AHHA Response to the Senate Inquiry into the provision of and access to dental services in Australia

Submission

5 June 2023

OUR VISION

A for a healthy Australia supported by the best possible healthcare system.

OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Effective
Accessible
Equitable
Sustainable
Outcomes focused

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EXECUTIVE SUMMARY

This submission has been prepared to provide input to the *Senate Inquiry into the provision of and access to dental services in Australia*. As an independent peak body focused on whole of system reform, the Australian Healthcare and Hospitals Association (AHHA) recommends that Governments commit to ensuring universal access to dental care, and to achieve this sustainably, embed a value-based health care (VBHC) approach that guides both universal policies (i.e. Dental Benefit Schemes) and public dental services.

This should include:

1. Providing longer term strategic direction and funding certainty, aligning the term of the National Partnership Agreement for public dental services for adults with the 5-yearly term of the National Health Reform Agreement. The Agreement should:
    a. Position and enable public dental services to focus upstream on preventative care.
    b. Develop an agreed national minimum dataset and data dictionary for oral health to enable the capture of nationally consistent and comparable outcomes data.
    c. Support greater coordination and integration of dental services with health services more broadly, including the digital infrastructure and policy environment for a systematic approach to iterative, data-driven improvements.
    d. Mirror place-based approaches and evaluation frameworks that foster a learning health system.
    e. Enable more sophisticated, place-based health workforce planning, within a national framework, that:
        i. Is integrated with planning for healthcare services and healthcare funding.
        ii. Can transparently respond to, and inform, skill-mix innovation.
        iii. Has the political commitment, governance and data to drive the necessary intersectoral support for a sustainable health workforce.
    f. Progress development of value-based payment reform.
2. Introducing a Senior Dental Benefits Scheme within a national framework for introducing value-based dental benefits progressively across priority populations.
3. Establishing national leadership with appointment of a Chief Dental Health Officer.

INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to provide input to the *Senate Inquiry into the provision of and access to dental services in Australia*.

ABOUT AHHA

AHHA has been the national voice for public health care for more than 70 years, maintaining its vision for an effective, innovative, and sustainable health system where all Australians have equitable access to health care of the highest standard when and where they need it.

AHHA is Australia's national peak body for public hospitals and healthcare providers. Our membership includes state and territory health departments, Local Hospital Networks (LHNs) and public hospitals, community health services, Primary Health Networks (PHNs) and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

In 2019, AHHA established the Australian Centre for Value-Based Health Care, recognising that a person's experience of health and healthcare is supported and enabled by a diverse range of entities, public and private, government and non-government. The Centre brings these stakeholders together around a common goal of improving the health outcomes that matter to people and communities for the resources to achieve those outcomes, with consideration of their full care pathway.

AHHA is a member of the National Oral Health Alliance (NOHA) and is an advocate for a universal approach to oral health on a scale and intensity that is proportionate to level of disadvantage.

ABOUT THIS SUBMISSION

This submission builds on consultation undertaken with health system leaders in developing a blueprint for health reform towards outcomes-focused, value-based health care, and activity with Dental Health Services Victoria and other members to reorient from volume to value in public dental health services.

In this submission, from the Terms of Reference, our central focus is *g. the pathway to improving oral health outcomes in Australia, including a path to universal access to dental services*. Achieving this will require:

- Effective governance (*c. interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services*).
- Data and performance information that is fit for purpose (*h. the adequacy of data collection, including access to dental care and oral health outcomes*).
- A sustainable workforce (*i. workforce and training matters relevant to the provision of dental services*).
- Funding that incentivises improved health outcomes.

1. ORAL HEALTH IS FUNDAMENTAL TO HEALTH

Improving oral health status and reducing the burden of poor oral health is fundamental to improving the overall health and wellbeing of Australians. The prevalence of oral diseases is significant. One in three Australian adults and one in four of children aged 5-10 have untreated tooth decay, and one in three Australian adults have moderate or severe gum disease. Oral health also has a notable impact on the acute sector, with dental conditions resulting in 63,000 preventable admissions each year, ranking second in the list of causes for preventable hospitalisations.

There are wide oral health inequities in access and outcomes, with varying underlying causes, as seen in the examples below.

EXAMPLES OF INEQUITIES

Affordability

The latest data from 2015-2016 reflects that personal expenses on dental services are the second highest spending category in all out-of-pocket healthcare expenses, after prescription and non-prescription medicines.[1] Most of the $11.1 billion total expenditure on dental services in 2020-21 was paid directly by individuals ($6.5 billion). Health insurance funding was second highest ($2.2 billion). In comparison, government (Commonwealth and State/Territory) funding on dental services in 2020-21 was just $1.3 billion. Over the past 10 years, the average per capita expenditure by all levels of government has been declining annually.

The Patient Experience Survey 2021–22 (ABS 2022) found that for people aged 15 and over, approximately 16% reported that they delayed or did not see a dental professional due to cost.[2] A delay due to cost was more likely in people aged 25-34 than those aged 85 years and over; more likely in people with a long-term health condition, than those without; more likely in those living in areas of socioeconomic disadvantage; and more likely in those living in outer regional, remote or very remote areas than those in major cities.

People living in regional, rural and remote areas

Children and adults living in rural and remote Australia experience higher rates of oral disease and dental decay relative to those in metropolitan areas. Children and adults residing in rural areas have higher levels of tooth loss and tooth decay relative to those in metropolitan areas as well. In addition, rural and regional populations are less likely to visit a dentist for routine purposes and are more likely to visit a dentist for dental complications relative to those residing in metropolitan areas.[3]

[1] Australian Institute of Health and Welfare. (2023) *Oral and Dental Health in Australia*. Available from: https://www.aihw.gov.au/getmedia/b44000d6-52c7-4f1d-a7fe-7938e104184f/Oral-health-and-dental-care-in-Australia.pdf.aspx?inline=true

[2] Australian Bureau of Statistics. (2022) *Patient experiences*. Available from: https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release

[3] Australian Institute of Health and Welfare. (2023) *Oral and Dental Health in Australia*. Available from: https://www.aihw.gov.au/getmedia/b44000d6-52c7-4f1d-a7fe-7938e104184f/Oral-health-and-dental-care-in-Australia.pdf.aspx?inline=true

There is an unequal distribution of dental practitioners with most located within metropolitan areas and an inadequate number of services in rural and regional areas.[4] According to the RFDS, 142,269 Australians do not have access to dental services within a 60-minute drive time.[5] In addition, rural and regional communities are burdened with a higher cost associated with receiving dental care due to increased costs and travel time.

Within rural and remote communities there is evidence of patients seeking dental services from a range of providers, other than dental services. Patients frequent primary care providers such as general practitioners and pharmacists for oral health issues including dental abscesses, mouth ulcers and pain as well as trauma. Patients also seek help from the tertiary care sector and frequently present to hospitals with oral health problems.[6] The care provision by these providers is limited to pain relief, antibiotics, and the advice to see their dentist due to their limited scope and expertise in providing oral care services.

First nations peoples

First nations Australian's suffer higher rates of oral disease as well as a higher number of dental issues relative to the general population. First nations peoples are also more likely to have a limited access to dental services and are more likely to visit the dentist for complications rather than a routine visit.[7] First nations children are more likely than non-Indigenous children to experience tooth decay because of social disadvantage and a lack of access to appropriate diet and dental services.[8]

First nations peoples are also more likely to smoke relative to non-Indigenous people, which in turn leads to worse oral health outcomes. First nations peoples are also more likely to reside in rural and remote communities, meaning that the specific factors influencing people in rural and remote communities are also likely to apply to Indigenous communities.

Indigenous peoples are more likely to avoid the dentist due to cost relative to non-Indigenous Australian's (49% relative to 39%).[9]

[4] National Oral Health Alliance. (2018) *Oral Health Policy - Rural and Remote Australia*. Available from https://oralhealth.asn.au/sites/default/files/Rural%20and%20remote%20policy.pdf
[5] Royal Flying Doctors Service (2020) *Equitable Patient Access to Primary Healthcare in Australia*. Barton, ACT: p. 44.
[6] Barnett, T. et al. (2017) *The relationship of primary care providers to dental practitioners in rural and remote Australia*, BMC Health Services Research, 17(1). doi:10.1186/s12913-017-2473-z.
[7] Tynan, A. et al. (2020) *Factors influencing the perceived importance of oral health within a rural Aboriginal and Torres Strait Islander community in Australia*, BMC Public Health, 20(1). doi:10.1186/s12889-020-08673-x.
[8] https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/priority-populations/aboriginal-and-torres-strait-islander-australians
[9] Australian Institute of Health and Welfare. (2023) *Oral and Dental Health in Australia*. Available from: https://www.aihw.gov.au/getmedia/b44000d6-52c7-4f1d-a7fe-7938e104184f/Oral-health-and-dental-care-in-Australia.pdf.aspx?inline=true

Older people

Oral health declines across the lifetime with an increase in the number of dental caries per person in relation to age and an increased burden of oral disease. Older Australians are also likely to avoid seeking dental care due to costs.[10]

The Royal Commission into Aged Care Quality and Safety identified significant issues regarding the provision of oral healthcare for people living in residential aged care (RAC) homes. During hearings it was made clear that in too many instances, residents' basic oral health needs are not being met. AHHA supports policy reforms that help to achieve the outcomes intended by the Royal Commission's recommendations, such as the requirements for RACFs to retain an allied health professional (including oral health practitioners), the establishment of a Senior Dental Benefits Scheme, a review of Certificate III and IV coursed in Aged Care to focus on oral health, and the availability of education and training in to improve the quality of care including oral health.

The outcomes of these recommendations will support and promote access to oral healthcare for older Australian within RACFs and living in the community.

People with additional or specialised health care needs

People with additional or specialised healthcare needs are also likely to have reduced access to healthcare as well as poorer oral health outcomes.[1112] Factors influencing access to dental care can vary and include the type of disability present as well as remoteness and gender. Those with psychosocial and physical restrictions are less likely to receive oral healthcare. People living with disabilities in regional and remote areas are also less likely to access dental care relative to people living with disabilities in metropolitan areas. Additionally, women living with disabilities are more likely than men to receive oral healthcare.

The Australian Dental Association notes that while there are 4.4 million Australians who live with disabilities, there are only 24 practicing special needs dentistry specialists. In addition, there is a great need for general dentists to be more proficient in providing care to patients with disabilities.[13] This is important because as patients with disabilities may only need reasonable adjustments to their care, and not necessarily need the services of a specialist and can also be managed within a generalist setting.

[10] Australian Institute of Health and Welfare. (2023) *Oral and Dental Health in Australia*. Available from: https://www.aihw.gov.au/getmedia/b44000d6-52c7-4f1d-a7fe-7938e104184f/Oral-health-and-dental-care-in-Australia.pdf.aspx?inline=true

[11] Devinsky, O. et al. (2020) Dental Health in persons with disability, Epilepsy & Behavior, 110, p. 107174. doi:10.1016/j.yebeh.2020.107174.

[12] Australian Institute of Health and Welfare. (2023) *Oral and Dental Health in Australia*. Available from: https://www.aihw.gov.au/getmedia/b44000d6-52c7-4f1d-a7fe-7938e104184f/Oral-health-and-dental-care-in-Australia.pdf.aspx?inline=true

[13] Australian Dental Association. (2022) *Special needs dentistry spotlight (part 1).* Available from: https://www.ada.org.au/News-Media/News-and-Release/Latest-News/Special-needs-dentistry-spotlight-(part-1)-1504202

2. THE CURRENT SYSTEM IS A POLICY ANOMALY

Australia's *National Oral Health Plan 2015–2024* was developed to provide a blueprint for united action across jurisdictions and sectors for all Australians to have healthy mouths. The four guiding principles in the Plan continue to be appropriate:

- a population health approach
- proportionate universalism
- appropriate and accessible services
- integrated oral and general health.

However, translation of the Plan into practice has been slow. Contributing factors highlight the policy anomaly that faces oral health in Australia, with access to dental care provided differently to other types of health care. Factors include:

- The scope of universal policy
- Current governance and funding arrangements through the National Partnership Agreement
- National leadership.

UNIVERSAL POLICY

Dental care is predominantly (85%) delivered by private providers and operates on a fee-for-service basis.[14] Costs of care are largely met by individuals, including through private health insurance subsidies.

The Australian Government funds the Child Dental Benefit Scheme (CDBS), for children aged up to 17 years and receiving certain Centrelink payments. However, program uptake continues to be a problem.[15] The Australian Government also funds the Department of Veterans' Affairs dental program.

In its final report,[16] the Royal Commission into Aged Care Quality and Safety identified that people receiving aged care, particularly those in residential aged care, do not consistently receive the oral and dental health care they need. A recommendation was made to 'establish a Senior Dental Benefits Scheme to fund dental services to people who live in residential aged care and people who live in the community and receive the age pension or qualify for the Commonwealth Seniors Health Card'. The Scheme would provide access to the full range of oral and dental services, as provided by oral health practitioners, general and specialist dentists and dental prosthetists.

[14] Tennant, M. and Kruger, E. (2014) *Turning Australia into a "flat-land": What are the implications for workforce supply of addressing the disparity in rural–city dentist distribution?*, International Dental Journal, 64(1), pp. 29–33. doi:10.1111/idj.12059.
[15] Nguyen, T.M. et al. (2023) *Is Australia's lack of national clinical leadership hampering efforts with the Oral Health Policy Agenda?*, Australian Health Review, 47(2), pp. 192–196. doi:10.1071/ah22278.
[16] Royal Commission into Aged Care Quality and Safety. (2021) A Summary of the Final Report. Canberra, ACT. Available from:. https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf

GOVERNANCE AND FUNDING ARRANGEMENTS

Public dental services are also available in all states and territories targeting priority populations identified in *Australia's National Oral Health Plan 2015-2024*. The Australian Government contribution to funding is identified in the National Partnership Agreement[17] with the State and Territory Governments. The most recent Agreement was signed in 2017 for a 3-yearly period through to June 2019. One-yearly extensions have subsequently been made.

While successive Australian Governments have made efforts to support oral health over the past 20 years, initiatives have lacked consistency, coordination, and adequate funding. This has resulted in oral health in general not being addressed adequately.[18] Contributing factors include the National Partnership Agreement being:

- Extended through only short-term agreements that result in significant uncertainty for public dental services. This can contribute to disruption in service planning and delivery.
- Negotiated without regard for the interrelatedness of oral health and overall health and wellbeing.
- Centred around funding the delivery of acute care, when it could better position the health system to focus upstream on preventative care.

NATIONAL LEADERSHIP

Recent research[19] has concluded that Australia requires national clinical leadership for oral health using a proportionate universal framework. This would be accelerated through the appointment of the first Commonwealth Chief Dental Officer.

[17] The Council on Federal Financial Relations. (2018) *National Partnership on Public Dental Services for Adults*. Available from: https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2020-08/adult_public_dental_services_npa.pdf

[18] Nguyen, T.M. et al. (2023) 'Is Australia's lack of national clinical leadership hampering efforts with the Oral Health Policy Agenda?', Australian Health Review, 47(2), pp. 192–196. doi:10.1071/ah22278.

[19] Nguyen, T.M. et al. (2023) 'Is Australia's lack of national clinical leadership hampering efforts with the Oral Health Policy Agenda?', Australian Health Review, 47(2), pp. 192–196. doi:10.1071/ah22278.

3. TOWARDS VALUE-BASED HEALTH CARE

Extending universal coverage to oral health through Medicare has long been advocated. However, it must be recognised that almost four decades have passed since Medicare was introduced. Much has changed; in both the health conditions that people manage and in the way care can be delivered. Greater coordination and integration of services across sectors is needed. Innovative models of care are needed, including through digital transformation and integrated teams working to top of scope. Alternate models of care must also be matched by complementary payment models, recognising that traditional payment mechanisms such as fee-for-service can create perverse incentives and entrench fragmented care.

For Australia to develop a path to universal access to dental services, value-based health care (VBHC) can provide the framework to bring the many stakeholders across the system together around a shared commitment.

WHAT IS VALUE-BASED HEALTH CARE?

VBHC is an evidence-based framework for health system reform focused on facilitating improvements in the outcomes that matter to people and communities for the cost of achieving those improvements, across a full pathway of care. It presents a person-centred approach to support place-based health care decision making and high-level system transformation. It can be used to:

- Shift care upstream, with **prevention and health promotion** activities.
- Adopt **alternate and innovative models of care**, utilising integrated teams with a workforce that works to top of scope and effective and sustainable adoption of digital technology.

Australia's Dental Health Services Victoria is a global leader in VBHC implementation in the dental care sector (see Box 1 and 2).

PREVENTION AND ORAL HEALTH PROMOTION

Research[20] shows that people with healthy oral health behaviours and routines experience less dental care need. Behaviours such as smoking and alcohol consumption are the greatest risk factors for poor oral health. In turn, these behaviours stem from social, economic and environmental factors, also presented as the wider determinants of health.

Fluoride in water is proven to reduce incidences of dental caries from a young age and acts a preventative measure that prevents the need for fillings and dental extractions.[21] However, nearly 3

[20] Dental Health Services Victoria. (2011) Links between oral health and general health the case for action. Carlton, VIC. Available from: https://www.dhsv.org.au/__data/assets/pdf_file/0013/2515/links-between-oral-health-and-general-health-the-case-for-action.pdf

[21] National Health and Medical Research Council. (2017) Water Fluoridation and Human Health in Australia. Canberra ACT. Available from: https://www.nhmrc.gov.au/sites/default/files/documents/attachments/water-fluoridationqa.pdf

million Australians, more than 11% of the Australian population, do not have a fluoridated water supply.[22]

Australia's water supply must be adequately fluoridated. Failing this, fluoride varnishes should be made available to communities who do not have access to adequately fluoridated water supplies.

BOX. 1 IMPLEMENTING VBHC IN DENTAL SERVICES[23]

Dental Health Services Victoria (DHSV) is the public dental service provider in Victoria and a global leader in the implementation of VBHC. DHSV is the 2022 winner of the international Value Based Health Care Prize for the successful implementation of a novel VBHC model co-designed with patients in public dental sector.

DHSV's model is unique as it captures both patient and population level outcomes. This is an important tenet of public dentistry which centres on equity of access to health care, health outcomes and efficient use of resources.

The model enabled patients and clinicians to become shared decision makers in achieving value and influencing improved oral health outcomes. This has been achieved by co-designing care with patients, resulting in clinicians having a deeper understanding, knowledge and respect for value from a patient perspective. In addition, co-designing process have resulted in significant advances with respect to aligning clinician's view of value (informed by evidence) and patients' perspective of what value is. The clinical team sees the patient through the whole cycle of care, tracks patient and clinical outcomes longitudinally for identified clusters of dental conditions, focuses on value as defined by patients and have applied the learning for continuous improvement.

Clinically integrated care delivered through coordinated interdisciplinary teams who can build on each other's expertise to achieve shared goals which are patient centric and defined by patient needs over the full cycle of care.

DHSV is using the ICHOM outcome measures to analyse the effectiveness of its services and prioritise high-value care (that contributes to improved oral health outcomes). Through a comprehensive audit of its services, DHSV has successfully eliminated services that are low-value, fragmented, disjointed and poorly coordinated. Through the Change Management and Respectful Workplace initiatives, there is a strong organisational culture of respect, capability and value.

A holistic integrated approach to health is needed to address a range of health issues in Australia, including oral health. Preventative and promotions programs and strategies help to achieve this, and

[22] Australian Institute of Health and Welfare. (2023) *Oral and Dental Health in Australia*. Available from: https://www.aihw.gov.au/getmedia/b44000d6-52c7-4f1d-a7fe-7938e104184f/Oral-health-and-dental-care-in-Australia.pdf.aspx?inline=true

[23] Value Based Healthcare Prize. (2023) *Dental Health Services Victoria's Value Based Oral Health Care Model*. Available from: https://vbhcprize.com/dental-health-services-victorias-value-based-oral-health-care-model/

the health system has an important role in facilitating this shift. It is important this role continue to receive support by governments.

Examples include DHSV having delivered successful and impactful oral health preventative and promotion programs (see ***Appendix 1***). The Brisbane Youth Service case study (***Appendix 2***) outlines the importance of preventative programs in supporting vulnerable Australians.

ALTERNATE MODELS OF CARE

INTEGRATED TEAMS WITHIN SUSTAINABLE WORKFORCE MODELS

A strong and effective health workforce is essential to a functioning health system. However, our members and stakeholders continue to identify workforce challenges as one of the most critical issues limiting universal access to health care. The challenges are diverse, and not unique to Australia:[24] workforce shortages, skill-mix imbalances, maldistribution, barriers to inter-professional collaboration, inefficient use of resources, poor working conditions, a skewed gender distribution, limited availability of health workforce data, persist, often within an ageing workforce.

The oral health workforce includes dentists, dental specialists, dental hygienists, dental therapists, oral health therapists and dental prosthetists. While it is widely recognised that the oral health therapy workforce provides high-quality and cost-effective dental services within their scope of practice, under the current workforce skill mix ratio, there is a reliance on the 'over-qualified' dentist workforce to provide less complex dental services. [25] These researchers have identified that the current Australian dental workforce model, which predominantly relies on dentists to provide dental care, is inefficient. They identify significant cost savings from utilising the oral health therapy workforce for dental services.

People also seek dental health care through primary care and acute care services.

A sustainable supply and appropriate skill-mix for the health workforce will require effective cooperation and governance across multiple sectors, including health, education, labour, trade, finance, gender and social welfare, as well as the engagement of the private sector, and across all levels of government – from the local to the national.

VIRTUAL CARE MODELS

Research confirms that redesigning services to incorporate virtual health care, in both cities and rural communities, can enable the provision of health care that is more responsive to the needs of patients, improves clinical effectiveness and increases service efficiency.[26] [27]

[24] World Health Organization. (2016). *Global strategy on human resources for health: Workforce 2030.* Available from: https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf
[25] Nguyen, T.M. et al. (2023) *Is Australia's lack of national clinical leadership hampering efforts with the Oral Health Policy Agenda?*, Australian Health Review, 47(2), pp. 192–196. doi:10.1071/ah22278.
[26] Snoswell, C, Gray, L, Brooks, P, et al. (2019) *Developing a policy strategy for telehealth in Australia: a summary of the telehealth FUTURES forum*, Online (Centre for Online Health): NHMRC Centre for Research
[27] The University of Queensland. (2020) Excellence in Telehealth. Available from: https://espace.library.uq.edu.au/view/ UQ:e39e00e, viewed

Like with health care more broadly, telehealth was introduced rapidly when COVID-19 restrictions were introduced. For example, SA Dental introduced a digital solution to remotely triage patients, reliably capture patient histories and deliver emergency specialist telehealth consults. They achieved this within weeks, embedding healthdirect Video Call within their digital patient pathway.[28] Another example,[29] in residential aged care, cameras can be used to collect images or videos of residents' mouths so that staff who believe there is a dental issue impacting a resident will be able to report the images for review by a dentist. The dentist can then determine what/if any treatments are required.

The technology may have been available for decades, but the willingness by practitioners and patients to embrace these technologies, and the system enablers for sustainable adoption, have often been lacking.[30] Increased practitioner utilisation and patient acceptance during COVID-19 provides a unique opportunity to not only substitute care pathways, but create new models of care, previously inconceivable.[31]

BOX 2. SYSTEM REFORM NEEDED FOR VBHC IN DENTAL SERVICES

A 2019 Deeble Institute Issues Brief co-authored by DHSV's Dr Shalika Hegde identifies reforms needed for public dental health services to achieve value-based health care in Australia. It has been included as an attachment to this submission and includes recommendations for:

- Standardising tracking of health outcomes and costs of care. This will require comprehensive and enhanced data collection systems with strong IT infrastructure.
- Developing an agreed national minimum dataset and data dictionary for oral health to enable the capture of nationally consistent and comparable outcomes data.
- Moving to an agreed blended funding model comprising a risk-adjusted capitation base and value-based health outcome components to achieve a balance between health equity and overall costs.
- Modelling the impact of proposed funding reforms and evaluating them during and after implementation.
- Developing pilot programs with inbuilt scalability to larger geographical areas with different patient segments.[32]

[28] Personify Care (2021) How to remotely triage patients and deliver emergency specialist consultations. Available from: https://personifycare.com/sa-dental-telehealth-patient-pathways/

[29] Australian Dental Association. (2023) 2023-2024 Pre-Budget Submission. Available from: https://www.teeth.org.au/News-Media/News-and-Release/Submissions/2023-24-Pre-Budget-submission-27012023/ADA-Pre-budget-submission-2023-24-Final

[30] The Australian Healthcare and Hospitals Association. (2020) *The effective and sustainable adoption of virtual health care.* Available from: https://ahha.asn.au/sites/default/files/docs/policy-issue/ahha_blueprint_supplement_-_adoption_of_virtual_health_care_-_july_2020_0.pdf

[31] Poirer, B, et al. (2022). *The evolution of the teledentistry landscape in Australia: a scoping review*. Aust J Rural Health;30(4):434-441.

[32] Deeble Institute for Health Policy Research (AHHA). (2019) Re-orienting funding from volume to value in public dental health services. Available from: https://ahha.asn.au/system/files/docs/publications/deeble_issues_brief_no_32_reorienting_funding_from_volume_to_value__0.pdf

RECOMMENDATIONS

The Commonwealth and States and Territories have long shared many roles in policy, funding and regulation of the health system, with service delivery largely undertaken by the state and territory governments and the non-government sector.

Governments must commit to ensuring universal access to dental care, and to achieve this sustainably, embed a value-based health care (VBHC) approach that guides both universal policies (i.e. Dental Benefit Schemes) and public dental services.

This should include:

1. Providing longer term strategic direction and funding certainty, aligning the term of the National Partnership Agreement for public dental services for adults with the 5-yearly term of the National Health Reform Agreement. The Agreement should:

   a. Position and enable public dental services to focus upstream on preventative care.

   b. Develop an agreed national minimum dataset and data dictionary for oral health to enable the capture of nationally consistent and comparable outcomes data.

   c. Support greater coordination and integration of dental services with health services more broadly, including the digital infrastructure and policy environment for a systematic approach to iterative, data-driven improvements.

   d. Mirror place-based approaches and evaluation frameworks that foster a learning health system.

   e. Enable more sophisticated, place-based health workforce planning, within a national framework, that:
      i. Is integrated with planning for healthcare services and healthcare funding.
      ii. Can transparently respond to, and inform, skill-mix innovation.
      iii. Has the political commitment, governance and data to drive the necessary intersectoral support for a sustainable health workforce.

   f. Progress development of value-based payment reform.

2. Introducing a Senior Dental Benefits Scheme within a national framework for introducing value-based dental benefits progressively across priority populations.

3. Establishing national leadership with appointment of a Chief Dental Health Officer.

APPENDIX 1. DHSV PROMOTION AND PREVENTION PROGRAMS

DHSV's health promotion programs focus on enhancing the skills of healthcare and early childhood experts to encourage oral health in their daily practice. These professionals collaborate with DHSV to offer information, guidance, and assistance to help their clients enhance their oral health and navigate the public dental system. By collaborating with trusted professionals from various fields, DHSV effectively reaches out to vulnerable and hard-to-reach groups who face higher levels of oral disease and are more likely to have limited health literacy.

Furthermore, DHSV collaborates with professionals and the public dental system to improve referral processes and facilitate access to care. Through a capacity building approach, DHSV maximizes the potential health benefits by cultivating a workforce specialized in oral health promotion across different sectors and disciplines. This workforce is able to exchange information, provide advice, and refer clients to appropriate care.

Two of DHSV's long-running programs that engage professionals to provide oral health information are:

Healthy Families, Healthy Smiles program

The objective of Healthy Families, Healthy Smiles is to enhance the oral health of children aged 0-3 years and pregnant women in Victoria. This is achieved by empowering health and early childhood professionals to promote oral health effectively.

Healthy Families, Healthy Smiles provides a variety of training, professional development packages, and resources tailored for professionals working with young families, aiming to support improved oral health outcomes. The program targets several professional groups, including:

- Midwives involved in antenatal healthcare.
- Maternal and Child Health nurses.
- Early childhood professionals, such as childcare educators, supported playgroup facilitators, and family support workers.
- Clinicians at Early Parenting Centres.
- Aboriginal health services and Aboriginal health workers.
- General practitioners, practice nurses, and refugee health nurses.
- Dietitians and other allied health professionals.
- Pharmacists.
- Tertiary education providers offering courses or disciplines related to pregnant women and children aged 0-3 years.

Smiles 4 Miles program

Smiles 4 Miles is an oral health promotion program specifically aimed at high-risk areas, implemented through collaboration with early childhood services. Its primary goal is to support and promote positive oral health habits and healthy eating among children in their care.

The program is primarily conducted in preschools and follows the Health Promoting Schools Framework established by the World Health Organization. This framework is widely acknowledged as a best practice approach internationally.

Smile Squad

In addition to health promotion initiatives, DHSV also provides a school-based prevention program known as Smile Squad. This program offers free dental care to primary and secondary school students in Victorian public schools, utilizing mobile clinics across Victoria.

Smile Squad has the objective of enhancing the oral health of school-aged children, providing them with the highest opportunity to maintain good oral health into adulthood. This involves fostering health literacy among school-aged children and their families, ensuring they have the knowledge and understanding to make informed decisions about their oral health.

APPENDIX 2. A COMMUNITY BASED DENTAL CLINIC FOR HOMELESS YOUTH IN BRISBANE YOUTH SERVICE

The problem:

The relationship between homelessness and ill health is complex. Many risk factors for homelessness such as unemployment, low income and substance abuse are also risk factors for poor oral health. For homeless individuals, in addition to poorer general health, oral health has also been reported as poorer with higher decayed, missing, filled teeth (DMFT) scores and poorer oral health related quality of life1.

Cost of care, waiting lists for publicly funded services, lack of transport, lack of information and fear are some of the reported barriers to accessing dental care for disadvantaged populations. In order to overcome barriers to access to dental care, previous studies have recommended integrating dental care, referral pathways and information within the overall care provided by support services available to people at risk of homelessness.

The strategy/program implemented:

A mobile dental clinic run by volunteer oral health professionals was implemented within a community organisation (Brisbane Youth Service) for disadvantaged youth in Brisbane in collaboration with the University of Queensland. The dental clinic was designed to run four times a year, for a week at a time. During this week, volunteer dentists, oral health therapists, hygienists and dental assistants provided preventative, diagnostic and basic restorative treatment.

Key barriers and enablers:

The financial cost of oral healthcare is largely the responsibility of individuals. Governments contribute funding through the private health insurance rebate (means-tested), the Child Dental Benefits Schedule (means-tested) and through public dental services. Significant barriers to oral healthcare for homeless youth are affordability and timely access to preventive dental care, which are exasperated by a lack of national leadership on oral healthcare. The purchase of dental equipment was the main cost associated with setting up this dental program.

Initial start-up funding is critical when implementing a local response to a local community need. This program highlights that performance should not only monitor input focused measures, such as the type and number of dental services delivered. It is essential to also monitor and improve health equity. Existing health measures do not identify the critical value of increasing access to care for at risk populations, such as homeless youth, who are the least likely to access services.

An enabler to this program is the use of volunteer dental professionals. This program has been shown to have valuable service outputs and can continue to be run at a low-cost because of the use of volunteer dental professionals. The reliance on volunteers appears to be sustainable for the program with numerous dentists, oral health therapists and dental hygienist interested and on a wait-list to volunteer in future weeks. Brisbane Youth Service's community-based dental clinic for homeless youth demonstrates the value of a local response to address barriers preventing homeless youth from accessing preventive dental care.

What is needed to scale-up the success?

Governments and external stakeholders need to recognise the importance for prevention and oral health promotion activities. The evaluation of this program found that the majority of the participants had not been able to access dental services since they in school by government clinics. Eligibility in Queensland for school dental services ends at age 16 and there appears to be a gap in accessible services for this population of young, disadvantaged people. 'Funding that is sustainable and appropriate to support a high quality health system' would benefit the Australia community and at-risk population groups with poor oral health.

Investing in oral health initiatives with a holistic approach to care and which connects at-risk populations to suitable oral health services and pathways is needed. Commonwealth, state and territory funding towards prevention and oral health promotion activities would provide a sustainable and cost-effective way of improving oral health and reducing the economic burden of poor oral health.