraging more timely care. An excellent Victorian resource reviews the evidence and identifies the value of a range of such initiatives, eg the South Australian Lift the Lip, which encourages maternal and child health nurses, community nurses and GPs to do a brief but regular screen of children's mouths. Other programs exist which are aimed at staff in aged care or intellectual disability residential settings.³ Victoria is currently developing health promotion programs around oral health and nutrition for child care, schools and workplace settings.

The rationale for integrating the locations and work of diverse primary health care practitioners is one that most consumers readily understand. For example, people with chronic diseases are often very frustrated by the lack of teamwork in addressing their conditions, by needing to travel to different

practitioners, having to tell their histories again and again, and having their data spread across multiple unconnected records.

There is good evidence that 'co-ordination of care improves health outcomes for patients and the higher the number of disciplines involved in integrated care, the greater the improvement in patient health outcomes'.⁴

The key issues here are not so much about what such services might look like: models already exist in Victoria and some other locations in Australia, and certainly overseas. Integrated services could feasibly grow from at least two directions: community health (or similar) services expanding their clientele beyond Health Care Card holders to collaborate with dentists, GPs and other allied health practices to develop new services over time serving the whole population in an area. And similarly existing dental practices could join with other professionals, especially GPs, to create new multi-disciplinary services where teamwork, not just co-location, is encouraged. Such two-pronged development would have the added benefit of bringing the public and private dental systems closer together.

The challenge has two key elements: first, how to encourage primary health care practitioners and governments/statewide dental services to put these models into place, and second, what funding models are needed to sustain them.

Medicare Locals (MLs) are the obvious vehicle for fostering such change – that is one of their main purposes. Most Medicare Locals are still establishing themselves. But a recent AHCR phone survey of the CEOs of some of the more advanced MLs revealed that they launched enthusiastically into their new expanded roles. They are building strongly on their successes as divisions of general practice but with a broader scope (and in some cases greater consumer participation).

Their population health planning roles in particular will provide new local data about gaps and inequities in many places for the first time.⁶ They have great potential to foster change but AHCR has argued strongly that they will certainly need more tools to be effective, including a stronger vision from the Federal Government (eg clearer signposts toward a more equitable and integrated primary health care system) and more policy and funding levers to actually foster and engineer change. Indeed the National Advisory Council on Dental Health has proposed a start to this.

Funding in the oral health arena could enable MLs to play a valuable role in creating more equitable and accessible oral health care locally, as well as more integrated service models. Such action could include identifying gaps and encouraging the development of more multi-disciplinary integrated primary health care services to address them. It could grow to acting as a fund-holder for significant proportions of dental funding, receiving needs-based funding programs and distributing

it to existing and new local services aimed at ensuring equitable access and the full range of (reasonable) needs being met. This could especially benefit currently under-served areas, eg rural and remote or low income. Such a mechanism, with its inherent bigger picture focus, could also work to ensure that there is a strong preventive focus and that funding does not simply encourage greater numbers of procedures without actively acting to prevent oral health disease. That is, it could assist in moving us from a predominantly individual-focussed system to one that looks at the needs of the population as well.

As part of creating a national and universal system, governments should actively seek to learn from the lessons of the existing primary health care system. Reforms need to encourage greater integration of oral health care with other primary health care services, and to actively ensure equitable access to care. Medicare Locals, if given the right tools, have the potential over time as they mature to play such key roles.

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Case Study: Rhonda and Mokopuna's story



'I used to work as a dental nurse so I have always been very aware of how important it is to make sure that any problems with your teeth are dealt

with straight away. When my husband Mokopuna damaged a front tooth while he was playing sport, I knew it should be fixed as soon as possible so I contacted our local community dental clinic.

Unfortunately they couldn't help him and said he would have to go to the dental hospital in Melbourne, which is about a two hour drive away from where we live. With four young children to look after we just couldn't get there. We thought that the only thing we could do was to try and save up and have the tooth fixed by a private dentist.

The dentist said Mokopuna needed a root canal filling which is quite expensive and the problem was that

even though Mokopuna works full-time and I work part-time, our jobs aren't very well paid and we just seem to need everything we earn for everyday expenses and to look after our children.

It took us about 12 months to save enough to get the tooth fixed and during that time the tooth was often really sore and Mokopuna was always really careful about it. We did try again to get help from the community dental clinic but they were just too busy to see him.

When the tooth was finally fixed it was great but the dentist told us that it would need a crown to make sure that it would cause no more trouble in the future. So we started saving all over again as the community dental clinic doesn't do that type of treatment.

Fortunately we heard about the help the Brotherhood of St Laurence could give us and they arranged for Mokopuna to go to a private dentist to have the crown. We were really, really happy that finally the tooth would be fixed permanently but somehow while Mokopuna was playing sport a couple

of days before the dental appointment, the tooth got knocked and at the appointment the dentist decided it couldn't be saved. So eventually, after everything we had gone through, it had to be taken out and a false tooth and plate made instead.

We understand that community dental clinics are really busy and they can't be expected to do everything but it just seems to us that if more help could be provided it would be better for everyone in the long run. For example, when your teeth are really painful you have to take time off work and that means that you lose income and it's bad for your employer as well. It's hard too, to feel good about yourself if your teeth are bad and that makes it even more difficult to get a job.

Hopefully neither Mokopuna nor I will have any more trouble with teeth for a long time. Now that our eldest son is at secondary school it would be good to be able to focus our saving on making sure that we can get him anything at all he needs for his education.'

How State dental services can improve access for those most in need

Dr Deborah Cole, CEO, Dental Health Services Victoria



In the past two years almost two million Australians who needed dental care were unable to access treatment because they couldn't afford

it. So what can State dental services do to improve access to dental services? An innovative, multi-strategy approach is needed if we are to make a real difference to the lives of disadvantaged Australians.

Until recently, the responsibility for providing the majority of dental services to those most in need rested with the State and Territory Governments. Unlike other health disciplines, there has been little Commonwealth contribution and no Medicare-like arrangements. States have struggled to meet the demand with the limited resources available and the focus has been on fixing dental problems through emergency treatment rather than on regular routine care. This has resulted in poor long term dental health outcomes for many Australians.

If we want to improve the public dental system, we need to look at the barriers that consumers face when trying to access care such as long waiting lists, confusing eligibility criteria and copayments or fees.

Generally, eligibility is dependent on holding a concession card. Eligibility for children is more universal but varies between jurisdictions. On top of this are the various copayments and fees associated with public dental treatment, which consumers often find confusing and cannot afford to pay. People who are eligible for public dental services also generally have to wait a long time to access services. While waiting, people often end up requiring emergency care or choose to see a private dentist. Often the treatment choices made when

seeing a private dentist are not ideal as patients simply cannot afford the best treatment option.

Various other factors also come into play. Often the nearest dental clinic is too far away and consumers don't have access to transport. Sometimes consumers simply don't know where the nearest service is located. Dental clinic staff are not always aware of how to appropriately deal with people from diverse cultural backgrounds, and many consumers do not seek dental services because they are afraid or have limited dental knowledge.

Recently, a CEO of a rural health service was describing to me his angst about being unable to reach a major disadvantaged community. Although his service had a proud tradition of treating large numbers of children, he became aware of children who had slipped through the cracks and were not receiving dental examinations and care. The CEO has now taken steps to address the situation, and while this is a good news story it raises the question – how many times is this being repeated around Australia?

The recent AIHW study¹ found that children from low socio-economic areas have 70 percent more dental decay than children whose parents are well off, and adults on low incomes are 60 times more likely to have no teeth than prosperous people. Concession cardholders are also less likely to have visited a public dental clinic for a check-up and many avoid seeking dental care because of the cost.

So what can we do about this?

The recent report from the National Advisory Council on Dental Health outlines policy options for increasing access to dental services.² A universal dental scheme will support prevention and early detection of dental disease and break down many of the barriers that Australians face when trying to access care. But it comes at a

significant financial cost.

The proposed Commonwealth system will offer a capped entitlement scheme that will apply equally to all disadvantaged people. While this will make a huge difference for many consumers, there will still be communities that will not access the service at all, except for emergency care. This is where the States can make a difference, as most jurisdictions know where the most disadvantaged communities are and what their particular needs are. They also have existing relationships with those communities.

Improving the dental health of disadvantaged communities requires partnerships and collaborations. It is critical that oral health reform be part of general health reform. For example, access to dental services should be considered within the scope for Medicare Locals.

'States can make a difference, as most jurisdictions know where the most disadvantaged communities are and what their particular needs are. They also have existing relationships with those communities.'

Public dental services can increase access through innovative approaches to the delivery, management and quality of services. Examples of innovative strategies include non-standard hours of operation (eg evenings and weekends), providing outreach services, taking family or group bookings, providing services that are culturally aware and child-friendly, and having Aboriginal and cultural liaison officers. Family-centred care is particularly important

given that risk factors are shared by family members. Strategies like these can improve both access and appropriateness of services for the community.

We also need to address the fact that many groups within the community who are eligible for public dental care do not seek out this care. Promoting the available services requires strong linkages across health areas and working closely with those in education, human services and the welfare sector.

For this cross-sectoral approach to work, there needs to be increased understanding of oral health issues by other professional groups. Oral health screening could be included in general medical assessments, allied health professionals could be trained to detect risk factors for dental issues and robust cross-sectoral referral pathways could also be developed.

Oral health messages need to be integrated with general health promotion as many of the messages are the

same. People need to eat well, drink well (with fluoridated water) and clean their teeth twice per day with fluoridated toothpaste.

We also need to enhance the capacity of the dental workforce to improve service delivery and increase access to services. Ensuring that all members of the dental team are used to their full potential is crucial. Clear communications, easy to navigate clinical settings and innovative models of care are all strategies currently being developed and tested. It is important that these activities are properly evaluated and that the findings are widely distributed. This will help us all make the right decisions about how to use our limited resources in the best way possible.

In summary, the States know how to deliver efficient public dental services. The expertise, the innovation and the passion are there. I am confident that we are on the right track to improving the population's dental health, which will lead to a happier and healthier Australia.

Dr Deborah Cole is CEO of Dental Health Services Victoria, the leading dental health agency in Victoria ensuring quality dental care for Victorians in need. Dr Cole has held CEO positions at Calvary Health Care in the ACT and Yarra City Council, as well as senior executive positions at Mercy Health and St Vincent's Health. A qualified dentist, Dr Cole was Director of The Royal Dental Hospital of Melbourne, held various senior management positions within the South Australian Dental Service and served as a Board Director on the Dental Practice Board of Victoria.

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Real reform that will work – Dental Access, not a universal dental scheme

Dr Shane Fryer, President, Australian Dental Association



The Australian Government's focus on dental care provides an opportunity for all dental practitioners to suggest ideas for real reform.

This debate about how dental care can be equitably and efficiently provided to all Australians is well overdue. In order to consider how this can be achieved, we need to understand how we have arrived to this point, and how the Australian Dental Association's (ADA) proposal will ensure that people who are in most need of dental care will have access to quality treatment.

Commonwealth dental schemes – past and present

In the 1990s, the Keating Government introduced the Commonwealth Dental Health Program. The Howard Government then removed it, saying the plan had addressed public sector waiting lists. A policy black hole in the area of dental health then existed for over a decade. After introducing some minor interim measures, in 2007, the then Minister for Health and Ageing, the Hon Tony Abbott, introduced the Chronic Disease Dental Scheme (CDDS) which sought to provide patients experiencing chronic diseases access to up to \$4,250 worth of treatment over two years for dental conditions. While the ADA welcomed the additional resources from Government for dental care, it

expressed great concern that this funding was not targeted to those in need and that the dental care able to be provided was not necessarily required to address chronic illness.

Studies show that 30 to 35 percent of Australians do not access oral healthcare due to issues such as cost and other disadvantage. The ADA's view was that since the CDDS was not targeted (means tested), it ultimately compromised the oral health of disadvantaged Australians. Some needy patients unjustifiably missed out.

Unfortunately, not only did the CDDS's shortcoming remain unaddressed, inadequate Government communication of the scheme's administrative requirements gave rise to the current problem of dentists being required to

pay back CDDS payments in cases of administrative non-compliance, such as failing to provide a treatment plan to the patient's referring medical practitioner. This is occurring in spite of the fact that the vast majority of these dentists provided patients with the quality dental care they need.

'The ADA's view was that since the Chronic Disease Dental Scheme was not targeted, it ultimately compromised the oral health of disadvantaged Australians. Some needy patients unjustifiably missed out.'

The opportunity to develop a new national dental scheme

The National Advisory Council on Dental Health (the Council) has developed a variety of ideas for a national dental scheme which would provide for efficient and equitable access to dental care for Australians. The Council's final report, released in late February this year, details their suggested options for delivery of appropriate dental care to the Australian community. As *Health Voices* itself has outlined, poor dental health leads to poor general health and in particular there is a link with cardiovascular disease. Other organisations, such as the Brotherhood of St Laurence (page 16), have outlined that the total direct costs and lost productivity of unaddressed oral health issues could be as high as \$2 billion each year. Naturally, not only is there a public health need to address dental care in Australia, but an economic and public interest reason in doing so.

How can we deliver appropriate dental care to those in need?

The crucial policy question that needs to be addressed is this: With limited and scarce resources available to Government, how can these resources be appropriately allocated to ensure those Australians in need receive quality dental care?

Any health scheme funded by taxpayers would need to give effect to the key principles of equity of access and effectiveness. A dental scheme based on principles of equity of access and effectiveness will not only best provide dental care to the disadvantaged, but will also instil further public confidence in that dental system.

The universal dental schemes proposed by some groups will offer, due to insufficient funding across the population base, only basic dental care – they will not deliver quality dental care to those most in need. This leads to poor dentistry for poor people and good dentistry for the more fortunate. Significantly limiting treatment options under such schemes is not an effective solution and shows little appreciation of the real problems facing dental delivery in Australia. Under such schemes, the disadvantaged (the group that needs to be targeted the most) will still miss out on appropriate care while those that can afford access will 'top-up' their own treatment to a level that should be available to all Australians.

The ADA's proposal: DentalAccess

In its Federal Pre Budget Submission 2012-13, the ADA provided its solution to the public dental needs of the community and outlined how appropriate care would be given to those most in need.

The ADA's submission identifies those groups within the community that are disadvantaged with regard to their oral health; that is those groups that either do not have timely or accessible services or experience financial barriers. These groups include:

- The financially disadvantaged;
- People living in rural and remote communities;
- Older people;
- People with special needs; and
- Aboriginal and Torres Strait Islander peoples.

The ADA's proposal, *DentalAccess*, is designed to target Government funding to those people most in need of dental care. *DentalAccess* will ensure that people who are in most need of dental care will have access to quality treatment – those who are

disadvantaged, chronically ill and special-needs patients. *DentalAccess* is specifically designed to provide equitable access to care so that all Australians will have the ability to receive the treatment they deserve.

Coupled alongside this scheme is the need for proactive oral health promotion and prevention activities. If oral health is to be improved and costs are to be kept at an affordable level, investment in prevention of oral disease has to be at the forefront of oral health policy in Australia. Oral health promotion, in all of its forms including education and fluoridation, needs to be an integral part of Australia's health plans. Optimal use of prevention-oriented programs and preventive allied dental personnel, such as dental hygienists, are an essential prerequisite. All dental schemes must include capacity for individuals to have education and support to change their behaviours, especially where dental decay and periodontal disease are proven risks. Ultimately, a person's oral health is in their own hands.

This is where the ADA's *DentalAccess* proposal marries the two ends of the necessary continuum of healthcare:

- Oral health prevention and promotion, to minimise the chances of oral health disease occurring at one end; and
- Providing access to dental care for those disadvantaged Australians that have oral health needs to be treated and managed at the other.

A targeted yet comprehensive scheme will provide universal access to valuable and worthwhile care for all Australians.

Dental care for the children and adults in greatest need

Cassandra Goldie, CEO ACOSS



While many people say they fear going to the dentist, it is more often the cost rather than the drill that causes the most pain. More than one-third

of Australians say they put off going to the dentist because they cannot afford it.

Australia ranks among the bottom third of OECD countries for adult dental decay and people on low incomes and those living in poverty and social disadvantage experience a disproportionate burden of disease. Research shows they experience higher rates of tooth loss and decay and the most difficulty accessing and affording dental services.

The expert report of the National Advisory Council on Dental Health, released earlier this year, seeks to address the current inequities in dental health by proposing a new national oral health system to provide equitable, affordable access to dental care for all Australians.

The report prioritises children and lower income adults as the first step to creating a more universal system. It outlines four options that would build on existing frameworks for an individual capped benefit scheme or expand state public dental services. Funding would cover basic dental services including diagnostic, preventive and routine care, with provision for more expensive services in exceptional circumstances.

The National Health and Hospital Reform Commission identified the need for dental reform as a priority nearly three years ago. It recommended universal access through a 'Denticare' scheme, which was rejected by the Government due to the \$3 billion price tag.

The Advisory Council's report

recommends a minimum \$56 million on child dental services and \$0.3 billion on adult services in 2012. Importantly, the report recommends foundational measures to develop a national scheme over time, recognising that even a blank cheque won't address current deficiencies such as numbers in the dental workforce and their disparate distribution across the country.

Opponents of a universal access scheme argue that our oral health workforce and infrastructure are inadequate to service the tsunami of people who would scramble to get into the dentist chair. Critics also argue that the cost of the scheme would be too great in the current economic climate.

'While a comprehensive dental system may be seen as financially costly, the cost of doing nothing is just as high and continues to mount. Poor access to dental care has significant costs to society. In 2009-10 the direct cost of dental services was \$7.7 billion, and indirect costs to the economy have been estimated at up to \$2 billion.'

While a comprehensive dental system may be seen as financially costly, the cost of doing nothing is just as high and continues to mount. Poor access to dental care has significant costs to society. In 2009-10 the direct cost of dental services was \$7.7 billion, and indirect costs to the economy have been estimated at up to \$2 billion.

Many of these costs could be avoided through timely, preventive dental care, including the costs to social and economic participation as stigma and

self-doubt from poor teeth undermine individual efforts to obtain and maintain employment and meaningful social relationships.

In recognition of the current funding climate the Advisory Council has proposed options that can be scaled up or phased in over time. They provide stepping-stones on the path to a universal access system. The most conservative model, targeting those people already on public waiting lists, would cost \$343 million in 2012-13. This is around two thirds less than current Commonwealth expenditure on dental programs.

While targeted measures for those children and adults most in need are essential, they must not be the end point. The Medicare principles underpinning our health system mean that all Australians are entitled to the same good quality care based on individual need rather than ability to pay.

This year's Federal Budget is the opportunity to commence a comprehensive plan to bring dentistry into Australia's universal health system. It is simply not fair that so many Australians are missing out on essential dental care, most noticeably for those on low incomes.

The Council report provides options that are fiscally responsible and pragmatic. They would improve dental care for those children and adults in greatest need, while laying the foundations for a more universal access system for all Australians.

Building on the Government's commitment to significant dental reform in this year's budget, the new Health Minister Tanya Plibersek has made welcome comments that revamping the dental system would be one of her priorities in the health portfolio. This Federal Budget, let's see the Government put its money where its mouth is.

It is time dental care became universal too

Nicola Ballenden, General Manager of Public Affairs, Brotherhood of St Laurence



Recently a young man, Brett, was referred to the Brotherhood of St Laurence by his job service provider. He couldn't work because his impacted

wisdom teeth kept getting infected so badly it made him ill and there was a 30 month wait for treatment at his local public dental health clinic. The job service provider had heard that the Brotherhood could help. Through a small philanthropic fund we were able to pay for private treatment and Brett is now actively looking for work.

Bad teeth or no teeth have long been synonymous with poverty. Visit any social welfare agency on any day of the week and you are likely to come across numerous people with bad or missing teeth and poor oral health. These conditions can be painful, making it difficult to eat and speak, and unsightly, eroding confidence and reducing job opportunities.

However it is not just the disadvantaged that have difficulties getting access to affordable dental treatment. A single mum, Karen, called us recently telling us that because she is on a reasonable income she doesn't qualify for access to a public dental clinic. Like so many parents, Karen chooses to put her kids first and while she was able to afford dental treatment for her teenage children, the cost meant that she delayed seeing the dentist about her own decaying teeth. By the time she got there the dentist had no option but to remove three of her teeth.

A strange historical anomaly has meant that Medicare has never covered dental or oral health leaving consumers with higher out of pocket costs than any other form of healthcare. For people

like Brett and Karen, the barriers to care are insurmountable. While up to a third of the population may be eligible for assistance from public dental health clinics, the waits are often very long. The clinics have limited funding so they only reach a small proportion of people who are eligible for their services. Others may be eligible for treatment through the Chronic Disease Dental Scheme but many Australians on low or even middle incomes struggle to afford dental care. A recent survey of 1,200 adults found that more than one third had delayed or avoided visiting a dentist in the previous year because of the cost. The toll on personal confidence, employment prospects and quality of life is immense.

Last year the Brotherhood commissioned health economists Bronwyn and Jeff Richardson to estimate the cost to the economy of poor oral health. Their report, entitled *End the Decay*, found that children in the lowest socioeconomic areas had 70 percent more decay in their teeth than children in the highest socioeconomic areas. Some 17.3 percent of people in the lowest income quartile have no natural teeth compared with just 0.3 percent of people on high incomes, making poor people nearly 60 times more likely to have no teeth than people on the highest incomes.

Lack of access to dental care also results in presentations to general practitioners and emergency departments in hospital. Dental admissions are the largest category of acute preventable hospital admissions, resulting in about 50,000 admissions with an estimated cost of \$223 million per annum. It is estimated that dental problems comprise between seven and ten percent of total GP services. Untreated oral health problems can also lead to a range of other illnesses including cardiovascular disease, stroke, peripheral vascular disease, pre-term

birth and pancreatic cancers, among others. Overall, untreated oral health problems are estimated to cost the economy between \$1.3 and \$2 billion in terms of lost productivity.

So as politicians argue about the costs of making dental care universal, it is worth remembering the costs of not doing anything is also high, both in economic terms and in human costs. It is also worth reflecting on why we are asking questions about the 'affordability' of universal dental care when most of us accept Medicare, Australia's taxpayer funded universal healthcare scheme, as part of the furniture.

'Untreated oral health problems are estimated to cost the economy between \$1.3 and \$2 billion in terms of lost productivity.'

Medicare is often taken for granted but it is one of the things that makes Australia such a great place to live. Free treatment at public hospitals, bulk billing GPs and government subsidies for visits to specialists and for pharmaceuticals all help to keep healthcare much more affordable than it would otherwise be. Medicare is based on principles of fairness – the idea that access to healthcare should be on the basis of need rather than ability to pay – but it is not just ideals that make universal systems of healthcare such a good idea. Universal systems often have lower administrative cost and can help control prices, support greater emphasis on primary and preventive care and reduce unfair anomalies (eg whereby those just above the cut-off point miss out). Universal systems also encourage community buy-in because everybody uses the health system and everyone pays for it, avoiding the risk of a two tier system of care developing. In the

US, which does not have a universal healthcare system, health costs as a proportion of GDP are twice what they are in Australia, and the life expectancy is lower and infant mortality is higher.

The National Advisory Council on Dental Health concluded in its report to the Federal Government that Australia's long term goal should be "universal

and equitable access to dental care for all Australians", but that in the current environment Australia should start with dramatically improving access to dental services for children and the most disadvantaged adults. There is nothing wrong with prioritising some vulnerable groups within the community, but continuing to limit reform to narrow means-tested systems is not the answer.

In the upcoming Budget, the Federal Government needs to give Australians a timetable and plan for universal dental care. With the introduction of Medicare, the Australian Labor Party introduced equity into healthcare in a way that has proved enduring and popular, and economically sustainable, but it is time they finished the job – it is time dental care became universal too.

Case Study: Michelle's story



Michelle, 36, is a happy, vibrant mother of three young children. She is involved in a range of community activities, has a circle of friends and is committed to helping her children in every way she can. Yet, for the majority of her life, Michelle struggled with self doubt, lack of confidence and isolation, simply as a result of severe orthodontic problems which forced her jaw out of shape, entirely changing her face.

Growing up in a family with no spare funds and lack of available help in the area in which her family lived, meant Michelle grew up feeling isolated from her peers.

'My teeth have always made me look different to everyone else,' she said. 'A school dentist told my parents that I needed orthodontic treatment but my family lived on a low income and couldn't possibly afford the cost, and apparently there was no government scheme available to help with the treatment I needed. My parents just said it could wait until I was old enough to pay to fix the problem myself.

It wasn't until my mid teens that I

realised my looks were very different to others and it really had an impact on my confidence and self esteem. I stayed inside and as a way of coping I started smoking pot. Then I got more and more withdrawn and struggled with everything for years. I normalised the way I was feeling, by saying things to myself like "this is who I am and this is the class of person I now belong to."

Unfortunately, I got into the wrong crowd at school and didn't knuckle down and do my studies, which I really regret. Then, while I was still in my teens, I got pregnant and all my focus was on my baby boy. Over the next few years I had two more children and I was constantly very busy. I always wanted to do something about my teeth but I knew the treatment was going to be very expensive and I just couldn't see how I was ever going to be able to afford it. Then when my daughter started school she began looking at me a bit strangely and she noticed that I looked different to everyone else. I know that children can be unkind even when they don't mean to be and I worried that my daughter might get picked on because of the way I looked. I didn't want my daughter to be ashamed of me.

At about the same time I noticed that the parents at her school were standoffish towards me. I thought they assumed that anyone who has bad dental problems like mine must have real difficulties, even a drug history.

That made me determined to do everything I could to get the orthodontic

treatment I needed. My actual teeth have always been okay, I've looked after them, my problems were orthodontic and my jaw. I was born with extra bottom teeth but my jaw was too small to fit them all. My daughter is just losing her first teeth and it looks like she has similar problems to mine. It's one generation after the other with the same dental trouble.

I finally found an orthodontist who was willing to arrange a payment plan for me to get braces, which would cost nearly \$8,000. But the orthodontist said I'd need to have surgery to break and realign my jaw and that it was pointless getting braces without the surgery. I was told that if I didn't get treated, I could get to a point where I wouldn't be able to chew.

I could pay for the orthodontists but I just couldn't find the money for the surgery, which had to be done by a maxi-facial specialist. Luckily the Brotherhood of St Laurence found me a public surgeon who performed the operation on my jaw, and it didn't cost me anything!

When your teeth look bad it's a real problem, in lots of ways. Not only do you have self esteem and confidence issues, but it also makes it more difficult to get a job. People can't afford a private dentist so they end up not going to the dentist at all. And waiting lists at community dental clinics are so long that no one even bothers to put their name down. Something needs to be done.'

How to make public dentistry work

Associate Professor Hans Zoellner, Association for the Promotion of Oral Health



State and Territory governments are responsible for delivering public dental services, but the national public dental waiting

list hovers around 500,000.

Especially daunting is that this figure underestimates actual demand because many who are eligible for public dentistry have no serious expectation of ever being seen, so don't register for appointments.

This would be damning of those responsible for public dentistry, were they not given excuse by being asked to do the numerically impossible; that is to deliver comprehensive dental care to almost 50 percent of the population with less than 16 percent of the nation's dental workforce. The psychology of failure is insidious, because when nothing can be done, nothing becomes expected.

The proportional imbalance between public dental workforce and eligible patient population forces public dentistry to focus on emergency-style treatment, rather than delivery of comprehensive dental care. The sense that public dentistry is 'poor dentistry for poor people' may be galling for many dedicated public dental clinicians, but it is nonetheless a truthful assessment of the facts.

Dental clinicians working in the public sector have salaries lower compared with income in private practice, while the focus on basic and emergency dentistry undermines satisfaction in work, and hence the capacity to attract and retain the public dental workforce.

One approach to correcting the imbalance between service capacity and demand in the public sector is to simply put more money into the public

dental system. Salaries can be raised, and more clinicians may be employed. While this is superficially attractive, it unfortunately doesn't work. Proof of this unpalatable fact lies in simple comparison of public dental spending across State and Territory jurisdictions. NSW, for example, spends close to half per public dental patient compared with many other states such as Queensland and Western Australia. Public dental waiting lists, and the type of service offered in these more richly funded states, however, are not appreciably better than in NSW. Separately, there are numerous rural incentive schemes to attract public dental clinicians to more isolated areas, but these programs are generally unsuccessful in redistributing workforce. Money simply doesn't seem to be enough.

During the Keating years, an increase in public dental spending was made through yearly Federal grants to the States. Although this was welcome, State services did not have internal capacity to spend the money, with much Federal funding directed to private dentists via vouchers. It is saddening that some States used the Federal funds to reduce their own dental investment, with the effect of overall reduced government dental spending when the Keating scheme was eventually closed by the Howard Government.

In our free-market economy where remuneration and conditions are more attractive in the private sector, it is unlikely that it will ever be possible to expand the size of the public dental workforce sufficiently to meet demand, unless the public system is structurally changed.

Another approach to supporting public dentistry has been to reduce eligibility criteria and tightly ration services. While this certainly makes public system statistics look better, it nonetheless fails dismally in actually providing care to people who cannot afford private dental practice. Of particular concern

is Australia's demographic profile of an ageing population, where most people have their natural teeth and require life-long dental maintenance therapy. We thus face a tsunami of demand for public dental service by ageing people on limited incomes, who will be increasingly unable to access public dental care in a progressively overwhelmed system.

All of this might sound hopeless, but I do believe there is a sensible solution that can be implemented in reasonable time to accommodate our rapidly ageing demographic. The solution is not to try and prop up the current public dental service, but to instead redefine the role of the public system by creation of universal dental Medicare. By providing access to private dental services via Medicare, public dental services would be liberated from their currently impossible task of serving half the community with a smattering of dental clinicians. Instead, public dental services could concentrate on those patients who have medical or other problems too difficult or expensive to be provided by private dental practitioners. This would properly match public dental workforce to demand, and ensure that everybody who can be safely seen by private dentists has access to such service.

'We face a tsunami of demand for public dental service by ageing people on limited incomes, but who will be unable to access public dental care in an overwhelmed system.'

Precedent is well established in medicine. Despite occasional grumbles about public hospitals, the fact remains that they successfully deliver comprehensive and complex medical care to patients who are

simply too difficult or too expensive to treat in private hospitals. Consultant physicians and surgeons derive high status from their public hospital appointments, as it is understood that only the better clinicians are able to cope with the complex needs of public hospital patients. The wide range of difficult cases encountered in public medical services also provides a rich educational environment for medical students, interns and specialist trainees. Note, this is the complete opposite to current arrangements in dentistry, where the public system has become largely limited to basic dentistry, and it is in the private sector where most advanced dental services are delivered. Putting dentistry into Medicare would not only make it possible for almost

everyone on the public dental waiting list to be seen immediately by private dentists, but would also create a market in outer metropolitan suburbs for private dentistry. Currently, there are less than half as many private dentists in outer metropolitan areas compared with the wealthier suburbs, despite the greater clinical need in poor areas. This maldistribution of the dental workforce is at least in part because more people in the poorer suburbs don't have the money for private dentistry, so there is no market to support new dental practices. Universal dental Medicare would create such a market, and help redistribute dental workforce to where it is actually needed. Some have argued that dental Medicare should be means tested. This would, however, be a mistake, not only because it is

inconsistent with the rest of Medicare, but also because universality is needed for bulk-billing dental practices to become established, and push down the prices in private dental practices charging a gap above the Medicare schedule.

Were dental Medicare introduced, as is the current Federal Greens policy and the Coalition's stated ambition, there would be no public dental waiting list, a shift in public dental services from emergency and basic dentistry to high quality service for complex and difficult patients, and creation of a public dental service attractive for the very best dental clinicians to exercise their skills. The public system can be saved, but only by investing in private dental service via Medicare.



Directions for improving oral health and dental services for Australians

Professor John Spencer, University of Adelaide



Australian children in the mid-1990s had among the best oral health in the world. Even with the deterioration seen across the last 15 years, the oral health of Australian

children still ranks in the top tier of OECD countries. On a population basis, the need for treatment is manageable and costs for the coverage of five million children are considerable, but not as confronting as for adults. The cost for treatment per child is about one-third to one-quarter the cost for a concession card holder adult.

Historically, Australia has invested in oral health and dental services for children through school dental services or community dental services. However, these services only reach a little less than 30 percent of primary and secondary school children. Services are somewhat loosely targeted toward lower and middle income families. While coverage has been declining rapidly since 2000, there is still a backbone of school or community dental services for children in Australia. What is desired is a system that captures those not visiting in any one year and which can re-orient dental services towards population and clinical prevention.

A number of issues favour the development of a universal approach to dental services for children. First, there is a desire for equality in opportunity to be dentally healthy as a child and for investment in future adult oral health. Second, the social pattern of both disease experience and untreated disease indicate that most children at risk will be excluded from a policy that targets only low income households, or less advantaged geographic areas. Only about half of children from low income households (<\$40,001) have experience

of dental decay and more than two-thirds of children with decay experience come from households with middle or higher incomes. An approach based on only school or community dental services will exclude many children at risk of dental disease. Third, there is already a strong base from which to develop a high quality parallel school or community and private dental services structure.

What is really required is a 'system' that reaches out and retains all children in a desirable pattern of use of dental services. All children should have an entitlement for dental services on an annual basis. This entitlement could be exercised in the existing school or community dental services or in private dental practices. The subsequent increased revenue flow to school or community dental services would be sufficient to allow them to take on the task of outreach to vulnerable population sub-groups and the task of identification and then retention in care of 'at risk' children. This would also encourage those States lagging behind in coverage by school or community dental services to expand their infrastructure, possibly with shared Federal and State/Territory funding agreements. When the 'system' stabilised it might be expected that about 50 percent of children would be treated by the school or community dental services and 50 percent by private dental practitioners. The 50 percent involved in care from the school or community dental services would include 'vulnerable' children and marginalised population sub-groups as well as a 'slice' of the population who prefer their service or for whom they are the only service available in under-supplied areas.

Implementation could be rolled out across three separate cohorts: pre-school, primary school, and secondary school children. The entitlement would be capped and for a benefit package of primary, preventively-oriented, dental services. This universal option would create an opportunity for planned data collection and evaluation and

refinement of details like fee for service schedules versus capitation payment, frequency of courses of care, standards of care/disease management strategies for dental conditions, and access to higher level dental services in exceptional circumstances.

'So this analysis is proposing the adoption of a universal entitlement program for children, phased in over a number of years by starting with pre-school children, then primary school followed by secondary school children.'

Adult dental services, particularly those for concession card holders, present quite a different situation. First, among concession card holders, about 50 percent have not made a visit in the last year. Second, even among those who have visited in the last 12 months, only one third visited a public dental service. Third, of those who visited a public dental service in the last year, most, about two-thirds to three-quarters, visited for an 'emergency' or same day dental care. This is a one-off, main problem, 'palliative' dental service. Hence, only about five percent of eligible concession card holder adults are receiving 'primary' dental care from the public dental services. The situation is one of acute resource scarcity and high level rationing of dental services through a range of approaches to reduce the demand on services to a level 'manageable' by the resources available. The key challenge is to provide greater support for access to dental services, but to ensure that the support is directed to those currently not visiting or visiting infrequently under adverse circumstances for 'emergency' dental care rather than simply picking up

the costs of dental services for those who already have greater access to good quality dentistry.

In any scenario for improved access to dental services for concession card holder adults, a substantial minority will need to be accommodated in the public dental services. This is the result of the requirement for many to receive some element of 'special care', whether it be because they have physical and intellectual disabilities, mental illness, complicating medical conditions, are frail, institutionalised, or residing in rural and remote areas. Many such adults and some others are neither comfortable nor readily welcomed into private dental practices operating under a fee-for-services payment arrangement. These adults require dental services provided by public dental services (possibly in collaboration with academic centres) in 'centres of excellence', somewhat akin to the best of the public hospital system.

This situation applies to a sizable sub-group of the population, possibly 40 to 50 percent of concession card holder adults. Their dental services are expensive because of the complications and situations under which dental services are provided.

A considerable investment is required to build and operate the infrastructure that can provide these public dental services. The public dental services need to be preferentially supported to grow. This meshes with the dental intern program already announced in the last Budget. This indicates that a public dental service program for concession card holders is the primary requirement among adults. Only once there has been substantial growth in the capacity and reach of the public dental services should there be an extension of the policy option to an entitlement for those concession card holder adults who have been successfully making their way in seeking dental services from private dental practitioners. The level of growth required in the public dental services is about four times the current capacity, all explicitly targeted to adults needing 'special care' who are currently the most under-served.

Growth of the public dental services can be phased across the forward estimates. Once public dental services exhibit real growth, there will be a tendency for concession card holder adults to move from the private sector to the public sector. This movement can be managed, but growth in demand from the concession card holders without additional claim to being a 'special patient' will signal the need to consider the next step of a wider entitlement program for all concession card holder adults. This is most likely beyond the four year horizon of the forward estimates.

So this analysis is proposing the adoption of a universal entitlement program for children, phased in over a number of years by starting with pre-school children, then primary school followed by secondary school children. Some additional support will be required to assist the state and territory school or community dental services to grow in their coverage of the child population and to actively engage in 'foundational activities'. For adults an option built initially around the public dental services within the state and territories and growing their capacity to be 'centres of excellence' for special care to disadvantaged concession card holder adults is most desirable, with levels of funding growing across the forward estimates. Again it will be important for this funding to also cover 'foundational activities' for adults, including in early years infrastructure expenditure. Only when such structures are in place should the option of an entitlement program for all concession card holder adults be considered. A universal entitlement program for adults remains an even more distant policy option.



The primary concerns for the report

Professor John Spencer, Deputy Chair, National Advisory Council on Dental Health

Two separate major issues are identified in the Report of the National Advisory Council on Dental Health: improving the oral health of children and teens, a concern in its own right and as the forerunner of the oral health of young and middle aged adults in the future; and reaching a more equitable access to dental services among children and especially adults. Access is socially patterned with a suite of characteristics all associated with unfavourable patterns of use of dental services (infrequent visiting, visiting mainly for a dental problem) leading to differences in treatment and oral health outcomes among adults.

The Report considers addressing these two major problems within a set of long-term aspirations. It calls for movement toward a dental service that is highly integrated with the broader health system and also shares characteristics like equitable access to preventive and treatment services. However, the Council's Terms of Reference requested consideration of how improvements could be phased over time. The background to this includes numerous concerns (cost, infrastructure and supply capacity) thought to be rate-limiting issues on growing dental services. As a result, the Report identifies two very short-term activities, and then presents a pair of broad policy options for both children and adults, supported by a block of enabling foundational or supplementary activities.

The policy options for children are put forward as 'universal' options, responding to the notion of equality of opportunity as well as the potential return to the population in an investment in future oral health. The policy options for adults are put forward as 'targeted' options, directed in the first instance to concession card holders.

What the Report does not overtly do is lean one way or the other between alternative policy options for children and adults. This leaves decision-makers room to move, but also with somewhat less direction than they may wish. The purpose of this article is to focus some light on those directions through a description of the desired structure for dental services in the medium term. Therefore, the time horizon includes the 2012-13 Budget and forward estimates through to 2015-16.

Dental reform can't be optional

Anna Greenwood, Senior Policy Manager, Consumers Health Forum



The oral health of Australians is undoubtedly an area that requires urgent attention and reform. Affordability and access issues present

major barriers to good oral health to a large proportion of the Australian population. Any activity that aims to address these barriers to access, and the inequalities that exist, is valuable.

The release of the National Advisory Council on Dental Health's report in February this year is a welcome first step to addressing the issues – but it is only a first step. This report cannot be allowed to sit on a shelf at a time when genuine Government commitment to reform is needed.

The report presents a comprehensive outline of the problems and barriers that need to be addressed, and also outlines long-term goals and aspirations which sit behind the more practical solutions proposed. The long-term goal for dental services is identified as *'An integrated national oral health system, as part of the broader health system, that provides equitable access for people in Australia to prevention, promotion and clinically appropriate, timely and affordable oral health care'*. The 'aspirations' are:

- Ensuring oral health is considered part of general health by including oral health as part of the health reform processes and the health care system
- Improving equity and access to dental services
- Investing in the future of oral health through dental programs for children
- Supporting oral health promotion across the population
- Clarifying roles and responsibilities of the states and territories and the Commonwealth
- Enhancing public dental services and academic and oral health centres
- Building workforce capacity for better service delivery and improved access

- Enhancing data collection, research and analysis.

It is difficult to argue against these goals and aspirations – they articulate what will be necessary for long-term reform, and give some sense of the size of the challenge ahead. What is needed, however, are practical strategies to achieve these 'aspirations'. The report presents four options for reform – two options for each priority groups; children and lower income adults.

The options identified for children are:

- *Option 1:* An individual capped benefit entitlement, which would cover basic preventative and treatment services and could be used in the public or private sector.
- *Option 2:* Enhanced access to public dental services, which would increase access for all children to basic dental services by enhancing existing public sector services.

The options for lower income adults are similar:

- *Option 3:* A means tested individual capped benefit entitlement, which could build on the legislative framework in place for existing programs, with access to high level services or caps provided in exceptional services.
- *Option 4:* Enhanced access to public dental services.

A major challenge common to all these options is that all are funded by the Commonwealth, either directly or through the states, but services will be delivered by the states. While CHF recognises the rationale for service delivery through existing state infrastructure and service systems, we have concerns about the consistency in service delivery options and service quality between the states and territories. The report only goes as far as to say that the details of how state capacity can be increased would need to be 'discussed at intergovernmental level'. The report appears to be placing faith in the ability of COAG to come up with solutions for the identified problems, and history shows that approach often

leads to less than substantial outcomes for consumers.

All service options would require major investments in workforce, infrastructure, etc. The Council's report has identified the need for 'foundational activities' (discussed further below). It is essential that these foundational investments occur in conjunction with the implementation of other options.

A number of questions also arise in relation to individual elements of each of the four options (see box page 24).

Regardless of the option or options that are chosen, there must be significant investment to support reform. The report identifies a number of 'Foundational Activities' that will be necessary for implementation, regardless of which of these options are selected. These activities would include work in the areas of:

- Dental workforce and infrastructure
- Data and research
- Oral health promotion
- Targeting groups with special oral health care needs.

CHF argues strongly that significant investment and reform in each of these areas is not optional – it will be essential if real success is to be achieved in dental reform. Without investment particularly in workforce and infrastructure, the options outlined above will simply not succeed.

If the Government is committed to real dental reform, they must commit to investment and new strategies for the system, rather than just tinkering around the edges. It is time for Australia to recognise oral health as part of overall health, and recognise the mouth as part of the body. A genuine commitment to dental reform in the 2012-13 Budget is what Australians need – and deserve. *'An integrated national oral health system, as part of the broader health system, that provides equitable access for people in Australia to prevention, promotion and clinically appropriate, timely and affordable oral health care'* – we don't think it's too much to ask for.

CHF's analysis of the Dental Advisory Council's options for reform

Children	
<p>Option 1</p> <ul style="list-style-type: none"> The capped benefit entitlement could be used for a range of dental services, listed on a dental benefits schedule. Services provided in the public sector would be free to the patient, and private dentists could choose to charge above the item benefit. CHF is concerned that this could result in a continuation of the current two-tiered system, as, at least in the short term, long waiting lists are likely to remain a feature of the public system, so those who can afford to pay for a private co-payment would be advantaged. Some children are already covered by private health insurance for these services, so for them the scheme would simply replace a private health benefit with a government benefit. CHF's view is that the emphasis should be on improving access to dental services for those who do not currently access these services, and this model might not improve access for those who need it, particularly in light of the risk of a two-tiered system discussed above. While the report raises the possibility of a 'fore-runner' program to target those currently missing out, CHF's concerns would still apply once this model is fully implemented. 	<p>Option 2</p> <ul style="list-style-type: none"> This model addresses some of the issues with Option 1. All children would be eligible for public dental services delivered through the states and territories. Services to concession card holder children would be free of charge, but non-card holder children may need to make a co-payment. The report notes that there is likely to be a significant number of families who will not participate in the program as they will continue to visit private dental practitioners –this could mean that access would improve for those who are not currently accessing services. The report recognises that take-up of the scheme will be limited in the short to medium term by capacity constraints of the public sector. It will be essential that these capacity constraints are addressed if long waiting lists are to be avoided. CHF is also concerned that the children of non-concession card holders might be required to pay a co-payment. While eligibility for a concession card is a reasonable proxy for disadvantage, it is not a flawless one, and the report identifies the access barriers for lower income families who are not eligible for concession cards and related benefits. Application of co-payments would need to be carefully monitored to ensure that they are not creating access barriers for those who are already disadvantaged.
Lower-income adults	
<p>Option 3</p> <ul style="list-style-type: none"> This option would be means-tested to include only adults who hold concession cards. As noted above, eligibility for a concession card is not an infallible proxy for disadvantage, and lower-income adults who are not concession card holders currently experience challenges in accessing dental services. It is noted in the report that the eligibility criteria should be expanded over time to include lower-income, non-concessional patients, but how income would be assessed is not explored. The option would also be expanded to include people with chronic disease who are currently receiving services through the Chronic Disease Dental Scheme, but it is unclear whether this would include all people with chronic disease or whether there would be some form of means-testing involved for them as well. Targeting measures to those who are not currently accessing services should be a priority, and learnings from the Chronic Disease Dental Scheme should be taken into account in this regard. Under this option, 'limited access to more complex high end dental items (eg bridges, crowns and implants) could be provided through a separate 'exceptional circumstances' mechanism'. Further detail on what would constitute 'exceptional circumstances' would be welcome, particularly as lower income adults who have not been accessing dental services might urgently need some of these 'more complex high end dental items'. 	<p>Option 4</p> <ul style="list-style-type: none"> Under this option, all concession card holder adults would be eligible for public dental services, including basic preventative and treatment services. As with Option 3 above, lower income adults who are not eligible for concession cards are also a group who experience disadvantage in accessing dental services. While the report notes that low income groups who are not eligible for concession cards could 'potentially' be given access, there is no indication of a timeframe for their inclusion or how income would be assessed. As with Option 3, the report notes that the option could 'potentially' be expanded to include non-card holder chronic disease patients. Again, CHF notes that targeting measures to those who are not currently accessing services should be a priority. Again as with Option 3, there is reference to an 'exceptional circumstances' mechanism to allow access to 'higher end services'. A definition of what is meant by 'exceptional circumstances' would be welcome.

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