



EXCL

ABN 98 729 112 634
6-8 Snapshot Drive
Coburg North VIC 3058
AUSTRALIA

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

30th January 2017

Dear Commissioner,

I am writing in response to the Productivity Commission regarding opportunities for Reform to Human Services.

My professional expertise is in public health dentistry, and the perspective I provide is that of my own opinion in the Victorian context. I am registered oral health therapist. I hold numerous appointments including as Honorary Fellow at Deakin University, Clinical Educator at The University of Melbourne, and President of the Australian Dental and Oral Health Therapists Association.

It is commendable that the Productivity Commission has included public dental services in the second phase of the review. This is due to the fact that the agenda of oral health has never had a consistent evidence-based policy direction in Australia, partly due to the shared responsibilities of the Federal Government and the State/Territory Governments, and different priorities at the time by the Federal Government. The format of my feedback will be in order on the questions requested by the Productivity Commission.

The Commission is seeking information on the effectiveness of public dental services in improving outcomes for patients, including:

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

I agree the existing eligibility criteria are targeted towards population groups at most-risk for oral diseases. Given the current funding constraints for the provision of public dental services, the limited amount of funding should be direct to populations who are unable to afford private general dental services.

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

Public dental services are limited by the way in which it is funded. In the absence of appropriate health outcome measures, dental treatment services are usually provided as fee-for-service model. This model does not focus on prevention.¹ In addition, consumers of public dental services have less control on their preference of their dental practitioner (inclusive of dentists, dental hygienists, dental therapists and oral health therapists), how frequently they can be and should be seen (regular dental check-up/review), where they can

¹ Victorian Auditor General's Office, Access to Public Dental Services in Victoria, PP No 227, Session 2014–16, Victoria Government Printer, Melbourne, 2016, p. ix.

receive dental services (location), and the type of services they receive. However, it should be clear the any dental treatment service that can be and should be provided must be at both the interest of the consumer and the societal consideration on the limited resources to achieve 'value for money'. There is a need to review how public dental services should be provided both in terms of the appropriate balance of the oral health workforce other than that of dentists,² location to receive services, how often they should receive dental services, what type of dental treatment services the government should fund, and how it is funded with the appropriate incentives and disincentives.

- *the scope to improve accountability through more public reporting, including on patient outcomes and cost effectiveness*

The accountability for public reporting is one of the least areas of concern. This is primarily due to the fact that current measures on patient outcomes and cost-effectiveness lack the support of the funding model (i.e. fee-for-service model). There is very limited research that has incorporated economic evaluation techniques in dentistry^{3,4} to inform appropriate measures to quantify the quality and efficiency of public dental services. Traditional measures of high performance have used the length of dental waiting list for benchmarking. Such measures in reality only determine the current dental service demand, rather than the performance of quality and efficiency of the organisation.

- *the quality and efficiency of public dental services, and how this differs across public and private providers, regions and jurisdictions.*

As I highlighted earlier, there is a significant gap in health services research in public health dentistry, particularly in Australia. I have experiences in both public and private dental practice; each sector has their advantages and disadvantages. Some of them are highlighted below. It is not an exhaustive list.

Public Sector

- | | |
|---------------|--|
| Advantages: | <ol style="list-style-type: none">1. Enhanced 'economy of scale' to provide dental services2. Established internal processes of dental practitioner performance review3. Minimal out-of-pocket expenses to the patient |
| Disadvantages | <ol style="list-style-type: none">1. Long dental waiting lists for adults including for specialist services2. Availability for dental appointments for dental treatment can be up to 3 months3. More limited range of dental equipment available constrained by capital funding (eg. 3D digital dental radiography)4. Minimal incentives for consumers to engage in improving self-care due to minimal out-of-pocket expenses to the patient5. Lower range of dental services that could be provided, which may be the patient's preference (eg. dental implants)6. Innovation of service delivery constrained by organisational policy |

² Victorian Auditor General's Office, 2016, p. x.

³ M. Morgan Met al., 'Economic evaluation of preventive dental programs: what can they tell us?' *Community Dent Oral Epidemiol*, vol. 40, Suppl 2, 2012, p 120.

⁴ U. Tonmukayakul, et al, 'Systematic Review and Quality Appraisal of Economic Evaluation Publications in Dentistry, *J Dent Res*, vol. 94, no. 10, 2015, p. 1353.

Private Sector

Advantages:	<ol style="list-style-type: none">1. Personalised dental care (eg. usually dental care is provided by the same dental practitioner)2. Location of private dental clinic can be in closer proximity to the patient than public dental clinic3. No adult general and denture waiting lists4. Greater flexibility for innovation of service delivery
Disadvantages	<ol style="list-style-type: none">1. High out-of-pocket expenses to patient2. Lacks performance review processes (usually dependent on the initiative of the business owner/corporation)3. Less efficient delivery of dental services due to, on average, smaller dental practice sizes4. Patient records not linked externally, resulting in negligible reporting on patient outcomes and service output5. No incentives to refer patients to the public sector for relevant services except for good will

The Commission is seeking information on the potential to give public dental patients greater choice between competing providers. This includes information on:

- *whether increased choice would lead to better outcomes for users, and how this would differ between patient populations and regions*

It is regarded within the oral health profession that there are generally accepted expertise of all members of the dental team inclusive of dental specialists, dentists, dental hygienists, dental therapists and oral health therapists.

Dental specialists clearly have unique skills sets that separate them from general dental practitioners. However, their employment is typically in larger public dental agencies such as the Royal Dental Hospital of Melbourne. Due to low utilisation of dental specialists to contain costs shifted towards general dentistry, consumer choice to seek these providers is limited in the public sector.

Dentists provide a broad range of dental services. Due to their scope of practice is unrestricted within the definition of dentistry. They are the most flexible provider of dental services. However, their training is predominately focused on surgical management of oral conditions, which to a modest extent, may not lead to sustainable outcomes for users, particularly if interventions are surgically focused.

Dental hygienists typically are the least employed in the public sector. This is the result of the traditional focus of public dentistry is on dental caries (tooth decay), not periodontal diseases (gum diseases), which is the area expertise of this profession. Despite this, severe periodontal diseases are highly prevalent in the adult population.

Dental therapists have traditionally been employed in the public sector, resulting from the primary focus for the management of dental caries for the child population through School Dental Services.

Oral health therapists provide dental care across the age continuum as part of dual qualified roles of the dental hygienist and dental therapist. Their university training is optimally delivered to meet the community demand as a result of their focus in oral disease prevention and health promotion.

It is arguable that informed user choice, would create efficiencies in service delivery and health outcomes for consumers. The review by the Victorian Auditor-General Office on public dental services recognises that:

‘To achieve a cost-effective system, the most resource-intensive staff (dentists) should focus on the most complex and difficult types of services, such as treatment. The least expensive staff should carry out other services that they can be trained to deliver safely and competently, such as oral health education’.⁵

There are inherent barriers to achieving cost-effectiveness in the delivery of public dental services even if there is an increase of choice of dental providers. Operationally, oral health program managers have autonomy in how they delivery dental services. Some dental clinics employ only dentists, whilst others employ a varied mix of other dental practitioners. In addition, patients have very little decision making with regards to who they see first by dental practitioner type, and the continuity of care is dependent on the availability of dental appointments of the responsible treating dental practitioner, especially if they work less than 0.5 full-time equivalent. Patients who receive dental check-up for a dental recall (a regular dental check-up) are generally booked with the next available dental practitioner by the dental reception team, not the original treating dental practitioner. Some community dental agencies have been able to optimise the efficiency of dental services by booking children to see the dental or oral health therapist, and dentists to see adult emergency patients only.

• *lessons from current and past voucher schemes in Australia and other countries, and how they could be redesigned to put greater emphasis on placing users at the heart of service delivery rather than as a means to utilise short-term funding to reduce waiting lists*

The previous ceased Chronic Disease Dental Scheme (CDDS) was a voucher scheme that enabled eligible adults \$4,250 value of dental treatment, who were vetted by their general practitioners (doctor). The scheme has been criticised by public health advocates⁶ because:

- 1) Those eligible may not necessary be at-risk for oral diseases
- 2) There were risks to fraudulent claims by dentists
- 3) The provision of dental services may not necessarily relevant to improving health
- 4) The costs to fund the scheme was extremely expensive

When the CDDS was ceased, the federal government then implemented the Medicare Teen Dental Plan (MTDP). It enabled eligible adolescents aged 12-17 yearly preventive dental services up to \$150 value, indexed annually. The scheme in principle met objectives of population health because is focused on the prevention and management of oral diseases. However, there were criticisms it was not sufficient because many eligible children still required surgical management of dental caries, which was not included in the scheme.

Public dental health activists provided recommendation to the government how the MTDP could be enhanced, particularly to increase funding to include greater numbers of the eligible population, and to include other permitted dental treatment services that could be reimbursed. The MTDP eventually became redundant and replaced by the Child Dental Benefits Schedule (CDBS), currently still in effect. Major revisions to the legislation included the eligible population of 2-17 years old, and capped benefit of \$1,000 over two years, and extended broader range of dental services. There were important advantages of the changes, however, the current federal government still pursued to cut the scheme to reduce

⁵ VAGO, 2016 op cit. p. 36.

⁶ A. Biggs, ‘Stalemate looms over closure of chronic disease dental scheme’, *Australian Government* [website], 11 November 2011, <http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/FlagPost/2011/November/Stalemate_looms_over_closure_of_chronic_disease_dental_scheme>, access 27 January 2017.

the overall government budget deficit, resulting in a reduced capped amount to \$700 as of January 1, 2017.

It is evident from past voucher schemes, that there has not been sufficient mitigation of risk assessment of current and past voucher schemes in Australia. This may be due to the inherent problem that the fee-for-service model is not linked to health outcome measures and that the inclusion of permitted services did not undergo a comprehensive literature review to determine its 'value for money'. For example, dental practitioners may be spending as much as 70% of their time replacing (and re-replacing) defective fillings,⁷ which does not manage dental caries biologically, leading to an inefficient delivery of primary health care. Dental treatment procedures such as root canal is time consuming and expensive, which only 'saves' one tooth from being removed surgically. We compare this to topical fluoride therapies, which has been proven to reduce dental caries prevalence by 37-43%.⁸

- *mechanisms other than voucher schemes that could give users greater choice between providers*

The involvement of the private health insurance as 'extras cover' certainly has played a role in consumers receiving and funding private dental services. Children who are insured are more likely to have favourable dental attendance patterns, and visited private practice.⁹ However, there are lessons that can be learnt, which should be considered with reforms to public dental services.

Many private health insurers allow for consumers to choose their dental providers, where they contribute towards a percentage towards the cost of dental services. This is ideal in a free market as an alternative method to voucher schemes. But in the current market, there are some private health insurers who either run their own dental clinics as 'preferred providers', or contract other independent practices to be preferred providers. Preferred providers typically provide higher rebates to the consumer in comparison to non-preferred providers. This is problematic because the market can be largely controlled by large corporations leading to coercion, limiting the freedom of choice, and reduction in contestability and competition between dental providers. This may affect the quality of care due to consumers being constrained financially to seek dental services by a preferred provider to undertake riskier dental procedures, which otherwise should be provided by a non-preferred provider.

In Sweden, all children under 20 years old are eligible for free dental treatment services. For the adult population, the National Dental Insurance scheme was implemented from 1974, which provides insurance coverage as a certain percentage of expenditure thresholds by the consumer. Fees are based on fixed pricing per treatment or time-based for preventive care. From 1999, patients are eligible for dental insurance at 30% of the costs of clinical care, which includes only 'basic dental care'.¹⁰ The range of service provided includes extractions, root canal treatment, and dental fillings. This model of care in effect is similar to private health insurance coverage for dental services in Australia. The incorporation of this type of model in Australia was proposed under Denticare by the National Health and Hospitals Reform Commission in 2009. There is merit by the Productivity Commission to review this

⁷ M. Tyas, et al, 'Minimal Intervention Dentistry - a review: FDI Commission Project 1-97', *International Dental Journal*, vol. 50, p. 10.

⁸ V.C.C. Marinho, et al., 'Fluoride varnishes for preventing dental caries in children and adolescents', *Cochrane Database of Systematic Reviews*, 2013; Issue 7. Art. No.: CD002279. DOI: 10.1002/14651858.CD002279.pub2, p. 3.

⁹ J.E. Harford & L. Luzzi, *Child and teenager oral health and dental visiting: Results from the National Dental Telephone Interview Survey 2010*, Dental Statistics and Research Series no. 64, Australian Institute of Health and Welfare, Canberra, 2013, p. 15.

¹⁰ G.L. Tayanin, 'Oral Health Care System and Services', *Malmö University* [website], <<https://www.mah.se/CAPP/Country-Oral-Health-Profiles/EURO/Sweden/Oral-Health-Care-System-and-Services/>>, accessed 27 January 2017.

original proposal. Under a health insurance model, there are incentives for the consumer to improve their health via self-care management plans, and disincentives for dental practitioners to over-diagnose oral diseases that require surgical dental treatment.

- *whether additional regulations and monitoring arrangements are required to protect consumers*

Providers of public dental services are usually accredited by the relevant authority, largely through high levels of good governance. Many notifiable concerns on the dental profession are about infection control, communication and quality of care. The incidents of such events are significantly low, are of low risk to health, and attributed (anecdotally) within the private sector. It would be inefficient to impose similar quality accreditation standards of public dental agencies to the private sector, because such regulative instruments are already in place to protect the public, including matters undertaken by the Dental Board of Australia, and the Health Services Commissioner (Victoria).

- *the costs and benefits of giving public dental patients greater choice, and their distribution between users and governments.*

There is a real risk that if consumers of public dental services were given greater choice, they would choose to seek care through private practice. This is due to the perception that public dentistry is 'poor dentistry', making community dental agencies potentially redundant. For many patients, even out-of-pocket expenses under Denticare could be too expensive, leaving them no options but to be treated in the public sector. For users of public dental services in rural and remote access, access to timely dental services would be a challenge. We could make allowances for certain population groups to be fee exempted. We need to be mindful that services provided in the private sector are not necessarily superior to the public sector. To minimise the public perception that public sector dentistry is 'poor dentistry', it would be beneficial to merge the markets of 'public' and 'private' sector dentistry. This has largely been achieved in Sweden through the National Dental Insurance scheme.

The Commission is seeking information on differences in public dental services provided by the public and private sectors, including:

- *differences in the unit cost, number and mix of services provided to public patients, and the causes of such differences*

Some of the causes of the differences in the unit cost, number and mix of services provided to public patients include the following factors:

- Large dental services sites typically provided by public dental agencies are able to capitalise on obtaining more competitively priced consumables at public sector fees
- The willingness-to-pay and willingness-to-accept alternative dental treatment options through private fees by public patients may influence preference on treatment decisions. For example, a tooth requiring a large filling could be provided under the public scheme but has significant risks for future failure, compared to an onlay or full coverage crown, where the risks of treatment failure significantly reduced, but the costs is not covered by the public scheme
- Private dental practices may have greater accessibility to various dental technologies not available at some public dental agencies.
- The unit cost and mix of services is also dependant on the types of dental practitioners employed. Many private practices do not employ dental hygienists, dental therapists or oral health therapists.
- Employed dentists in the private sector may have special interests in certain areas of dentistry, therefore, could provide dental treatment services that would have been otherwise been referred to the Royal Dental Hospital of Melbourne. For example, oral surgery and special needs dentistry.

- *issues that would need to be addressed to ensure that clinically- and cost-effective services are delivered to public patients if there were greater private sector provision of public dental services.*

The major issue that will need to be addressed to promote clinically appropriate and cost-effective delivery of public dental services, including greater private sector participation, is the development of a funding mechanism that are linked to patient outcomes.

Under the current implementation of the CDBS, the philosophy to include dental services as part of Medicare is valuable. However, the fee-for-service model is not linked to patient outcomes. Now into the 1st cycle of the scheme, some of the issues are outlined below:

- There is a low percentage of the eligible population utilising the CDBS, estimated to be 30%. This appears to be the result of the scheme being under-promoted, and/or 'voucher schemes' are not clearly understood by the target population.¹¹
- Some children receive dental services through 'preschool/school-based dental screening' programs. Dental practitioners can claim for services as per the program requirements, however, many children who need dental treatment are simply given a letter for the primary carer to seek follow-up dental treatment at a dental clinic of their choice. This creates no continuity of care, and there are significant inefficiencies for referred children to require a re-examination by another dental practitioner. The legitimacy of obtaining informed consent should also be questioned for children who receive dental services such as an examination and topical fluoride treatment without the primary carer in attendance. This occurs in many dental screening programs.
- There is certain service claiming restrictions defined under the CDBS. For example, a regular dental check-up and topical fluoride treatment is claimable only every 6 months. From personal experiences, there are issues for claiming dental treatment services under the scheme. For some children who have seen another dental practitioner and decided to seek dental treatment elsewhere, claims may be rejected by the new treating dental practitioner due to these claiming restrictions. This is unfair to both the patient who may be required to pay out-of-pocket expenses to cover these costs, and the treating dental practitioner. They would provide the dental treatment in good faith and could feel pressured to waive the rejected claim as a result of the restrictions.
- The claimable fee attributed to the item codes is based on the fee schedule under the Department of Veterans' Affairs (DVA) for dental services. The CDBS fee schedule is only slightly less than the DVA, which largely overestimates the costs to provide such services. Oral disease patterns between adults and children are different. Thus, it is not cost-effective to set the CDBS fees that do not reflect the complexity and time required to perform the procedure compared to adult patients. For example, the complexity and time utilised for a scale and clean for an adult patient is significantly different to one provided for a child patient. From professional experience, scale and clean procedures for children (if required) is at least half of that compared to adults.
- Inefficiencies are likely to occur if dental treatment services are provided in a fee-for-service model. There are currently 15 different item codes for dental restorations (dental fillings). The result is increased complexity when dealing with permitted claimable items for one treatment that relates to multiple item codes. There is a need to standardised item codes that relate to health outcomes. For example, a tooth requiring a large restoration (dental filling) which required item codes 88411 and 88432, could simply be merged under one item code. For regular dental check-up and preventive care, item codes 88012, 88022, 88114, 88121, could be merged as one item code. These item codes cover a dental check-up, diagnostic radiographs, a

¹¹ Australian National Audit Office, Administration of the Child Dental Benefits Schedule, Australian Government, Canberra, 2015, p. 39.

scale and clean and topical fluoride application. Commonly, these services are provided in one visit.

- There are inefficiencies for the dental reception and oral health program managers to check the eligibility of child patients under the CDBS. Confusion arises when either 1) children have exhausted all their dental treatment funds and/or 2) children were eligible at the time of the dental appointment being scheduled, but by the time of their dental appointment, they have become ineligible for various reasons.

The Commission is seeking input on the information needed to facilitate greater competition, contestability or user choice in public dental services, including:

- *the information users would need to make informed choices, how this varies by user group, and how the data should be presented and provided*

Greater public reporting on patient outcomes and cost-effectiveness may not necessarily lead to beneficial outcomes. This is due to the fact that there is limited published work to define appropriate outcome measures, and what is considered 'cost-effective'. To date, there is no standard (or benchmark) on the acceptable willingness-to-pay towards the management of oral diseases from a health service perspective, unlike treatment for other health conditions which has had extensive work. Willingness-to-pay thresholds provide guidance to evaluate interventions and technologies. If the cost per quality of life gain is lower than the threshold, generally to standard practice/care, then there is evidence that the intervention or technology should be adopted. My area of research has shown evidence outreach school-based dental check-up programs are less costly and more effective than standard care dental services.¹² There is a strong need to develop more research evidence to bridge the gaps in the evidence.

Any additional information of public reporting that could be useful for users may be limited. Patient expectations are generally based several factors: 1) can they see a dental practitioner timely relative to their dental concerns, 2) do they feel comfortable with the treating dental practitioner, 3) can the treating dental practitioner can resolve their concerns and/or be able to organise a management plan, 4) the service they receive is understood to be valuable, and 4) the cost of care is a minimal as possible. Given these parameters, additional public reporting may not be clinically relevant to the majority of users of public dental services.

- *how barriers to greater public reporting on patient outcomes and cost effectiveness could be overcome, including changes needed to collect and provide relevant information to users*

To overcome barriers to greater public reporting, the Productivity Commission should refer to the report on Access to Public Dental Services in Victoria, released by the Victorian Auditor-General's Office in 2016.

- *the information needed to monitor and evaluate service providers and the treatments provided to public patients.*

I recommend the following information is necessary for performance monitoring:

- 1) Patient's oral disease risk status: The provision of dental treatment services is intended to promote and maintain oral health. Thus, it is important to track and monitor over time if patient's oral disease risk has improved, including information on improved quality of life. The modifications of risk factors for oral diseases would lead to improved health outcomes and lower clinical costs of care. This includes common risk factor interventions like smoking cessation and dietary counselling.

¹² Nguyen, T.M., Hsueh, A., Morgan, M., Mariño, R. & Koshy, S., 'Economic Evaluation of a Pilot Targeted School-Based Dental Check-up Program' Journal of Dental Research, vol. 95, Spec Iss B:abstract number 0330, 2016, (www.iadr.org).

- 2) Type of dental services provided: The type of dental treatment services provided is beneficial to measure clinical performance. Whilst some services is difficult to measure quality, (such as the diagnostic skills of the dental practitioner), relative frequencies of re-treatment can identify quality performance. For example, we would expect a dental restorations (dental filling) to be functional and survive at least 5 years before being re-treated.
- 3) Any dental treatment adverse events: This is important to monitor quality of care and consistency of care, and to minimise public health risk such as poor infection control.
- 4) Patient complaints and feedback: This is essential from a user perspective to provide constructive feedback for quality/performance improvement for the dental practice/dental practitioner.

Commission is seeking information on whether and how public dental services could be made more contestable, including:

- *lessons from past commissioning of public dental services*

I fail to see how existing providers of public dental services should be subject to contestability given the significant amount of public good they do to the community. Their philosophy of health care is different to that of the private sector, which makes them ideal to negotiate and be drivers of primary health care that meets the needs of the community that they serve. The private sector has different motivations; therefore, thoughtful care is necessary to ensure the tendering process for the private sector should involve local champions of community dental agencies, and the local Primary Healthcare Network.

- *the models of tendering that would best suit different services, patients and settings*

The Productivity Commission may wish to seek the current processes on tendering that occurs in New Zealand for the private sector to provide public dental services. Public dental services in New Zealand are commissioned by district boards. Adolescents up to age 18 receive dental services in the private sector.¹³

- *the design of tender processes and management of contracts, such as the length of contracts, the coverage of services, and how to adequately define services and monitor outcomes*

The Productivity Commission may wish to seek the existing the federal government tendering program on Dental Relocation and Infrastructure Support Scheme (NRISS). However, unlike the NRISS, any tendering should be open and transparent to include private dental practices that are owned and operated by non-dentists. There are many successful dental practices and partnerships owned by dental hygienists, dental therapists and oral health therapists. The length of contracts should be sufficient enough to collect and evaluate performance, ideally, at least two years.

The coverage of dental services should be subject to an independent review of the Child Dental Benefits Schedule and the Department of Veterans' Affairs', consistent with the objectives of the Medicare Benefits Schedule Review to improve efficiency and promote oral health outcomes that are meaningful. This will lead to more fiscal financial sustainability of public dental program funding. There are both costs and health gain outcomes that could be achieve through this process.

- *the costs and benefits of more contestable arrangements, and their distribution between users and governments.*

There are benefits to contestable arrangements for investing in the private sector to provide public dental services. Providers of public dental services in Victoria are already de-

¹³ Minister of Health, 'Visiting a dentist', *New Zealand Government* [website], <<http://www.health.govt.nz/new-zealand-health-system/publicly-funded-health-and-disability-services/visiting-dentist>>, accessed 27 January 2017.

centralised, whereby they are considered independent entities, and have autonomy to provide private dental services. Many publicly funded agencies provide dental services through a private practice model. Naturally, utilising the infrastructure resources of private practice saves costs to deliver dental services that are beyond the current capacity of the public sector. Thus, government funding can purely focus on funding service delivery, and not on capital funding. The costs to undertake a tender process for contestability would vary depending on the scale in which the federal and state/territory government is willing to commit in expanding the current funding arrangements.

The Commission is seeking information on the implementation of reforms to increase competition, contestability and user choice in public dental services, including:

- *the role of alternative payment models for providers, such as capitation payments, and how different models affect incentives for users and providers*

The type of payment models is instrumental in how users seek dental services, and how dental practitioners provide dental treatment services. A literature review suggests that capitation payments decreases restorative treatment, decreases dental caries incidence, and increases preventive care.¹⁴ This trend is supported by a recent study in Sweden, supporting correlations that a fee-for-service model has a 1.5 increase in dental caries incidence compared to a capitation model, over a six year period.¹⁵ Patients were more satisfied with the capitation payments model compared to the fee-for-service model (98% vs 85%).¹⁶ However, there is limited information whether such services are matched to quality of services and patient outcomes.

A capitation payment model has been tested for a cohort of children in New South Wales. The research suggests that a diagnostic capitation pathway according to paediatric age groups and active caries experience can address individual needs with a prevention focus and was financially attractive to non-government organisations.¹⁷ Dental treatment needs between different populations groups vary. Thus, it is no surprise that the level of capitation payments need to reflect these differences, which was confirmed by large population study in the United Kingdom.¹⁸

- *changes in how demand is managed*

In Victoria, patient demand for public dental services is categorised into five types of dental care: 1) emergency dental care, 2) adult general care, 3) child general care, 4) specialist dental care, and 5) removable prosthetic dental care. For children, once they have receive a complete course of general care, they are placed on a dental recall for 12-months, 18-months or 24-months depending on their dental caries risk, for a regular dental check-up. Adult patients typically wait up to three years to receive general dental care. For adults who have completed a course of general care, they need re-add their name on the waiting list.

Based on the international evidence, it is clear that this model of care is insufficient to meet the needs of patient because many people who are at high-risk for dental caries need to be seen more frequently, as much as every 3 months.¹⁹ Since a large majority of time is spent

¹⁴ V. Johansson, et al., 'Financial systems' impact on dental care; a review of fee-for-service and capitation systems', *Community Dental Health*, vol. 24, no. 1, 2007, p. 18.

¹⁵ C. Andås & M. Hakeberg, 'Payment systems and oral health in Swedish dental care: Observations over six years', *Community Dental Health*, vol. 33, no. 4, 2016, p. 259.

¹⁶ M. Hakeberg & U. Wide Boman, 'Patient characteristics in relation to dental care payment model: capitation vs fee for service', *Community Dental Health*, vol. 33, no. 4, 2016, p. 254.

¹⁷ J. Conquest, et al., 'Design of an innovative paediatric capitation payment approach for public sector dentistry: an Australian experience', *International Dental Journal*, vol. 66, no. 1, 2015, p. 37.

¹⁸ M. Busby, et al., 'The relationship between oral health risk and disease status and age, and the significance for general dental practice funding by capitation', *British Dental Journal*, vol. 217, no. 10, 2014, p. 5.

¹⁹ N.B., Pitts, et al., *International Caries Classification and Management System: Guide for Practitioners and Educators*, London, 2014, p. 29.

on repairing or replacing dental fillings due to dental caries, there is a need to shift towards a funding model that focuses on prevention.

I would suggest that a policy change whereby the eligible adult population of public dental services receive direct access to preventive dental care with no waiting list, and any emergency care should be prioritised. All other non-urgent restorative care should be deferred, and patients are then placed on another waiting list for restorative care. As a result of shifting towards preventive care, patients are more likely and motivated to self-manage their oral health. This replaces the alternative of standard practice, where adult patients continue to wait up to three years for dental treatment. Their oral health would continue to decline since there is no intermediary preventive model of care to promote self-care for oral diseases that are largely preventable.

- *whether workforce reforms are needed to enable more effective use of dental professionals in the private and public sectors*

There is a community need for workforce reform to enable more effective use of all members of the dental team, including dental nurses. A majority of dental nurses only complete Certificate III in Dental Assisting. Their role can be expanded to other areas of dentistry including dental radiography and oral health promotion. The expanded scope of practice skills would complement the care pathway of patients, and support the clinical role of dentists, dental hygienists, dental therapists and oral health therapists.

Models of care in the private sector and public sector vary, which is rooted in the traditional ways in which dental practitioners are utilised. In the public sector, dental therapists and oral health therapists practice autonomously like independent dental practitioners. In contrast, the private sector typically has the dentist to delegate dental treatment services like scale and clean, take dental radiographs, and provide dental restorations to the dental hygienist or oral health therapist. For example, the dental hygienist or oral health therapist would perform a scale and clean, while the dentist will come into the surgery to perform a dental check-up up to 10 minutes, and then leave to attend to their own scheduled patients. This model of care creates inefficiencies because the dental hygienist or oral health therapist can already perform a dental check-up as part of their current scope of practice. There is a call to review the current scope of practice of dental hygienists, dental therapists and oral health therapists to be independent practitioners.²⁰ The scope of practice for dental hygienists, dental therapists and oral health therapists will be reviewed by the DBA in later 2017.

If there is proposed legislation to introduce Denticare or alternative funding models for the public dental services, there is a need to ensure independent practice status is issued to dental hygienists, dental therapists and oral health therapists to facilitate service delivery and monitoring. Currently, dental services provided by these dental practitioners are masked by a practicing dentist, which does little to assure appropriate billing of claims, accountability for dental services rendered, and heightened anxiety borne by the practicing dentist. Fundamentally, the practice is illegally fraudulent from an external point of view.

- *changes in training arrangements for dental professionals, including possible alternative models of training*

The current arrangement for training dental professionals is largely consistent for dentists; however, there are State/Territory differences for the training of oral health therapists. Very few dental programs provide training for dental therapists and dental hygienists. Oral health therapists generally have restricted scope of practice to provide dental restorations to persons under 18 years old, with the exception in Victoria permitting age extended to under 26 years old for some time. In the last five years, the oral health therapy scope of practice currently has no age restrictions to provide dental restorations, but formal training must be obtained to be legally recognised extending individual scope of practice.

²⁰ Health Workforce Australia, Scope of practice review: Oral Health Practitioners, Adelaide, 2011, p. 11.

Currently, not all university bachelor degree in oral health therapy provide training with exempted age restrictions for restorative care, and are subjected to the onerous program accreditation by the Australian Dental Council. Only two approved postgraduate certificate course programs provide the extension of scope of practice (The University of Melbourne and The University of Adelaide). One may argue that there is little difference between the complexity of oral health issues of a 25 year old and a 30 year old, although the theory of oral disease management is applicable across all age groups. I would support interim provisions to extend the scope of practice for dental therapists and oral health therapists without formal qualifications, to rapidly upskill the current dental workforce to meet the community needs in providing a life-course approach to dental services.

My experiences from the public sector supports efficiency gains can be achieved by using the full scope of practice of all members of the dental team. For example, oral health therapists with expanded scope of practice will be able to see emergency patients if their patient booked as part of the normal scheduled appointments fail to attend their dental appointment. This relieves the pressure for dentists who would traditional see all emergency patients due to their reliance of flexibility in scope of practice. Patients could be seen for emergency care earlier by an oral health therapist than anticipated if there are no dentists available to see them.

I welcome the Productivity Commission to be in contact with me for clarifying any discussion points raised in this submission, and I look forward to an outcome that would provide recommendations actionable to benefit all Australians.

Yours sincerely,

Mr Tan Nguyen
Honorary Fellow, Deakin University
Clinical Educator, The University of Melbourne
Oral Health Therapist, Coburg Hill Oral Care
Director, DEXCL
BOraHlth GCertDentThrpy MPH (Mel) MSc (Clin Ed) (Edin)