



The National Oral Health Alliance (NOHA) provides the following comments in response to the Productivity Commission Draft Report - Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services. Specifically the comments relate to section 10 Public Dental Services.

| Key points from Productivity Commission report | NOHA Response |
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| | <p>Overall context This response from NOHA starts from this understanding of the current oral health care sector in Australia.</p> <ul style="list-style-type: none"> • It is the sector with the greatest inequities in access in terms of geography and affordability in the whole health sector (e.g. the highest out of pocket consumer expenses) • It is the sector with a large private sector but also the greatest divide between private and public services • It has a high quality workforce but this is maldistributed relative to need • There is a relatively low focus on prevention and early intervention, mainly caused by funding structures which act as effective barriers in this regard |
| <p>Public dental services do not focus on the prevention and early intervention needed to improve Australia's oral health.</p> | <p>NOHA strongly agrees that the current 'system'* does not focus adequately on either of these key aspects of care – at least for adults. Some jurisdictions have included prevention in their public children's dental services This is driven by:</p> <ul style="list-style-type: none"> • funding mechanisms which place relatively low priority on prevention (e.g. fee-for-service in the private sector and a focus on emergency treatment in the overloaded public sector) • inadequate use of the primary health care, maternal and child health, schools and aged care services sectors in basic prevention, basic monitoring and referrals <p>In public dental services, the current funding model in Australian dentistry places the focus on throughput of patients rather than sustained oral health outcomes being achieved. The most effective way to address this concern is to have an agreed set of oral health outcome indicators and the</p> |

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| | <p>necessary data collection processes to support assessment against this framework. As a first step in this regard, Dental Health Services Victoria is currently developing a set of oral health outcome indicators with the International Consortium for Health Outcomes Measurement (ICHOM).</p> <p>* This is an area where considerable leadership is needed nationally, and urgently. NOHA notes that Australia does not really have an oral health 'system' except by default. There is fragmented service delivery, poor allocation of resources relative to need, a lack of uniformity of care and access, no overall responsibility for outcomes and no overall planning across public and private sectors, and divided (and not necessarily compatible) funding responsibilities.</p> |
| <p>Patients lack choice and too often require emergency and invasive restorative treatments. Reforms to improve and support choice, better identify patient need and to focus public dental providers on timely minimally invasive intervention, can improve patient outcomes.</p> | <p>High to medium income earners in metropolitan or regional cities typically have a choice of private providers. However, about half the population (those with less than average incomes, without private health insurance or living in rural Australia) lack reasonable access to any timely and affordable care, let alone a reasonable choice of providers. Given one third of the population is eligible for public care, the public sector funding of approximately 7.9% of the annual national spend on oral health is hopelessly inadequate to meet need. It results in totally unsatisfactorily long waiting lists and a focus on emergency care. The private system, while offering high quality care in most circumstances, has evolved as a high-end model of service delivery and is therefore similarly expensive. Out-of-pocket costs for dental care are estimated at 61% of total costs, compared to an average of 17% for the whole health system. These levels of private cost and long public waiting lists therefore exclude a significant proportion of the population from timely, regular and appropriate access to preventive and conservative care.</p> <p>Disadvantaged populations include hard to reach vulnerable communities. The challenge is to identify the most appropriate response to not only treating oral disease in these communities, but, just as importantly, providing effective preventive oral healthcare. The public sector has a major role in facilitating prevention through a range of health promotion programs, a role not within the scope of individual private providers who are instead focused on the provision of patient care While evaluation of these programs is not comprehensive, there is evidence of positive impacts on oral health outcomes associated with these preventive health measures.</p> |

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| <p>Services exist in a silo, with little integration with the broader health system.</p> | <p>With the notable exception of Victorian community health services, and several Aboriginal Medical Services, few dental services are integrated into general primary health care services where oral health needs can be seen in the context of people’s broader social context and other relevant health needs.</p> <p>There is little history of significant cooperation and collaboration between the oral health professions and primary health care services (GPs for example) such as regular exchanges of information (dental practitioners can identify early signs of some chronic conditions) or joint access to relevant patient data.</p> |
| <p>Short-term funding boosts in recent years have improved access to public dental care, but have done little to ‘break the cycle’ of problem-based treatment and repair.</p> | <p>Whilst the introduction (and recent retention) of the Child Dental Benefits Schedule has been welcomed by NOHA as potentially increasing access to care for children, NOHA also recognises that the scheme has been poorly promoted, under-used and to some extent inadequately targeted. NOHA has proposed a range of improvements around promotion, data collection and analysis to improve the scheme through better targeted promotion and more appropriate prevention-focused and personalised models of care.</p> <p>At the same time, Commonwealth funding for adult public oral health services has been gradually reduced over recent years and this is once again increasing waiting lists in the State-run services. Equally it can be argued that the States and Territories have historically under-funded oral health services relative to need.</p> |
| <p>Improved choice and consumer-directed care would enable users to make decisions that suit them, generate incentives for providers to be more responsive to patients’ needs (providing the right treatment at the right time), and enable users access to a greater range of providers.</p> | <p>NOHA supports the notions of both increased choice and consumer-directed care.</p> <p>We agree that enabling consumers, especially those currently with limited choices, to have a wider access to a broader range of service options would improve access in a geographical sense. However cost remains a significant barrier to many, as noted above. Increasing choice between services you cannot afford is no choice at all.</p> <p>The concepts of increasing the capacity of consumers to be partners in care, to be fully informed, and to receive care that is based around their needs, are supported by NOHA. However, implementing</p> |

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| | <p>such an approach in the oral health arena requires significant changes to both funding and service approaches. These changes clearly include greater funding and incentives for prevention and development of sustainable early intervention models. It also requires an investment in increasing the health literacy of consumers – an investment that would provide considerable returns across the health system. The geographic accessibility of the private sector for dental services may not be matched by its socio-demographic accessibility. While income constraints is an obvious issue for many in need of dental care, factors related to social and cultural determinants of health can also play a part. It should also be noted that in some rural areas, local private providers are unable to satisfy private demand and are unwilling to treat subsidised public patients.</p> |
| <p>Shifting the focus of care toward prevention could enable the system to avoid the costs of deteriorating dental conditions, and improve outcomes and the effectiveness of services.</p> | <p>The evidence of the value of prevention is strong across most of the health sector. Oral health is no exception and much future cost (eg unnecessary hospital admissions for children, complex restorative dentistry) could be avoided by more strategic preventive activity. Sadly, current funding structures provide little incentive for such activity.</p> <p>NOHA notes that development of a preventive approach will require national discussion and commitment of COAG to changes in funding to support the delivery of these services. The mechanisms for funding would also need considerable discussion.</p> |
| <p>Public reporting of performance (against an oral health outcomes framework) and clinically-acceptable and risk-adjusted waiting times would improve accountability in the sector. It would also provide the basis for more comprehensive reforms to promote targeted preventive care. Performance benchmarks and outcome measures are important prerequisites for reform and should be developed and implemented as soon as practicable.</p> | <p>NOHA agrees that better data collection and analysis would enable better understanding of care provided at both practice and system level. However, if this is limited to public services, the value will be minimal. Where there are inadequate services, no level of information about their effectiveness is likely to affect consumer behaviour.</p> <p>Performance measures across the whole system (public and private) would be valuable but would require significant structural changes or incentives to encourage all providers to participate.</p> <p>Timeliness of reporting is a significant issue. To be valuable to policy makers, data needs to show trends over time to assess the effectiveness (or otherwise) of programs. Having access to data that is three years old is of no use whatsoever.</p> |

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| | <p>While there are limited national efficiency and accountability measures published, the National Oral Health Plan has a set of key performance indicators recommended for reporting to health ministers. This should ideally be complemented by a broader suite of oral health outcome indicators. Comparisons of public and private access to dental services using currently available service data is also limited due to the absence of “per patient” level of data that would enable assessments of the mix of services provided according to levels of need and future risk.</p> |
| <p>Implementing choice will require development of a new payment model for public dental services.</p> | <p>NOHA recognises that funding systems in health care drive practice.</p> <p>NOHA supports funding systems that:</p> <ul style="list-style-type: none"> • increase access to oral health care and make it more equitable • promote personal and community oral health literacy and appropriate access and mix of care based on need and future risk • focus on value-based care reporting against outcomes measures • reward a greater focus on prevention and early intervention, especially for children and young people, and vulnerable populations • recognises the need for greater time to be spent with consumers with complex conditions or contexts • facilitates optimal cost-effective use of the public and private oral health sectors • encourages optimal development and efficient use of a multiskilled oral health workforce |
| <p>At this stage, the Commission proposes development of a blended payment model that rewards preventive care and the overall quality of care, rather than the number of treatments provided. Such a model (as is being progressively trialed in England) should involve the user choosing their (either public or private) dental provider, and thereafter the provider would receive:</p> | <p>NOHA Members will respond to this issue individually through their responses to the report.</p> <p>Consideration of this issue could include the use of rigorous independent national pricing for dental items to underpin Commonwealth funding.</p> |

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| <ul style="list-style-type: none"> • a payment per enrolled patient, weighted to reflect their risk and treatment needs (a risk-weighted capitation payment) • payments for achieving clinical and patient outcomes • activity payments for complex and hard to define treatments (such as dentures). | |
| <p>Triaging patients according to their escalating risk of oral disease would target the oral health of those most at risk in the eligible population and retain governments' ability to constrain the costs of service delivery</p> | <p>Regardless of its impact on budgets, NOHA supports the value of more effective triaging of consumers on the basis of need. Clearly, the data would need to be used to identify community and population groups and at risk. This would enable more effective use of allied health practitioners to support good dental health and hygiene as already occurs to some extent in the public sector, particularly in Victoria, Queensland and South Australia. At this stage NOHA is not clear how this might occur more regularly within the private sector given cost barriers.</p> |
| <p>The payment model should not apply to all treatments, consumers could pay extra for some services but careful monitoring of patient outcomes and the payment of extra fees would be needed to ensure consumers are not exploited</p> | <p>This issue of payment systems and the level of acceptable out of pocket costs must be the subject of trialing and ongoing discussion.</p> |
| <p>A digital oral health record incorporated into the My Health Record system could improve linkages with the broader health system (including GPs and hospitals), assist in the identification and triaging of high-risk patients, and support user choice by ensuring a person's records are portable between providers.</p> | <p>Oral health is one aspect of general health, not a separate domain of wellbeing. NOHA strongly supports greater integration of oral health care into primary health care especially and sees the integration of oral health care into the My Health Record as an essential component of such holistic care.</p> <p>Adoption of this proposal would highlight the current inefficient diversity of electronic oral health records currently being used across the public sector.</p> |
| <p>Patients would also be provided with consumer-oriented information (locations, waiting times, outcomes) to enable their choice of provider.</p> | <p>NOHA considers this a core element of greater consumer participation in all health care and believes that such information dissemination should be a part of current oral health care, let alone future arrangements. NOHA has made this case strongly in relation to the Child Dental Benefits Schedule for</p> |

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| | <p>example. More broadly, NOHA would support initiatives to increase oral health literacy more generally and believes this would enable consumers both to make better decisions about their care but be more proactive in prevention.</p> |
| <p>However, there are some circumstances where competition in the market would not be effective, such as in remote locations, where governments would need to commission providers. Improvements to governments' commissioning processes are required, including a more systematic approach to selecting providers, monitoring performance against outcomes, and selecting providers that promote oral health.</p> | <p>NOHA members have argued this case for many years, in particular the National Rural Health Alliance but also many others. Rural and remote areas where there are often inadequate levels of health services and workforce require a more collaborative community engagement approach to meeting community needs. Competition undermines such approaches.</p> <p>NOHA would also support commissioning approaches that prioritise prevention, early intervention and collaboration among a diverse range of health services, not just within the oral health sector, to meet broad needs.</p> <p>It is feasible to use teledentistry in the public system to have a wider reach. Best practice examples are currently taking place, such as in Victoria.</p> |

The National Oral Health Alliance (NOHA) is the major alliance of organisations with an interest in oral health care in Australia - dental professional, consumer and other health and community peak bodies (see list of members below).

Our core principle is that all Australians should be able to access quality oral health services in the same way they can for diseases of any other part of the body.

NOHA comprises:

- Australian Council of Social Service
- Australian Dental Association
- Australian Dental and Oral Health Therapists' Association
- Australian Dental Prosthetists Association
- Australian Health Care Reform Alliance
- Australian Healthcare and Hospitals Association
- Consumers Health Forum
- Council on the Ageing
- Dental Hygienists' Association of Australia
- National Rural Health Alliance
- Public Health Association of Australia
- Royal Flying Doctors Service

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