NSW Oral Health Alliance

Submission to the House Standing Committee on Health and Ageing Inquiry into Adult Dental Services in Australia

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Council of Social Service of NSW (NCOSS)

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About the NSW Oral Health Alliance

The NSW Oral Health Alliance is a forum of organisations with an interest in oral health issues for low income and disadvantaged people in NSW. The Alliance is convened by the Council of Social Service of NSW (NCOSS).

This submission is endorsed by the following Alliance members:

- Australian Dental Association NSW (ADA NSW)
- CJD Support Group Network
- Combined Pensioners & Superannuants Association of NSW Inc. (CPSA)
- Council of Social Service of NSW (NCOSS)
- Hepatitis NSW
- Homelessness NSW
- Mental Health Association NSW Inc (MHA NSW)
- National Seniors
- NSW Users and AIDS Association (NUAA)
- Positive Life NSW Inc

About NCOSS

The Council of Social Service of NSW (NCOSS) is a peak body for the not-for-profit community sector in New South Wales. NCOSS provides independent and informed policy advice, and plays a key coordination and leadership role for the sector. We work on behalf of disadvantaged people and communities towards achieving social justice in NSW.

NCOSS' health priorities

NCOSS' objective in the health portfolio is to reduce inequities for disadvantaged people and improve population health outcomes. We believe that health policy and systems need to be based on principles that recognise health as a human right, the social determinants of health, and the importance of strengthening the role of the community and consumers in the development and delivery of health services.

NCOSS health priorities are primary and community-based health, oral health, mental health, health transport, and aids and equipment for disabled people. Our funding recommendations to the NSW Government on these issues are outlined in our *2013-14 Pre-Budget Submission*. We also advocate on health system reform, consumer and community engagement and health equity issues.

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Introduction

The NSW Oral Health Alliance (NSW OHA) welcomes the opportunity to provide this submission to the House Standing Committee on Health and Ageing Inquiry into Adult Dental Services in Australia.

Oral health continues to be one of the areas of greatest health inequity in our society. Disadvantaged and low-income Australians have higher rates of complete tooth loss, higher rates of extractions, and more self-reported treatment needs.[1]

The Alliance provides this submission to supplement formal quantitative data with qualitative evidence about the extent and nature of demand for adult dental services. It reflects the perspectives of not-for-profit community sector organisations who work with those people most at risk of poor oral health and who struggle the most to access dental services.

For comprehensive oral health data, we refer the Committee to the Australian Research Centre for Population Oral Health, as well as Australian Bureau of Statistics, Australian Institute of Health and Welfare, Health Workforce Australia, and state public dental services such as the NSW Centre for Oral Health Strategy.

Terms of reference 1: Demand for dental services across Australia and issues associated with waiting lists

Demand for public dental treatment in NSW far outweighs existing capacity and resources, and has done so for decades. There were 117,369 people (89,219 adults and 28,150 children) on the waiting list for public oral health services in NSW as at December 2012.[2] This is almost double the number of people waiting for elective surgery in NSW public hospitals (67,438 patients as at 31 December 2012).[3]

High demand and long waiting lists mean that those people who rely on public dental services are less likely to receive timely, preventative care and more likely to develop serious, more costly oral health problems.

The 2006 NSW Legislative Standing Committee inquiry into the provision of dental services concluded: "…*the overstrained and under-resourced public dental system is limited to providing emergency, acute treatment to patients, who are therefore being deprived of the preventive and comprehensive treatment necessary to reach a satisfactory level of oral health.*"[4]

[1] Australian Institute of Health and Welfare & Dental Statistics and Research Unit (2001), *Research Report: oral health and access to dental care – the gap between the 'deprived' and the 'privileged' in Australia.* Cat. no. DEN 67. Adelaide: AIHW, 2001

[2] Public Oral Health Services (Non-admitted) - Child & Adult Waiting Lists, NSW Health, http://www0.health.nsw.gov.au/cohs/list_flow.asp#para_0, accessed 20/03/2013

[3] NSW Bureau of Health Information, *Hospital Quarterly: Performance of NSW public hospitals October to December 2012*, Sydney, March 2013

[4] Standing Committee on Social Issues, Report 37 - Dental services, NSW Legislative Council, NSW Parliament, March 2006, p97

Waiting times for public dental services was the most common issue identified in the Alliance's report on access to dental services for clients of non government human service organisations. Of those who were currently on a waiting list, nearly two-thirds of respondents had been waiting for longer than six months and one quarter waiting for longer than two years.

Waiting times are particularly an issue for disadvantaged people with complex needs, in periods of crisis, or in unstable accommodation. Maintaining up to date contact details and appointments over long periods can be difficult for people with poor living skills. People in transient situations may move before dental appointments can be met, such as women and children at a refuge.

The Alliance believes the official waiting lists do not reflect the full extent of demand by eligible adults for dental services in NSW. Both the reality and the perception of long waiting lists for public dental services can act as a disincentive to seeking treatment. The Alliance is aware of people who have 'dropped off' the waiting list as they give up on receiving public treatment. They either live with the pain and discomfort or pay for private treatment, often exacerbating existing financial hardship.

Official demand estimates may also be distorted due to other access barriers. Community sector organisations frequently report a lack of information about available services or referral pathways impedes their clients' access to services. The Alliance has received anecdotal feedback that some public dental services do not promote their services to the local community to minimise demand.

The Alliance believes the already high demand for NSW public dental services will increase further as a result of the closure of the Medicare Chronic Disease Dental Scheme (CDDS) in December 2012. In the five years the CDDS was in operation, the NSW public dental waiting list fell by around one-quarter.[5] Given over three-quarters of people using CDDS in NSW were eligible for public dental services it is likely a large proportion will default back to the public system.

Terms of reference 2: Mix and coverage of dental services supported by state and territory governments, and the Australian Government

The NSW government primarily supports the provision of emergency and acute dental services. High levels of demand mean the system has little capacity to provide more preventive -focused care. Consequently those people who rely on the public system are more likely to develop serious oral health problems that are more complex and costly to treat long-term.

While NSW has a commendable oral health promotion service, it doesn't have the staff or resources to implement the comprehensive range of initiatives required to support an effective prevention-focused system. However, the extensive roll-out of fluoridation across the vast majority of NSW is a note-worthy achievement. The Alliance commends the NSW Government and in particular the NSW Centre for Oral Health Strategy for continuing to support this safe and effective evidence-based initiative.

[5] Down 25% from 158,791 (June 2007) to 118,000 (March 2012)

The mix and coverage of dental services available through the NSW public dental system has been constrained by chronic under-funding by successive state governments. The NSW public oral health budget in 2012-13 was $178m, the equivalent of just $24.50 per person. Despite the high unmet need there has been no real increase in the state dental budget for a number of years.

The Alliance is concerned the net effect of the NDHR package with the closure of the CDDS may further constrain the mix and coverage of dental services available for low income and disadvantaged people in NSW. We estimate NSW faces an oral health funding shortfall of approximately $227 million in 2012-13 and almost $800 million over the next four years under the national funding changes (see Appendix 1).[6] This is partly due to NSW's proportionally higher utilisation of the CDDS compared to other jurisdictions.[7]

In addition to increasing the capacity of the public system to service high-needs people, the Alliance believes both Commonwealth and state governments need to place greater emphasis on preventing dental disease through evidence-based clinical and population approaches. The Australian National Preventative Health Agency and Medicare Locals should be clearly tasked with driving the integration of oral health into general health as part of a comprehensive primary health care approach.

Terms of reference 3: Availability and affordability of dental services for people with special dental health needs

People with special dental health needs face multiple barriers to accessing timely appropriate dental services.

Cost is a major impediment to treatment for people with special needs as they are also more likely to experience poverty and financial disadvantage. More than one-quarter (27%) of people with disability are currently living below the poverty line – double the poverty rate of the general population (13%).[8]

Feedback to the Alliance is there continues to be a lack of appropriate public and private services tailored for special needs groups, including people with intellectual disability, people experiencing homelessness, people with substance misuse issues, refugees, Aboriginal people, and people with complex medical conditions.

The 2006 NSW Legislative Committee Dental Inquiry noted many special needs patients often cannot be treated in private or small public dental clinics due to their extensive and severe oral health problems, which often have to be treated under general anaesthetic. It found such treatment in the public system is constrained by lengthy waiting lists during which time their oral health further deteriorates.

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[6] Based on 1/3rd share of $4bn Dental Reform Package ($1.3bn adults and $2.7bn children) pro-rated over 6 years, NSW is estimated to receive $228 million per annum - a funding shortfall of $200m per annum based on 2011/12 CDDS funding of $427.5m million.

[7] NSW CDDS expenditure in 2011-12 was 48% of all national expenditure

[8] Australian Council of Social Service (ACOSS), **Poverty in Australia 2012, Sydney, Updated March 2013.**

The Alliance believes the common requirements among special needs groups identified by the Inquiry are still yet to be fully addressed. Foremost is the need for specialised programs and dedicated flexible clinical service models taking into account the unique circumstances of each group.

Other key requirements are training for dental workers in the specific needs of people in the different groups, dissemination of service information tailored to people in the various groups, and data collection and monitoring of service delivery and the health outcomes of people with special dental needs.

Terms of reference 4: Availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations

The Alliance regularly receives feedback from community organisations about the difficulties low income and disadvantaged people experience accessing and affording dental services both within areas of metropolitan Sydney and in some regional and rural areas of NSW.

The primary barriers reported to the Alliance are systemic. They include the high cost of private dental services; the lack of dental services in some areas (both private and public); and long public dental waiting times.

The affordability of dental services is a major issue. Just under half (43%) of health care card holders avoided or delayed visiting a dentist due to cost in 2010.[9] Almost all of the respondents (94.6%) in the Alliance's 2009 dental report identified the cost of private dentistry as the main factor affecting client access to dental services.

Cost is an issue across the social gradient, not just concession card holders. Nationally, almost one-third (28%) of Australians avoided or delayed a dental visit due to cost.[10] People on low-to-moderate incomes who are not eligible for public dental services are also unable to afford private insurance or basic dental care. This includes people in low paid or casual employment and retirees on limited incomes.

The lack of locally available public and private dental services was also identified as a major barrier in the 2009 Alliance report. This is a particular issue for low income and disadvantaged people who live in areas poorly served by public transport, do not have private transport, or cannot afford the cost of travelling significant distances to access services in other regional centres.

The lack of available dental services is partly attributable to workforce issues. There is a maldistribution of dentists in rural, remote, and low socio-economic metropolitan areas, and an under-utilisation of oral health professionals and multi-disciplinary approaches. This issue is addressed further under Terms of reference six.

[9] Australian Institute of Health and Welfare (2012) *Oral health and dental care in Australia: key facts and figures 2011*, Canberra, accessed at: http://www.aihw.gov.au/dental/cost/

[10] Australian Institute of Health and Welfare (2012) *Oral health and dental care in Australia: key facts and figures 2011*, Canberra, accessed at: http://www.aihw.gov.au/dental/cost/

Terms of reference 5: Coordination of dental services between the two tiers of government and with privately funded dental services

The 2012 National Dental Health Reform (NDHR) package is a welcomed first step to improve the dental policy framework and provision of services. However, the Alliance is concerned about on-going fragmented policy and funding responsibility for dental services between the two tiers of government, and the scope and coverage of services funded under the package.

The Alliance is concerned about the lack of a clear, comprehensive national framework for oral health policy and funding. The current shared approach between the states and the Commonwealth is piecemeal and fragmented. Blurred responsibilities between the two tiers of government in the absence of a comprehensive framework leave the system exposed to gaming and perverse incentives.

Over the past five years, NSW governments' anticipation of Commonwealth oral health reform has in effect frozen state-level investment in public dental services. This is despite State Governments responsibility to provide public dental services under the National Healthcare Agreement (s26(g)), which was re-affirmed by COAG in the 2011 National Health Reform Agreement.

The Alliance and the Council of Social Service of NSW (NCOSS) have long advocated successive NSW governments for increase core public dental funding.[11] However, impending Commonwealth dental reform has been used as a reason for not committing any additional resources to the public system.

The Alliance is concerned the partial Commonwealth funding contribution to state public dental services under the NDHR package will only reinforce State governments' reluctance to adequately fund their own systems. In the absence of a comprehensive national funding framework that fully addresses the historic under investment in public services or provides a long-term funding plan beyond 2018, the public system remains exposed to under-resourcing.

Commonwealth and State oral health funding and policy must be aligned within the context of the new NDHR package. There must be a clear agreement between State and Federal Governments on their respective roles, priorities and funding responsibilities.

Longer-term, the Commonwealth government must commit to implement a national, universal access oral health system that provides all Australians with the opportunity to maintain good oral health, as recommended by the National Dental Advisory Council.

The Alliance believes there are opportunities for better partnerships to be created between private, public and NGO agencies through the NDHR package to ensure best use of resources and improve service access, especially in regional and rural settings.

[11] See NCOSS PBS 2013-14: Building Fairness First; NCOSS 2012-13 PBS: Making NSW Number 1 for Fairness; NCOSS 2011 State Election Policy: Vote 1 Fairness in NSW; NCOSS 2010-11 PBS: A Community Services Stimulus Package; and NCOSS 2009-10 PBS: Towards Triple A Rated Community Services

For example, services provided through Aboriginal community controlled organisations, community health models that integrate oral health care with physical and mental health, and encourage oral health promotion through a range of professionals.

Terms of reference 6: Workforce issues relevant to the provision of dental services

As noted under number four, workforce is a key factor affecting the affordability and availability of dental services. Maldistributed workforce, under-utilisation of the full range and capacity of oral health practitioners, and on-going vacancies in the public dental system all negatively impact on service capacity.

The maldistribution of dentists in NSW is a significant problem. There is an unequal distribution of dentists between metropolitan and rural areas, with nearly three times as many practicing dentists in Sydney than in remote areas. However this issue is not confined to non-metropolitan areas, with some low socio-economic areas of Sydney experiencing rates of practicing dentists similar to under-serviced rural areas.[12]

A concentrated workforce mix and a narrow scope of practice limits service capacity and impede more cost-effective approaches. The dental labour force is dominated by general dental practitioners and specialists. The AIHW estimates there are 50 dentists, 6 dental therapists, 3 dental hygienists, 2 oral health therapists and 4 dental prosthetists per 100,000 Australians.[13]

A more diverse oral health workforce supports the provision of multi-disciplinary team care. Establishing team care approaches as the basis for training of oral health practitioners would also promote and embed more efficient care arrangements.

Some Alliance members believe the scope of practice of dental therapists, dental hygienists, oral health therapists, dental assistants and allied health workers could be expanded to increase the efficiency of the dental team. This would need to be accompanied by appropriate training to maintain safety and quality standards.

Within the public system, a lack of workforce constrains full service capacity. We note NSW is working to increase the recruitment and retention of public oral health professionals, and introduced a new Oral Health Award in 2008 to drive improvement in the public sector. However, the Alliance understands there continues to be on-going vacancies and under-utilized dental facilities in some areas.

Further Information

For inquiries or further information please contact Ms Solange Frost, Senior Policy Officer (Health) on 02 9211 2599 ext. 130 or solange@ncoss.org.au

[12] AIHW Dental Statistics and Research Unit, 2008, *Dentist Labour force in Australia 2005*, AIHW Dental Statistics and Research Unit Research Report No. 33, Cat. no. DEN 172, Australian Research Centre for Population Oral Health.

[13] Australian Institute of Health and Welfare, *Cost of dental care*, accessed at http://www.aihw.gov.au/dental/cost/

Attachments:

NCOSS PBS 2013-14: Building Fairness First;

NCOSS 2012-13 PBS: Making NSW Number 1 for Fairness;

NCOSS 2010-11 PBS: A Community Services Stimulus Package

NCOSS 2009-10 PBS: Towards Triple A Rated Community Services

NSW Oral Health Alliance Advocacy Kit, NCOSS, Sydney, 2010

NSW Oral Health Alliance, Access to public dental services, NCOSS, Sydney, 2009

Standing Committee on Social Issues, *Report 37 - Dental services*, NSW Legislative Council, NSW Parliament, Sydney, March 2006

Appendix One:

COMMONWEALTH ORAL HEALTH FUNDING TO NSW 2011-12 to 2015-16

Year	Program	Funding ($m)*	Funding shortfall^
2011-12	Medicare Chronic Disease Dental Scheme (CDDS)	427.5	
	Medicare Teen Dental Plan (MTDP)	20.8	
	Sub-total	**448.3**	
2012-13	CDDS (5 months estimate to 30 Nov)	178	
	MTDP (based on 2011-12 expenditure)	20.8	
	Public dental waiting list program	22.3	
	Sub-total	**221.1**	**227.2**
2013-14	Public dental waiting list program	50	
	Child Dental Benefits Schedule	67	
	Sub-total	**117**	**331.3**
2014-15	Public dental waiting list program	38.5	
	Adult public dental services	64.5	
	Child Dental Benefits Schedule	207	
	Flexible grants program (1/3 of $50.5m)	16.5	
	Sub-total	**326.5**	**121.8**
2015-16	Adult public dental services	95.1	
	Child Dental Benefits Schedule (approx)	217	
	Flexible grants program (1/3 of $55.5m)	18.5	
	Sub-total	330.6	**117.7**
Total budgeted funding 2011-12 to 2015-16		1443.5	
Five yr funding estimate based on continuation 2011-12 funding		2241.5	
Shortfall			**798**

TABLE DATA NOTES:

* Figures outlined in the Mid-Year Economic and Fiscal Outlook (MYFEO) 2012-13. Where funding is not identified at the state level, NSW funding is calculated on one-third of the national total.

^ The NSW funding shortfall is calculated using Commonwealth oral health funding in 2011-12 as a base amount ($448.3 million). For example, in 2012-13 the shortfall was $227.2 million ($448.3 - $221.1 = $227.2)

PROGRAM NOTES

Program closures:

- *Medicare Chronic Disease Dental Scheme (CDDS)* ceases 1 December 2012, saving approx $3.51 billion nationally over four years (based on cost of $878 million pa in 2011-12)
- *Medicare Teen Dental Plan (MTDP)* ceases 31 December 2013, saving $513.4 million nationally over six years ($37.2m in 2013-14, $103.7m in 2014-15, $112.6m in 2015-16, $123.8m in 2016-17, $136.2m in 2017-18)

New funding programs:

- *Public Dental Waiting List Program* - $345 million nationally over three years for public dental waiting list blitz. To be allocated as a National Partnership Agreement. (2012-13 Budget).
- *Adult Public Dental Services Program* - $1.3 billion program for low income adults over four years from 2014-15 to support the provision of dental health services to adults who rely on the public dental system. To be allocated as a National Partnership Agreement. (Dental Reform Package, August 2012).
- *Child Dental Benefits Schedule* - $2.9 billion nationally over six years to provide basic dental services for eligible children aged 2 to 17 years. Funding commences from 1 January 2014. Available to public and private sectors via Medicare. (Dental Reform Package, August 2012).
- *Flexible grants program* - $227 million over four years from 2014-15 to support dental infrastructure and workforce initiatives in outer metropolitan, regional, rural and remote areas (2012-13 Budget).

Other funding (not included in analysis):

- *Increasing the capacity of the dental workforce* - $158.6 million nationally over four years to introduce an Oral Health Therapists (OHT) graduate year program ($45.2m); expand the Voluntary Dental Graduate Year Program ($35.7m); Rural and Remote Infrastructure and Relocation Grants for Dentists ($77.7m) (2012-13 Budget).

- *Oral health promotion* - $10.5 million nationally over three years for oral health promotion (2012-13 Budget).
- *Pro-bono dental services* - $0.45m over 3 years (2012-13 Budget).
- *Voluntary Dental Internship Program* - $53.1 over 3 years (2011-12 Budget).