Oral Health

Victorian Healthcare Association

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Position Paper:

The VHA view

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The Victorian Healthcare Association is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes improvement of health outcomes for all Victorians from the perspective of its members.

Produced by the VHA. This document has been prepared by the VHA with input and feedback from VHA members. While this position statement aims to broadly reflect the views of the health sector in Victoria, it remains the position of VHA and does not supersede any submission or position stated by any member agency.

1.0 | Prefacing Comments

The National Health Reform Agreement outlines the roles and responsibilities of the Commonwealth, state and territory governments towards a unified and locally-controlled health system that will "ensure future generations of Australians enjoy world class, universally accessible health care". However, there remains little detail on how oral health needs will be met and enhanced through the reform process.

The Victorian Healthcare Association (VHA) is seeking to reiterate the pertinent issue of good oral health and the need for publicly-funded dental healthcare that is accessible and affordable for all. Improving service coordination and efficiency alone will not address the significant gaps and delays in access to dental care. Funding reform and increased investment – particularly in prevention, promotion and early intervention – are essential if this goal is to be achieved.

1.1 | The Context

Good oral health is essential to overall health, wellbeing and quality of life. It enables people to eat, speak and socialise without pain, discomfort or embarrassment. Yet oral healthcare is often siloed away from doctors, medicine and primary healthcare. Apart from complex cases, it is largely outside the remit of Medicare.

Untreated diseases such as dental caries or periodontal disease are associated with infection, pain, disability and social isolation. Delays in treatment can lead to more acute symptoms and secondary infections, potentially leading to hospitalisation. According to the Department of Health, dental admissions are the highest cause of acute preventable hospital admissions in Victorians ages up to 19[2].

Almost all oral diseases are preventable, yet oral health is the second most expensive disease group in Australia, with direct treatment costs of over $6 billion annually (6.2 per cent of total health expenditure) and additional care costs of $1 billion[3]. Dental problems consume substantial Medicare resources as patients use subsidised consultations from non-dentally trained health professionals, often without the problem being resolved.

More than one third of Australians delay or avoid dental treatment for financial reasons, or are sitting on long waiting lists for public dental care[4]. According to the final report of the National Health and Hospital Reform Commission (NHHRC) released in 2009, there are approximately 650,000 Australians on public dental waiting lists, with some people waiting up to five years[5].

2.0 | A Fragmented System: the VHA position

One objective of Australia's healthcare system is to ensure that individuals have access to care on the basis of need, rather than on the ability to pay. However, this objective has not been fully met in regard to dental health services. There is an unequal distribution of dental care across Victoria and Australia, which has emerged from successive government policies and a lack of cohesion between state and federal governments.

Since the Coalition Government ceased the Commonwealth dental program in 1996, public dental waiting times have been steadily rising in the states and territories. Optimism emerged that new funding may be provided to public dental services when the federal Labor Government came into office in 2007 with a platform that included investment in a new Commonwealth dental program. The program, however, never eventuated. The federal remaining dental program is the Medicare-funded Chronic Disease Management (Enhanced Primary Care) program, also known as the Chronic Disease Dental Scheme (CDDS). The scheme funds up to $4250 for dental services, but only if a GP attests that a patient's teeth problems are contributing to a chronic illness. For those who can afford private health insurance (PHI) to subsidise their dental expenses, the Federal Government provides a 30 per cent rebate on PHI.

Other public dental services are funded by the state and territory governments. However, this arrangement has caused funding fragmentation which, combined with inadequate funding, means dental services are not reaching those most in need. Public sector dental care, which was supposed to be a safety net for disadvantaged Australians, has failed to supply services equal to those supplied in the private sector.

Public dental care is only available to Health Care Card holders (HCC) who, by definition, are socio-economically disadvantaged. The HCC has been issued to about 30 per cent of the population, yet only 25 per cent of this group can access dental care in any 12-month period[6], due to the shortage of public dental services.

The accessibility problem means that people who are eligible for public dental care or who cannot afford PHI, will endure high out-of-pocket expenses for private care or receive no care at all. This has placed greater reliance on emergency care in hospitals, reflected in the high proportion of patients receiving tooth extractions and lower percentage receiving preventative, maintenance and restorative services[7].

As a country that values the concept of a 'fair go', the question must be asked why such inequity of access to dental care has emerged. The financial fragmentation issue has possibly arisen from the constant debate between federal and state governments regarding responsibility for the service, rather than the appropriate level of funding and the funding priorities. Perhaps another reason for the inequity of access is that dental disease is not generally considered life-threatening and is viewed as a consequence of lifestyle choices. This attitude is unjust as dental disease is not only due to lifestyle choices, and lifestyle choices contributing to other diseases do not preclude access to medical care.

Oral disease a key indicator of disadvantage and social vulnerability. As Professor Andrew Wilson described in his submission to the Senate Select Committee on Medicare (2003) "this is a condition which is probably, of all the conditions in Australia, the most strongly socioeconomically related. The people who have the worst oral health are the most disadvantaged in the community….there is a large amount of dental disease in the community, and we need a strategy to deal with it". Certainly, the strategy required is one that creates a unified and collaborative approach.

2.1 | Population Health

Like many of the chronic diseases affected by the social determinants of health, oral health is inextricably linked with geographic isolation and economic disadvantage. Indigenous populations, rural and regional communities, people on low incomes and the aged experience greater levels of oral disease, which require subsequent targeted interventions. In general, adults who face financial pressure have more untreated oral disease and more missing teeth than adults who are advantaged[8].

Oral disease prevention and basic dental care has decreased since the demise of the Commonwealth dental program. Australia needs to restore its investment in child oral health so that tomorrow's adults have an opportunity to enjoy good oral health. An Australian Institute of Health and Welfare (AIHW) report identified that the proportion of children who brushed their teeth less than once a day had almost doubled between 1993 and 2000[9].

It is also alarming that dental decay costs Australia more than coronary heart disease, hypertension or diabetes. Notably, all these preventable diseases share the common risk factors of a high sugar diet, excessive alcohol consumption and smoking. There is scope for oral health to be integrated into general health promotion initiatives but it is currently being left out of the debate. The most effective integrated dental health initiatives include interventions that focus on screening and individual risk assessment, health education and skill development, social marketing and health information, community actions and settings, and supportive environments[10].

Fluoridation of drinking water remains the most effective and socially equitable means of achieving community-wide exposure to fluoride, which prevents dental caries. However, approximately 370,000 Victorians do not have access to fluoridated water[11]. For example, in some rural communities the access to fluoride in tap water is problematic as residents rely on tank water for drinking. Alternative solutions must be identified with a new funded fluoridation plan.

2.2 | Workforce

The gap between Victorian's oral health demands and the number of clinicians available to meet them also contributes to the inequity of access to dental care. This is evidenced by an AIHW research report that found an overall reduction in the mean level of service, number of hours worked, and number of patient visits per dentist between 1983 and 2010[12].

Put simply, demand far outweighs supply. An appropriate, well-distributed and sustainable oral health workforce is crucial. Workforce redesign and training of the current health workforce could also help address workforce shortages.

Despite the discussion on policy, directions and actions to address workforce issues in the National Oral Health Plan 2004-2013, the disconnection between federal and state responsibilities and portfolio interests has led to an uncoordinated and fragmented response.

The misdistribution of the dental workforce between highly-populated metropolitan areas and regional and rural areas remains an issue. Governments need to develop incentives for dental clinicians to work in rural and regional areas, and with disadvantaged populations. Public dental agencies, particularly in rural and regional areas, must compete with the private sector, which allows dentists to determine their own work hours, fees and remuneration often within a central business district or upper/middle-class suburb of a major population centre. At present there are government grants for doctors who relocate to rural and regional areas, but none exist for dentists.

An example of a strategy to encourage rural dentistry is the establishment of the La Trobe University School of Oral Health and Dentistry in Bendigo, Victoria. As the first rural and regional dental department in Australia and a leader in dental education, the faculty has impacted positively on the profile, workforce and general capacity of the dental sector in Bendigo.

Another initiative was announced in the 2011-12 Commonwealth budget with the investment of $53 million over the next four years to introduce a voluntary dental internship year, a program the VHA has long advocated for.

Other dental clinicians, besides dentists, are crucial and should also be supported through programs like the Victorian Government's dental employment scheme to attract oral health clinicians to the public sector. Funding is committed over the next four years to provide training and support for supervising clinicians. The VHA believes this should encompass all dental disciplines that play a critical role, and in addition to dentists, dental therapists, oral health therapists and dental prosthetists, include increasing the number of dental technicians and dental hygienists and enabling them to expand their standard scope of practice.

The VHA also recognises that doctors, nurses, allied health professionals and personal care attendants can play a role in disease prevention, oral health promotion and early intervention of dental disease but they need to be trained adequately.

The VHA remains concerned about inadequate infrastructure and resources to accommodate workforce increases. This includes the number of chairs and mentors available in rural areas, appropriate floor space in rooms that provide places for reflection and discussion, and infrastructure that safely enables practical learning – all of which influence the willingness, capacity and ability of public funding models to support Victoria's dental employment program. Investment in training and capital infrastructure is necessary for any scheme to achieve meaningful gains for potential interns and to improve the long-term capacity of the oral health workforce

2.3 | Funding reform

The NHHRC's final report contained 123 recommendations to the Federal Government for health reform, including oral health. It proposed Denticare Australia – a scheme supporting universal access to basic dental services to be funded through a Medicare Levy increase of 0.75-2.25 per cent of taxable income. The basic package of dental services would include preventative work (such as scaling and cleaning), diagnostic (x-rays), extractions and restorative work (filling cavities) and the provision of dentures. Additional services such as orthodontics would not be provided. Under this scheme, individuals could choose whether to have the basic dental package through a private or public dental arrangement and be funded by Denticare Australia at a subsidised cost. However, this scheme has not been implemented.

The current federal CDDS ceases in March 2012. While 80 per cent of its services go to people who hold a HCC, the scheme has been criticised for inappropriate use of high cost services. The funding should be redirected to a population health based program that targets marginalised Australians. More upstream investment is needed in prevention, promotion and early intervention as an alternative to the episodic dental treatment supported by the current Medicare-funded program.

At a state level, there has been no recurrent growth in dental funding since 2004-05, according to a review of annual reports by Dental Health Services Victoria (DHSV). Static dental budgets diminish opportunities for service innovation and efficiency, such as: acquiring and updating equipment to improve dental services; opening and maintaining infrastructure for outreach clinics; developing strong and structured mentoring programs for newly-graduated dentists; promoting and supporting continuing education; staff development; and the integration of oral health into the general health of the population.

Decreased dental budgets reduce the dental service capacity itself. Victoria's recent change to an activity based dental funding model has decreased funding and threatened service capacity for some dental agencies. Consequently, this funding model has compromised

Victoria's ability to provide best practice dentistry and forced the modification of services to the barest essentials in order to function within budget constraints. This is concerning because many special needs populations require additional investment to support access to particular oral healthcare, such as programs that engage, screen and create linkages. For some agencies, it may involve the closure of some dental chairs.

The VHA acknowledges that the funding model had to change to ensure greater equity and transparency, but is concerned that the model has not been piloted and trialled before its execution across the state. The past 18 years of Casemix funding in Victoria's acute health sector have demonstrated the many variables within public health services and that standardisation is not always ideal. There are variances in cost and in performance that produce the underlying cost driver for each individual agency – an understanding of this will ensure effective implementation.

Overall, there is inconsistency between the approaches of state and federal governments in addressing the funding of oral health. A coordinated and streamlined response is necessary to inject investment into increased community-based dental care and substantial capital infrastructure, particularly towards areas most in need.

While individuals need to accept personal responsibility for their own oral health through good oral hygiene and diet, governments also need to increase investment in prevention, education and early intervention measures. Most importantly, the public healthcare system must ensure that oral health treatment and maintenance is both accessible and affordable for all.

3.0 | Conclusion

The Federal Government should take the action required to overcome the cost and blame-shifting that, over the past decade, has exacerbated existing inequalities in the oral health system.

Any agreement within the Council of Australian Governments presents an opportunity to integrate dental healthcare into the wider health system, to gain synergies and create a collaborative effort. Only then will this minimise the fragmentation that has caused many sub-groups to miss out on decent oral health.

Oral health is an essential aspect in health and wellbeing and should not be separated from primary healthcare and the broader Australian healthcare system, as has happened to date. The time for action is now to prevent future Australian generations succumbing to the worsening problems of oral health neglect.

References

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4.0 | VHA Recommendations:

Population Health

- Access to oral health teams that focus on holistic approaches to preventative care, rather than specific episodes of dental practitioner care, must be funded.
- The benefits of fluoridation should be maximised and available to all Victorian communities in accordance with the Victorian Public Health and Wellbeing Plan 2011 -2015. This should occur with a new funded fluoridation plan.
- The population health focus of Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013 is still a relevant and viable blueprint for the future of oral health in Australia and should be implemented.

Workforce

- Support for the implementation of an intern year for oral health workforce with the appropriate resources and infrastructure. Adjustment of existing design guidelines to support the fiscal recognition of the true costs inherent in good mentoring and supervision of students/interns.
- Government incentives are established to attract dentists and other oral workforce staff to rural and regional areas of Victoria.
- The integration of oral health into the curriculum of tertiary health courses, such as nursing, medicine and other allied health practitioners. This would allow for better opportunities for oral health promotion and screening within the broader scope of health service provision.
- The Victorian Government's dental employment program to also include dental technicians and dental hygienists and enable them to expand their scope of practice.

Funding reform

- Any new funding formula arrangements should be piloted, trialled and evaluated before implementation in full across the state to ensure it does not threaten service capacity of dental agencies.
- The VHA supports a phased targeted approach with the introduction of universal dental health services that focuses on prevention, education and early intervention measures.

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