



Submission 4 June 2023:

Select Committee into the Provision of and Access to Dental Services in Australia

About Us

ForHealth is the second largest primary health provider in Australia. Our mission is **accessible healthcare**.

We serve **>7 million consults p.a.** through **80 large scale medical and dental clinics**. Our network promotes access in some of Australia's most health vulnerable communities in **outer metropolitan, regional and remote** Australia.

Our services include General Practice, Dental, Specialists, Imaging, Pharmacy and Pathology. Our **dental business is branded *Primary Dental*** and is the fifth largest provider in Australia.

ForHealth is the local **leader in *Urgent Care Clinics*** that triage Emergency Departments (EDs) presentations at one-third the taxpayer cost. We have 15 government funded sites in areas of need. In each site there is an **adjacent *Primary Dental* facility**.

Executive Summary

ForHealth strongly supports the Australian Dental Association's (ADA) submission to the inquiry and their perspectives on the current state of our public Dental system.

Our system is failing our most vulnerable, and we note the following context for consideration:

- ***Preventable Dental Hospitalisations are growing fast*** (+14% in two years)¹
- Access is **skewed to affluent, urban populations** and will be further impacted by **cost-of-living pressures** and the emerging prospect of **state payroll tax**.
- Public dentist supply is insufficient with a **median wait time of >20 months**²
- There is **<40% take-up of child benefits**, and no schedule for pensioners or healthcare card holders.³
- This is despite **"unutilised" dental capacity** available in the private sector.

Intervention, and new funding pathways are needed.

Our recommendations:

- a. An **expanded, and nationally consistent voucher system** that unlocks latent private dental sector capacity.
- b. Investment in creating awareness and **uptake of the child benefits schedule** and establishment of a **pensioner and healthcare card** benefits schedule.
- c. Expansion of government funded **Urgent Care Clinics to include Dental** presentations (where infrastructure exists) to triage ~3-4% of ED presentations⁴
- d. A national **resolution regarding payroll tax** for the primary health sector.

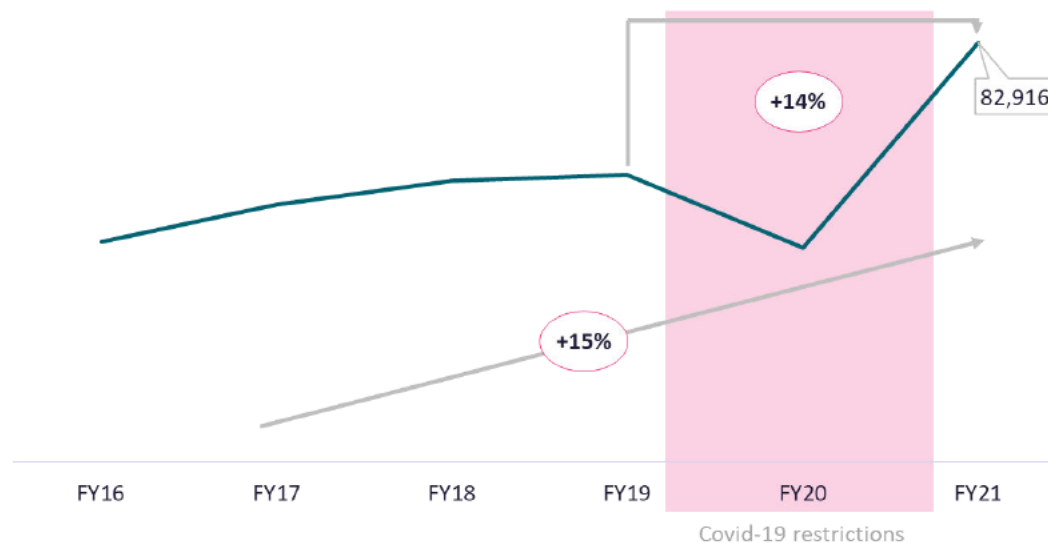


Inquiry Reference Items:

1. The experience of children and adults in accessing and affording dental services

An important indicator of Dental access is **preventable dental hospitalisations** which have **risen sharply by 14% since FY19** following the COVID period.⁵ This is a long-term upward trend that is indicative of a general decline in access.

Figure: # Preventable Dental-related Hospitalisations, FY16-21 (Source: AIHW)



The level of access, and rate of decline varies significantly:

- **by socio-economic cohort** given a predominantly private billing model.
- **for remote communities** given distance to dental services.
 - For example, preventable hospitalisations for children were +18% for regional, +50% for remote, and +100% for very remote communities versus major cities.⁶

In the current **cost-of-living context** we see the relationship between access and socio-economic status worsening and expect downward pressure on private health coverage.

The **emerging threat of state payroll tax** is a significant risk to affordability. Should there be a legal basis, a practice would need to **increase prices an estimated ~12%*** to offset the cost. This step-up, in addition to current inflation, will impact visits and private health premiums.

The flow-on **impacts to the secondary healthcare system** and to taxpayer costs also need to be considered. The *Primary Health* sector remains the most efficient and least costly part of the system. Reducing access to this first layer ultimately results in a further burden to the hospital system and public dental system. The hospital system is generally accepted to be ~20x the cost of the primary system. The cost of building new capacity in the Public Dental system is ~\$1m in infrastructure alone for a 4-chair practice (and before operating costs).

* Assumes a practice service fee of 60% and a corporate tax rate of 30%



In **summary**, we observe declining Dental access with costly flow-on impacts to secondary healthcare. We see significant distribution issues for low socio-economic cohorts and for remote communities. This access and maldistribution will worsen with cost-of-living pressures, and undoubtedly step-down if the emerging push for state payroll tax succeeds.

Inquiry Reference Items:

2. The adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional, and remote areas.

In 2019 *The Grattan Institute* noted that despite one-third of Australians being eligible for public dental services, there was **only capacity for ~20% of eligible patients** for treatment.⁷

Whilst there are limits to published data, we note the following from aggregated datasets for South Australia, Victoria, and Western Australia:

- **4% decrease in public treatment** from FY18-22⁸ vs. population growth of 4%.⁹
- **15% growth in dental-related hospitalisations** over the same period.¹⁰

At a national level we know the **median wait-time is 20.6 months** for general dental care in the public system.¹¹

Further, in Victoria, the ADA reported a **22% decrease in public dentists between 2018-22**.¹²

This capacity constraint is unnecessary given a **significant level of unutilised chairs** in the private sector and a comparable advantage in building and attracting workforce.

In **summary**, there is a clear supply-gap in the public system and wait-times are not acceptable. This is distressing patients with severe dental issues and placing further pressure on our hospital system. The issue is most pronounced in low socio-economic / **outer metropolitan, regional and remote areas** with access and affordability constraints. The private sector has unutilised capacity, and we recommend stronger public-private partnerships and greater funding for the voucher system in these areas of need.

Inquiry Reference Items:

3. the provision of dental services under Medicare, incl Child Dental Benefits Schedule

First, we note there is limited access to MBS for dental services outside the Child Dental Benefits Schedule. However, our experience across both General Practice and Dentistry gives us a unique perspective on a **significant level of MBS activity related to Dental pain** and public dental wait times. In assessing the need for new pathways, this hidden cost, in addition to ED costs, should be better understood.

Our understanding is the **adoption of the Child Dental Benefits Schedule is low (i.e. <40%)**.¹³ This implies a lack of awareness of entitlements and intervention points with guardians.



Currently, patients are required to sign into myGov or call Medicare to check eligibility and remaining entitlements. These processes are open to difficulties relating to language barriers, access to bulk-billing dentists, technology literacy, and other factors.

To address this, we suggest:

- Patients receive a **biennial physical voucher** to serve as a reminder of funds available, the rollover of a new year, and to educate and build awareness
- **GPs access eligibility status** for children and remind them of any remaining balance
- Dental clinics are given an **online portal to view entitlements** for their patients.

Inquiry Reference Items:

4. Pathways to improve oral health outcomes, including a path to universal access

Universal dental access requires assessment beyond the scope of this submission.

In the context of funding constraints, limited resources must be targeted at vulnerable populations. To this end, we welcome the recent Federal Budget measure to triple the MBS bulk-billing incentive for healthcare card holders.

In line with this approach, we recommend **increased funding to the sector**, targeted at **communities and cohorts in need** while better utilising existing private capacity, including:

- **Urgent Care Clinics** (add Dental where available):
The Commonwealth is investing significantly to establish Urgent Care Clinics to triage Category 4 and 5 ED presentations back to 58 General Practice clinics. Most of the successful clinics are large format practices with adjacent Dental services.

Dental presentations are typically 3-4%¹⁴ of ED traffic and can be triaged back to Urgent Care Clinics using the same hospital triage line to be seen by a Dentist. We estimate this would cost ~50% less than an ED attendance, release scarce ED capacity, and (with a voucher) allow the underlying cause to be treated on the day.
- Expansion of a **uniform voucher system**:
Patient vouchers leverage private capacity to treat public patients. This improves access to timely and clinically skilled treatment. An expanded and uniform national program is required with a focus on outer metro, regional and remote areas.

Studies also show '**Adults attending public dental are more likely to have teeth extracted**, and less likely to receive preventive services', than in private clinics.¹⁵
- **Public-private partnerships**:
Block grants and an EOI process for providers in outer metro, regional and rural areas to dedicate capacity to the public system. A 4-chair surgery costs ~\$1m and the private sector has unutilised capacity and can better attract scarce workforce.
- **Pensioner and healthcare card** benefits schedule:
Development of a pensioner and healthcare card holder benefits schedule to increase capacity for vulnerable populations in line with MBS bulk-billing incentives.



References

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- ³ Commonwealth of Australia, Report on the Fourth Review of the Dental Benefits Act 2008, <https://www.health.gov.au/sites/default/files/documents/2022/04/report-on-the-fourth-review-of-the-dental-benefits-act-2008.pdf>
- ⁴ Skapetis et al, 2011, Management of dental emergencies by medical practitioners: Recommendations for Australian education and training, <https://onlinelibrary.wiley.com/doi/10.1111/j.1742-6723.2011.01384.x>
- ⁵ AIHW, Hospitalisations interactive 1: Potentially preventable hospitalisations due to dental conditions, states and territories, 2010–11 to 2020–21
- ⁶ AIHW, Oral health and dental care in Australia, Hospitalisations interactive 2: Potentially preventable hospitalisations due to dental conditions^a, by selected characteristics, Australia, 2016–17 to 2020–2, <https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/hospitalisations>
- ⁷ Filling the gap A universal dental scheme for Australia, <https://grattan.edu.au/wp-content/uploads/2019/03/915-Filling-the-gap-A-universal-dental-scheme-for-Australia.pdf>
- ⁸ AIHW, Public Dental Waiting Times National Minimum Data Set, Dental care interactive 15: Public dental services and waiting times data, states and territories, 2013–14 to 2021–22
- ⁹ Australian Bureau of Statistics, 3101.0 National, state and territory population, TABLE 4. Estimated Resident Population, States and Territories (Number), <https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release>
- ¹⁰ AIHW, Public Dental Waiting Times National Minimum Data Set, Dental care interactive 15: Public dental services and waiting times data, states and territories, 2013–14 to 2021–22
- ¹¹ AIHW, Oral Health and Dental Care in Australia, <https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/dental-care>
- ¹² ADA, Change in Victorian public sector dentist numbers (FTE) by region 2018–2022, <https://adavb.org/advocacy/campaigns/respect-public-dentistry>
- ¹³ Commonwealth of Australia, Report on the Fourth Review of the Dental Benefits Act 2008, <https://www.health.gov.au/sites/default/files/documents/2022/04/report-on-the-fourth-review-of-the-dental-benefits-act-2008.pdf>
- ¹⁴ Skapetis et al, 2011, Management of dental emergencies by medical practitioners: Recommendations for Australian education and training, <https://onlinelibrary.wiley.com/doi/10.1111/j.1742-6723.2011.01384.x>
- ¹⁵ Filling the gap, A universal dental scheme for Australia, <https://grattan.edu.au/wp-content/uploads/2019/03/915-Filling-the-gap-A-universal-dental-scheme-for-Australia.pdf>