Australian Healthcare and Hospitals Association

Submission to the
The Department of Health and Ageing public consultation for the Australian Government's child dental benefits schedule – *Grow Up Smiling*

17 May 2013

Introduction

The Australian Healthcare & Hospitals Association (AHHA) welcomes the opportunity to provide a submission to Department of Health and Ageing public consultation for the Australian Government's child dental benefits schedule – *Grow Up Smiling*.

The Australian Healthcare & Hospitals Association is Australia's largest health care group, representing providers of public and not-for-profit health care services. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Medicare Locals and primary healthcare providers, universities, and individual health professionals and academics. We are uniquely placed to be an independent, national voice for universal high quality healthcare in public hospitals, aged care, community and primary health sectors.

The AHHA believes that an improved oral health system is an essential part of a more equitable and effective health system. Oral health is a vital component of overall health and well-being. Poor oral health impacts negatively on people's ability to fully participate in society and can lead to malnutrition, unemployment and social isolation. If untreated, oral problems develop into more serious health conditions requiring intensive treatment and hospitalisation.

The long-term trends suggest that the degree of inequality in dental care access has increased over the last 30 years and these inequalities appear to have been influenced by government policies[1]. The community's lack of access to affordable dental health services means that Australia ranks among the bottom third of OECD countries for rates of dental decay among adults[2]. There is also

[1] Australian Institute of Health and Welfare Dental Statistics and Research Unit 1996, *Commonwealth Dental Health Program*, Research Report 3, University of Adelaide

[2] National Health & Hospitals Reform Commission Final Report 2009

evidence that the oral health of Australian children has declined, reversing the gains made in the 1970s and 1980s[3].

Our goal is for all Australians to have universal access to preventive and restorative oral health care, regardless of their ability to pay.

The AHHA recognises that a universal access scheme would require a phased implementation, commencing with a focus on early intervention and treatment for disadvantaged groups concurrently with enhancing health promotion and prevention programs. .

The AHHA welcomes the long overdue the inclusion of comprehensive dental services in Medicare. It is critical that the program is structured to ensure the maximum benefits are released by the maximum number of people. This will require the GUS program to be structured to encourage the application of best practice models of care which provide the most appropriate care based on the individuals risks and needs.

To inform the development of the GUS program the AHHA provides the following comments and recommendations.

SCHEDULE OF ITEMS – SCOPE OF SERVICES

The public sector dental services are driven by a mission to optimise oral health at the population level. This requires programs and services to be developed that provide the maximum benefit to the maximum number of people. In contrast the private sector is by definition driven by the need to maximise profits.

It is possible that the GUS program may generate a shift in service provider mix from the public sector to the private sector. This potential shift brings an associated risk of a shift in focus from a preventive population based approach to service provision to a profit driven fee for service model.

The public sector has a strong commitment to preventive care and early intervention in its children's programs and an increasing focus on minimal intervention dentistry (MID). Some items that would be integral to the provision of a MID focused treatment plan are excluded from the proposed schedule of items such as saliva testing (047), application of concentrated re-mineralising agents (123) and oral hygiene instruction (141). All items associated with the MID approach must be included in the schedule in order to support best practice models of care. Appropriate restictions on frequency or combinations of service could be applied

Options to encourage both best-practice care and care provision to targeted population groups must be considered. While the evidence relating to the effectiveness of financial incentives to improve performance is varied, this should be considered. An approach similar to the Practice Incentive Programs available to general practitioners which provide additional rebates for the provision of a structured package of care to selected patient groups may be an appropriate starting point for discussion.

[3] Mejia GC, Amarasena N, Ha DH, Roberts-Thomson KF & Ellershaw AC 2012. Child Dental Health Survey Australia 2007: 30-year trends in child oral health. Dental statistics and research series no. 60. Cat. no. DEN 217. Canberra: AIHW

The structure of the rebate schedule could also be used to encourage the provision of health promotion programs. The National Oral Health Promotion Plan, currently under development, may provide appropriate guidance for services or packages of care that could be prioritised and encouraged through the rebate structure.

A significant omission in the proposed schedule of items is the provision of mouthguards. The schedule includes items which cover the provision of treatment of trauma (eg 384, 386) but does not include the provision of a mouthguard to help prevent trauma occurring. While the potential for mis-use of this item is apparent, the inclusion of criteria including evidence of participation in a contact sport and limits to the frequency of provision could be applied.

***Recommendation 1**: That the schedule for the GUS program be structured to ensure an appropriate focus on preventive and early intervention services.*

***Recommendation 2**: That the schedule specifically includes all items associated with the provision of MID based care.*

***Recommendation 3**: That the provision of mouth guards be included in the schedule.*

FEES AND BILLING

Rural and remote

The geographic inequities in access to dental care are well documented with the ratio of providers to population in urban areas around twice that of rural and remote areas. Concurrently there is clear evidence that the oral health of rural and remote residents is poorer than their metropolitan counterparts.

The additional costs associated with provision of care to residents of rural and remote areas are recognised in the IHPA Pricing Framework through the incorporation of pricing adjustments. The 2013-14 Framework includes loadings for outer regional residents of 8.0%, remote - 15% and very remote - 24%.

Precedents exist in the Medicare Benefits Schedule which provide incentives to bulk bill general medical services provided to targeted groups in rural and remote regions (MBS Items 10990 and 10991). A similar process should be applied to the child dental benefits schedule.

***Recommendation 4**: That the child dental benefits schedule incorporate loadings or item numbers in recognition of the additional costs of service provision in rural and remote areas.*

Aboriginal and Torres Strait Islander Children

The additional costs associated with provision of care to Aboriginal and Torres Strait Islander peoples are recognised in the IHPA Pricing Framework through the incorporation of a pricing adjustment of 5%.

Aboriginal and Torres Strait Islander children carry an excessive burden of oral disease. Public sector services have established a range of programs to increase access for Aboriginal and Torres Strait Islander children. These programs include the engagement of primary health staff and Aboriginal Health Practitioners in screening programs and in some cases the provision of preventive care.[4]

The Medicare Benefits Schedule includes items which cover services provided by a practice nurse or registered aboriginal health worker on behalf of a medical practitioner.[5] The application of fluoride varnish is a cost effective and evidence based intervention which can significantly reduce the incidence of dental caries in children. To facilitate the engagement of nurses and AHPs in the provision of screening and preventive care similar item numbers to cover services provided under supervision of an oral health practitioner should be included in the child dental benefits schedule.

***Recommendation 5**: That the child dental benefits schedule incorporate loadings or item numbers in recognition of the additional disease burden experienced by Aboriginal and Torres Strait Islander children.*

***Recommendation 6**: That the child dental benefits schedule incorporate item numbers to cover relevant services provided by registered nurses and aboriginal health practitioners.*

SERVICE RESTRICTIONS

The Consultation Paper identifies exclusions from the GUS program including:

- In-hospital care, funded through the National Health reform Agreement
- state and territory responsibilities for treating children with special needs and complex cases.

The National Oral Health Plan defines special needs clients as those with intellectual or physical disabilities, or medical or psychiatric conditions, that increase their risk of oral health problems or increase the complexity of oral health care

The Consultation Paper has indicated that the states and territories are responsible for treating children with special needs. The basis for this determination is not clear and it is assumed that this is based on the historical assignment of responsibility for dental services to the states and territories. The AHHA does not support the exclusion of special needs care from the GUS program.

The provision of care to complex and high needs clients is predominantly a public sector function as the economic realities of care to this group do not support the private practice model. The challenge in managing care provision to this client group is the limited data available to describe the population's size, distribution and treatment needs.

[4] http://www.health.nt.gov.au/Oral_Health/Oral_Health_Promotion/index.aspx
[5] Australian Government, Department of Health and Ageing, Medicare Benefits Schedule Book, pg 85

Improved access to general care and assessment for children will increase demand for more complex care by exposing the unmet need that currently exists. This will place additional pressure on public sector services who are the primary provider of complex care for children particularly in relation to services provided under general anaesthetics.

The assumption that funding required to support in-hospital care is accessible through the National Health reform Programs is possibly misguided. Access to operating theatre time in public hospitals varies significantly between and within jurisdictions and allocated time is frequently lost through reallocation to emergency cases unrelated to the dental service. Dental theatre lists can also be managed independently of the hospital surgical waiting lists and are thus not included in hospital waiting time reports or funding structures further reducing access to theatre time.

If appropriate resources are not provided to jurisdictions to respond to this demand, waiting times will increase and clinical outcomes for a group of patients with significant identified needs will decline.

The unmet demand for special needs services is compounded by the limited number of special need specialists in Australia. Increased investment in training of special needs specialists will be required to address demand.

***Recommendation 7**: That the exclusion of special needs services from the GUS prgram be removed*

***Recommendation 8**: That resources be allocated to jurisdictions to respond to the anticipated increased demand for complex care and general anaesthetic services.*

***Recommendation 9**: That the structure and administration of waiting-lists for hospital based dental services and interactions with existing surgical waiting list management processes be reviewed to improve access to theatre time and activity based funding programs.*

***Recommendation 10**: That the workforce and infrastructure requirements for special needs dental services be reviewed and appropriate resources be allocated.*

DENTAL PROFESSIONAL REQUIREMENTS FOR SERVICE PROVISION AND BILLING ELIGIBILITY

Dental therapists and hygienists and oral health therapists

A challenge to evaluation of the Teen Dental Program was the limited ability to identify the care provider. In the public sector, a small number of dentists were nominated as the Representative Dentist, regardless of who the actual provider was. In both the public and private sector all Teen Dental services were assigned to a dentist's provider number resulting in no information being available in relation to the provision of care by dental therapists or oral health therapists.

While there has been much debate about the allocation of provider numbers to dental therapists and oral health therapists, it should be considered in the context of supporting more effective

clinical governance and auditing of the GUS program and to allow analysis of the workforce impact of the program.

The impact of the GUS program on the public/private service mix is unclear. Current population coverage by the public sector services varies between jurisdictions, existing public sector programs eligibility do not align directly to the Family Tax Benefit A eligibility of the GUS program and little information is available in relation to the volume of private services provided to children.

If there is increased service provision in the private sector this may create a shift of the existing workforce from the public to private sector. This will become an issue if it generates an under-supply of staff in the public sector and may adversely affect those families not eligible for the GUS program and unable to access private dental care.

***Recommendation 11**: That provision of provider numbers to dental therapists, hygienists and oral health therapists is considered.*

***Recommendation 12**: That the public/private service mix and associated workforce impacts are considered as part of the GUS evaluation.*

LESSONS LEARNED

Given the governance issues that occurred with the Chronic Disease Dental Scheme it is essential that the administrative processes and requirements of the GUS program are clearly defined and that providers are appropriately informed as to their responsibilities

The uptake of the Chronic Disease Dental Scheme and the Teen Dental Program varied significantly between jurisdictions reflecting factors including capacity of the private sector, promotion of the program and support of the local professional associations. Replication of this pattern under the GUS program will result in significant inequities in service distribution, access and outcomes.

COMPLIANCE AND REGULATION

Governance and evaluation

A major flaw of the Teen Dental Program was the inadequate analysis of the effectiveness and efficiency of the program. Analysis was hampered by the use of a single item number which resulted in a complete absence of service level data. The GUS program must incorporate item level data collection.

While the cap on rebates will help deter over servicing to some degree, close scrutiny of service patterns and behaviours will be essential to avoid the provision of unnecessary services and excessively frequent services.

Ongoing analysis of service volumes and patterns including comparisons between service providers, service sectors and geographic areas is essential to support evaluation of the program

While this will contribute to the reporting burden to some degree, the majority if not all, of the required data is already collected in the public sector and the private sector. In some circumstances additional investment in electronic information systems may be required and this should be supported by the Australian Government.

The oversight of the program will require input of members of the dental profession with knowledge and experience in the provision of services to children and teenagers. The establishment of a suitably qualified and experienced advisory board, with representation from both the public and private sectors will be essential.

***Recommendation 13**: That ongoing evaluation and auditing of the GUS program is implemented.*

***Recommendation 14**: That an advisory board with representation from the public and private sectors is established.*

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