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Submission in response to

**Introducing Competition and Informed User
Choice into Human Services: Reforms to
Human Services**

**Productivity Commission Draft Report
Overview & Recommendations**

Public Dental Services

July 2017

We appreciate the opportunity to respond to the Productivity Commission's Draft Overview and Recommendations into the reform of Human Services, specifically in relation to public dental services. This submission has also taken into account the Commission's original report outlining its preliminary findings released in September 2016 and the responding submissions made with respect to this report. This submission attempts to capture perspectives of the primary stakeholders for the reform of public dental services; namely, patients eligible for public dental care, federal and state governments, public and private dental providers, and the academic sector training our future dental workforce and providing research for improved health outcomes.

The state of affairs

At a population level, oral health service delivery faces a number of challenges. Due to a lack of public dental infrastructure, geographical spread of the population, low affordability of dental care and high rates of oral disease in lower socioeconomic population groups, governments must rely, at least partially, on the private sector to deliver their agenda.¹ Approximately 85% of the dental workforce operates in the private sector and has the capacity to deliver a national oral health agenda, however, the remaining 15% in the public sector currently serves a disproportionately larger population over a wider geographical area that suffers a far greater burden of oral disease.²

The global oral health objectives for 2020 set by the World Health Organisation and the World Dental Federation embed 'a primary health focus based on diagnosing, preventing and managing disease with cost-effective and sustainable policies'¹.

Whilst the Commission's report bases better oral and general health outcomes, on the premise of introducing patient choice, competition and contestability better oral health outcomes, overarching goals of person-centred care and a high value health care system need to be the focus. Reform must be measured and should consider vital lessons learned from the past. The Inquiry into the reform of public dental services will hopefully result in strong public-private partnerships that will deliver on a patient-centric model of care that significantly improves efficiency in delivering high quality oral health care, equitable access to the appropriate level of care, accountability at all levels of care delivery and timely responsiveness to the oral health needs of the population. Ultimately, the goal is to keep people healthy and improve the health of those who are unwell. In order for this to happen, the following principles detailed by the Australian Healthcare & Hospitals Association (AHHA)³ are endorsed by WSLHD and should be considered in the government's planning of a 'blended payment model':

- i. There must be a high level of **transparency** among oral health providers about the
 - a. costs of treatment,
 - b. quality of dental care provided and timeframe in which it can be delivered, and
 - c. health outcomes achieved for individual patients

¹ Lam R, Kruger E & Tennant M 2015, 'Conundrums in merging public policy into private dentistry: experiences from Australia's recent past', *Australian Health Review*, 39: 169-174

² Marshall M & Spencer A 2006, 'Accessing oral health care in Australia', *Medical Journal of Australia*, 185: 59-60

³ Australian Healthcare & Hospitals Association 2016. [Submission] Introducing competition and informed user choice into human services: Identifying sectors for reform. Productivity Commission preliminary findings, available

- ii. Consumers of dental care must be equipped with an appropriate level of **health literacy** to appraise relevant health information in order to make informed choices about their choice of provider and decisions that relate to their care with respect to their own particular circumstance.
- iii. Relevant **healthcare data** is made available to all participating practitioners so that competitive alternatives can be made. Careful management of qualitative and quantitative healthcare data is critical to engineering a future healthcare delivery system that appropriately identifies and prioritises vulnerable population groups.
- iv. Dental care provided must remain **integrated** with the remainder of each patient's healthcare and should provide demonstrable benefit to the patient's overall health and wellbeing. The ultimate benefit of health equality across Australian populations should become apparent through measurable health outcomes and should not be impacted upon by enticing perversion through short-term high financial gain of dental health providers.
- v. The resulting health outcomes achieved through a public-private partnership should offer better value to the patient, healthcare system and tax-payer through **sustainable efficiency** in delivering high quality dental care that minimises the impact of oral disease and prevents it in future generations.
- vi. Funding mechanisms should reflect the complexity of dental needs, with allocations matched appropriately to where a high quality service can be provided.
- vii. Appropriate **contextual frameworks** for the competition of services in regional and remote areas of Australia is considered so that user choice is maintained.
- viii. The full suite of **skill mix** within the dental profession is maximised to ensure that good quality dental care is provided at the lowest possible cost.

In NSW, the Priority Oral Health Program (POHP) serves to stratify health risk and dental needs among the eligible patient population and offers clinically acceptable waiting times. Although reporting against benchmark waiting times is internally reported to NSW Health, public reporting improves transparency but doesn't necessarily inform the public of efficiency without a detailed knowledge of how public dental services are resourced. As the AHHA argues, there are a number of constraints relating to public hospitals that can result in variations in performance.³ Furthermore, states and territories differ in the size and geographical location of populations. So publicly reporting performance against benchmark waiting times should be indexed according to differentials in population size, location and clinical complexity.

Healthcare performance should be measured against a hybrid of clinical outcome measures and Patient Reported Outcome Measures (PROMs) to guide higher level decision making over strategies that aim to improve quality of life. The final objective needs to focus on the patient, with social

investment as a key driver for delivering sustainable oral health. We would suggest that the Standard Set of PROMs for Oral Health devised by the International Consortium for Health Outcome Measurement (ICHOM) be amenable to a general consensus reached by all state and territory oral health committees prior to implementation to ensure they remain applicable to local populations and that benchmarks are achievable within the existing capabilities of local providers and infrastructure.

The common oral diseases (caries and periodontal disease) and those less common (e.g. oral carcinoma), are mostly preventable. Genuine prevention of these oral diseases is best directed using a population approach by qualified public health practitioners rather than at a granular level within individual practices which are not well placed to manage community-wide prevention programs. This would help to ensure that government expenditure on oral disease prevention is targeted appropriately towards patient groups most susceptible to oral disease because these groups are often most susceptible to poor general health. Consideration should also be given to the impact that other sectors have on oral disease and general health such as the food and retail industry in relation to the nutrition value and cariogenicity of foods and beverages that are made available and affordable to vulnerable groups. Further, whilst a preventative focus is important, the approach needs to be carefully considered. Knowledge gained from preventative approaches for other chronic diseases, which are increasing in prevalence such as diabetes, cardiovascular disease and obesity, needs to be analysed, so that errors are not repeated.

In NSW, public dental services are provided in a range of settings from small community clinics to large interdisciplinary tertiary and quaternary health facilities. Integrating dental care with other health care is essential as it facilitates a common risk factor approach, provides access to a “one stop shop” for health care, facilitates referral between health care providers, emphasises the importance of oral health in systemic health and provides sites for translational research and workforce development. Such integrated sites can range from primary health networks to large hospital sites. An example of the latter is in the Westmead Precinct, where both public and private patients with complex oral health needs are managed. Such sites are essential as they form the nidus for training of the entire dental workforce including general and specialist practitioners. It is necessary to ensure an appropriate case mix of patients remains available for the clinical training of tomorrow’s dental workforce. In NSW, the relationships between the public dental sector and academic institutions have been developed in some cases over 100 years with mutually beneficial outcomes of workforce development, patient care and clinically relevant research. Without the public dental sector functioning properly, training and education of oral health clinicians will become a challenge.⁴

The relationship between the academic and public dental sectors is very beneficial for the community. There are real and tangible benefits including direct patient care by student clinicians (approaching 500,000 hours of care by University of Sydney students), development and implementation of best practice informed by research, public sector workforce retention through expanded opportunities in teaching and, research and interdisciplinary care through student-led clinics.

Furthermore, there needs to be consideration of initiatives such as social impact investing, as defined by the NSW Government Office of Social Impact Investment (<http://www.osii.nsw.gov.au/what-is-social-impact-investing/>), "...seeks to generate social impact alongside financial return." This is characterised by opportunities to transform and improve health service delivery through a number of

⁴ Australian Dental Association NSW Branch 2016. [Submission] Productivity Commission preliminary findings report – Human Services: Identifying sectors for reform, available from http://www.pc.gov.au/data/assets/pdf_file/0005/209597/subpfr339-human-services-identifying-reform.pdf (accessed 4 July 2017)

mechanisms, which include: measurement and payment predicated on outcomes; employing innovation to establish incentives and eliminate controls of inputs on services; forming strategic partnerships across government and non-government sectors, such that risks and benefits are shared; and a change in investment strategy, in order to concentrate spending on prevention by shifting expenditure away from acute services, which have a tendency to be associated with high costs.

Lessons learned

A ‘blended payment model’ needs to be approached with both caution and precision. There were a number of lessons learned about clinical quality, perversion and accountability from the Enhanced Primary Care scheme/Chronic Dental Disease Scheme in Australia and National Health Service plan in the United Kingdom.

Enhanced Primary Dental Care Scheme (EPDCS) / Chronic Disease Dental Scheme (CDDS)

Aimed at improving access to primary health dentistry, utilisation of the Enhanced Primary Dental Care Scheme was significantly poor with approximately 16000 dental services submitted for processing between 2004 and 2007.¹ To encourage participation from the private sector, the program was replaced with the CDDS which increased the scope of dental services to include reconstructive services with a significant increase in capitated payments of up to \$4250 over 2 years in an attempt to reduce the impact of oral health disease for patients suffering from chronic diseases.¹ In the first year of the CDDS (2008-09), over 5 million services were processed with claims costing the government over \$1 billion.¹ The CDDS was initially budgeted to cost \$385 million over 4 years and from 2008 to 2013 expenditure totalled \$2.8 billion, with almost \$100 million spent per month in 2012.⁵ More than two thirds of the CDDS expenditure involved the provision of porcelain fused to metal crowns (non-preventive procedure) which was previously excluded under the EPDCS. CDDS data indicates that, on average, every second patient received a crown (with a fee representing one third to half of the \$4250 allocation), in comparison to one in every 400 patients receiving a diagnostic saliva test (preventive service).¹

Cost containment of the CDDS became difficult soon after the increase in scope of services and the ever increasing expenditure beyond the projected budget. This made the scheme unsustainable. Policy makers and decision makers should pay particular attention to prosthodontic and restorative services in order to control expenditure in a government funded scheme⁶ and ensure sustainability. Birch indicates that there is a ‘tendency’ among dentists to over treat patients where the dental care is covered by a third party⁷ and altruism (putting patient needs before one’s own interest) is found to deteriorate when healthcare becomes a financially oriented transaction.⁸ During the CDDS, Medicare conducted audits of participating private practitioners where the intense scrutiny of claims resulted in repayment of funds back to the government for practitioners claiming items not actually delivered _____

⁵ Crocombe LA, Kraatz J, Hoang H, Qin D & Godwin D 2015, ‘Costly chronic diseases: a retrospective analysis of Chronic Disease Dental Scheme expenditure’, *Australian Health Review*, 39: 448-452

⁶ Brocklehurst P, Price J, Glenny A, Tickle M, Birch S, Mertz E & Gryten J 2013, 'The effect of different methods of remuneration on the behaviour of primary care dentists', *Cochrane Database of Systematic Reviews*, 11: CD009853.pub2

⁷ Birch S 1988, 'The identification of supplier-inducement in a fixed priced system of health care provision: the case of dentistry in the United Kingdom', *Journal of Health Economics*, 7: 129-150

⁸ Holden ACL 2013, 'Justice and NHS dental treatment – is injustice rife in NHS dentistry?', *British Dental Journal*, 214(7): 335-337

and failing to formulate an appropriate treatment plan.¹

It is our understanding that some public patients who sought services in the private sector under the CDDS, returned to the public dental service with isolated reconstructive work in part of their mouths to manage the acute burden of disease and relieve pain and/or improve function. They had been advised to seek remaining treatment in the public system as the funds under their CDDS voucher had simply 'run out'. In many of these cases, patients found themselves stranded between conflicting professional opinions once returning to public dental care. In the absence of overall dental health, reconstructive and restorative dental work will fail.

Finally, there was disproportionate utilisation of the CDDS across Australian regions. Given that the oral health of Australians is poorest in areas outside of capital cities,⁹ one would expect greater utilisation of the CDDS in these areas, however, the reverse was apparent. In 2011, the greatest average number of dental services delivered per capita occurred in major cities (1.088) and this successively decreased across inner regional (0.757), outer regional (0.549) and remote/very remote areas (0.161).¹⁰ Fixed and removable prosthodontics and endodontics items (non-preventive services) per dental practitioner were most frequently delivered in major cities whereas basic restorative care and oral surgery were the most frequently supplied services per dentist in regional areas. This suggests that publicly funded dental care provided by the private sector may not improve the inequality in access to dental care.¹⁰

However, the CDDS was founded on sound principles and there is no reason why a similar national dental plan cannot benefit from the reclassification of funded service item codes that will distinguish between unnecessarily expensive care and those that will offer therapeutic value in controlling oral disease and, therefore, improving the general health and wellbeing of the population. With a preventive focus in mind, dental caries and periodontal disease should be treated as a priority and then ongoing access to basic dental care ensured. The Government funded public dental care delivered by the private sector needs proven assurance, through honest accountability and transparency, so that treatment remains preventive and primary care focused.

The current fee-for-service model rewards a fragmented approach to health care and a focus on reconstructive services because fee-per-item remuneration rewards these procedures well.⁶ It is accepted that such services are sometimes necessary, but need to be planned and delivered in the context of a broad set of health outcomes. Importantly, fee-for-service or indeed, course of care, models are not appropriate; instead a focus on health outcomes in a value-based health care model needs to be developed and implemented and evaluated.

⁹ Australian Institute of Health and Welfare 2009, *Geographic Variation in Oral Health and Use of Dental Services in the Australian Population 2004- 2006*. Adelaide: AIHW, Report No. 41

¹⁰ Kraatz J, Qin D, Hoang H, Godwin D & Crocombe LA 2014, 'Regional use of the Australian Chronic Disease Dental Scheme', *The Australian Journal of Rural Health*, 22: 310-315

Recommendations for Reform

We agree with the Productivity Commission that the contestability of public dental services has the potential to improve oral health and general health outcomes across communities using a blended payment model through carefully arranged public-private partnerships.

An efficient and value-based dental care system will deliver on sustained health outcomes and positive patient reported outcomes. These outcomes are influenced by equity in access to care and appropriate levels of care that are individually focused for improved quality of life. We offer the following recommendations for consideration by the Commonwealth Government:

1. A value-based health care model needs to be developed, implemented and evaluated. This will likely be a hybrid model which incentivises appropriately with a focus on broad range of health outcomes.
2. A public-private partnership will succeed if private practitioners and/or organisations remain accountable to providing publicly funded care in a continued fashion that demonstrably results in the sustained elimination and prevention of oral disease. We envisage the future of healthcare to be guided by Value Based Health Care with social impact investment that aims to improve patient outcomes and the financial sustainability of our health system.
3. Assessment of the oral disease status and oral health needs of patients can be undertaken within the public dental sector for the purposes of population health research and auditing.
4. Payments should be weighted based on the presenting complexity of patients for the same dental service item. For example, restorative work for a patient with special needs should earn a higher weighted payment than the same restorative work that presents little or no medical or dental complexity.
5. Private practitioners or organisations providing publicly funded dental care should be required to demonstrate compliance with minimum standards of safety and quality and this should be visible to the public to inform choice of where treatment will be received.
6. Participating private practitioners or organisations will be diligently monitored and subscribe to meaningful and regular reporting, prior to being accepted to participate in the public-private partnership.
7. Regular and detailed evaluation of the reformed structure in public dental care should include clinical performance outcomes and PROMs with cost-efficiency comparisons and a determination of the 'value' of care delivered.

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8. Public patients should be incentivised to receive a broader scope of publicly funded dental care from training dental professionals in public teaching hospitals so that workforce development is not impacted on by the competitive environment that results from a blended payment model.
 9. The strong and mutually beneficial relationships between academic institutions and public dental services needs to be considered with any reform to public dental services, as changes may reduce the benefits to the community.
 10. The Federal Government should make greater efforts to support workforce specialisation in public dental health and consider greater investment in public dental health research to guide future strategic directions within the health portfolio of Federal and State Governments. In 2010, less than 5% of dental specialists in Australia were recognised in public health dentistry.¹

We offer continued involvement and field expertise to support the Productivity Commission's Inquiry into the Reform of Human Services in relation to public dental health services. The opportunity to participate in future discussions with other key stakeholders is also welcomed.

Sincerely,

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