Victorian Oral Health Alliance

2 December 2020

Committee Secretary
Senate Standing Committees on Economics
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Select Committee members,

RE: SUBMISSION TO THE INQUIRY INTO REGIONAL AUSTRALIA - ACCESS TO ORAL HEALTH

This brief submission specifically addresses the below terms of reference of the inquiry:

a. improved co-ordination of federal, state and local government policies;
b. enhancing local workforce skills;
c. any other related matters. – specifically health

It describes the significant inequities in access issues for regional Victorians in particular for public oral health (dental) care, but this inequitable access has also historically been indicative of the same or worse situation across Australia.[1] Many regional Australians have to wait close to the length of a Parliamentary term to just receive basic oral health care. Poor access to health care more generally is a key factor impacting the sustainability of rural and regional communities, and the willingness of Australians to stay in or move to these essential parts of Australia.

The Victorian Oral Health Alliance (VOHA) is a group of key professional peak bodies, welfare and consumer organisations as well as community dental services (refer to *VOHA's members list*). VOHA is committed to improving Victorians' oral health and access to dental care.

[1] https://www.aihw.gov.au/getmedia/df234a9a-5c47-4483-9cf7-15ce162d3461/aihw-den-230.pdf.aspx?inline=true

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In brief, VOHA wishes to bring attention to the following points:

1. **Oral health care is not discretionary care** - it is not separate from general and allied health, on the contrary, it is a crucial part of good health care. Poor oral health is already a silent and pervasive epidemic, impacting on people's everyday lives. It disproportionately affects Australia's vulnerable and disadvantaged populations, who we know from the analysis of socioeconomic status (SES) are located in higher proportions throughout regional and rural Australia.[2] Essentially there is a higher need for oral health care in rural and regional Australia, however, there are significant infrastructure, access and funding issues preventing these needs from being met.
2. **Oral health care is primarily an individual expense with limited Commonwealth and state and territory funding available.**[3] Oral health care is not funded in the same way to Australians as other health services e.g. via Medicare for general practice. This results in patients not seeking oral health care when required and then needing to access hospital care (more than 70,000 preventable hospitalisations in Australia annually) instead.[4]

   The recently released AIHW data on health spending for 2018-19 shows that patients continue to pay for the vast majority of oral health (dental) care (public and private) and are increasingly having to pay more to look after their teeth, while government spending is decreasing.

   In 2018-19, oral health care cost $424.61 per person in Australia. Of this, consumers paid 81% through out-of-pocket costs and health insurance premiums, whilst the Commonwealth paid 13% and the states and territories just 6%. The consumer share is growing - AIHW estimated that three years earlier in 2016-17 consumers had paid 77% of costs.[5]

[2] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Socio-Economic%20Advantage%20and%20Disadvantage~123

[3] https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2018-19/contents/data-visualisation - government funding in 2018-19 was equivalent to $79.21 per person in Victoria.

[4] https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction

[5] Australian Institute of Health and Welfare. Health Expenditure Australia 2016–17. Canberra: AIHW; 2018.

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However hidden in these figures is the fact that much of the Commonwealth spending is via the rebate to those with private health insurance. For public dental care, the States pay the vast majority of these costs – the Commonwealth National Partnership Agreement only comprising roughly 12% of funding. The Commonwealth does fund the Child Dental Benefits Scheme but it is worth noting less than 20% of Australian children access this due to underpromotion and other reasons.[6]

Grattan summarised this:

> *In practice the Commonwealth has made only a modest funding contribution through the National Partnership. In 2016-17 the Commonwealth provided $104.5 million for public dental services, compared with state spending of $836 million. At the same time, the Commonwealth provided $701 million to subsidise private health insurance for dental services.*[7]

Thus access by lower income people, especially in rural Australia, is vastly poorer than those able to afford private dental care, with significant health impacts for those reliant on public care. A Victorian rural health service CEO noted to us recently that he sees inequalities in oral health status in his area as the greatest of all health inequalities but that this issue 'doesn't get a look in' when governments consider their budgets.

3. **VOHA's primary concern is that there is an unacceptably long waiting period to access public dental care** in most of regional Victoria. Whilst priority and urgent cases receive quicker care, waiting lists for general dental care in Victoria metropolitan areas are close to two years (for community clinics). Although there is some variation, many regional Victorians have to wait much more than this. Waiting lists for general care in specific regional locations in Victoria include:

   - Maryborough - 42 months
   - Wangaratta – 33 months
   - Benalla – 33 months
   - East Grampians – 24 months
   - Albury Wodonga – 23 months
   - Portland - 22 months

[6] Australian Institute of Health and Welfare (AIHW) (2018b). *Patient Experiences in Australia: Summary of Findings, 2017-18,* Cat. No. 4839.0, Canberra.
[7] https://grattan.edu.au/wp-content/uploads/2019/03/915-Filling-the-gap-A-universal-dental-scheme-for-Australia.pdf

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- Baw Baw – 30 months
- Latrobe – 30 months
- Seymour – 22 months

4. **Waiting times for dentures are generally longer and are dependent on general dental care needs being met**, meaning patients can often wait three years for general dental care and an additional 12 to 48 months for dentures. In this period patients have significant bone loss, bone resorption (jaw atrophy) and face shrinking resulting in malnutrition and general health decline. This is compounded by the fact that some patients in regional areas will often have to travel '*up to 12 hours requiring up to 3 to 6 visits until treatment is completed'.*[8]
5. **The eligible population (for public dental services) is not small** - there are 2.5 million Victorians in total who are eligible under the current scheme including all children aged between 2 - 17 (where good oral health care can set them up for life) and health care and pensioner concession cardholders of this approximately 30% of the regional and rural Victorians have some form of health care card.[9] The issue, however, is the ability for public and private oral health services to keep up with public oral health demand; the longer the underfunding of oral health care continues, the higher the likelihood of unmanageable waiting lists. Many Victorians have waited so long that their oral health has declined to a level that requires urgent dental care; these patients use appointment times that would have otherwise been used to reduce the dental waiting list. Long waiting lists lead to a deteriorating oral health status often requiring urgent care directly impacting the capacity for dental health services to reduce the long waiting lists. On average Victorian services use 47% of their appointments for urgent care - a vicious cycle which impacts regional populations the most.[10]

[8] https://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=haa/./dental/report/index.htm.
[9] https://www.ruralhealth.org.au/book/health-card-holders
[10] Data source: Dental Health Services Victoria, obrained via FOI

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There are two further issues for consideration:

i. There is growing evidence that poor oral health has a significant impact on general health.[11] There are well-established associations between systemic diseases and dental infections, including clear links between periodontal disease and pregnancy, diabetes mellitus, preterm and low birth weight babies, chronic obstructive pulmonary disease, renal disease, cardiovascular disease and stroke. [12] This indicates a decline in oral health that not only affects dental waiting lists, potentially preventable hospitalisations due to dental conditions [13], federal funding and individual costs but also impacts the cost and burden on general health services. VOHA estimates that preventable hospitalisations for example cost Australian taxpayers approximately $240 million annually,[14] which is almost twice the amount of funding provided by the Commonwealth on dental services annually.[15]

ii. The percentage of the population who are Aboriginal and Torres Strait Islanders is higher in *remote* areas (18% of the population) and nearly half of the population in *very remote* areas (47%).[16] This, compounded with the fact that Indigenous populations are 2.5 times more likely to have missing teeth, more likely than other Australians to have multiple caries and untreated dental disease, and less likely to receive preventive dental care,[17] results in unique oral and general health challenges for the indigenous population which in turn places a tremendous burden on treating health services.

6. **VOHA has considerable concerns about the short and long-term impacts of the delays in oral health care caused by the COVID-19 pandemic**. As noted above, delayed care can lead to both short and long-term oral health issues as well have a detrimental impact on general health and chronic disease

[11] https://www.dhsv.org.au/__data/assets/pdf_file/0013/2515/links-between-oral-health-and-general-health-the-case-for-action.pdf
[12] https://www1.racgp.org.au/ajgp/2020/september/medicine-and-dentistry
[13] https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/hospitalisations
[14] https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/06-human-services-reforms-dental.docx.
[15] https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/extending-the-national-partnership-agreement-on-public-dental-services
[16] https://www.aihw.gov.au/reports/australias-welfare/profile-of-indigenous-australians
[17] https://www.aihw.gov.au/reports/den/231/oral-health-and-dental-care-in-australia/contents/summary

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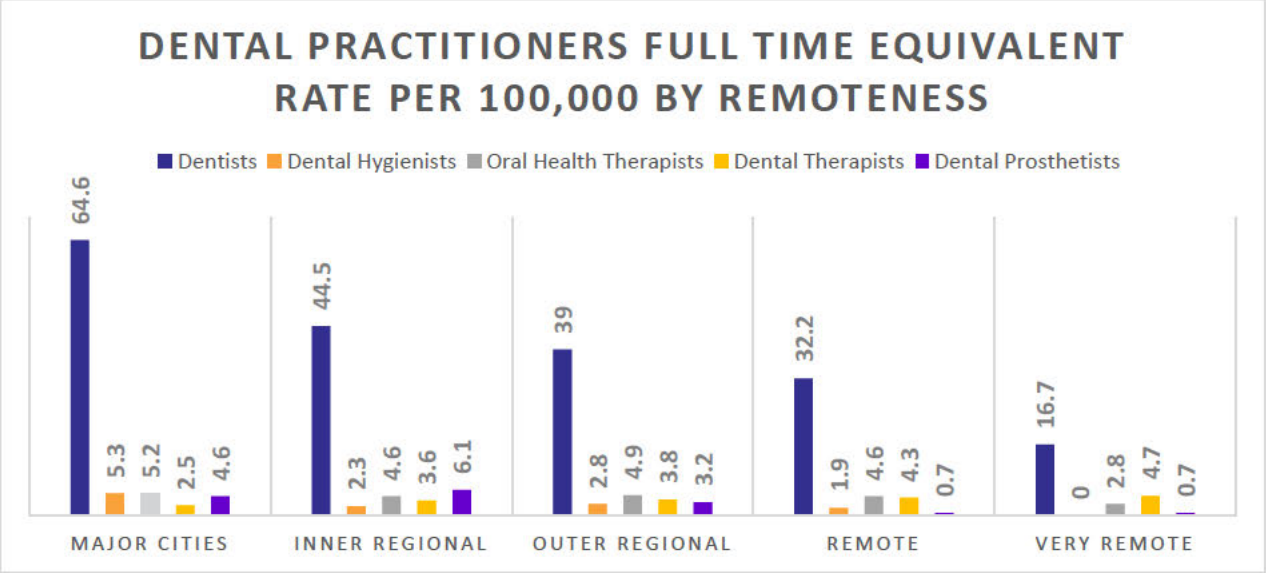
management. Services estimate that 70-80% of expected clients have not been treated, meaning that over 100,000 (predominantly low-income) Victorians have missed out. Further, given the economic impact and sharp rise in unemployment, the number of eligible Victorians (metro and regional) for public dental care is bound to have risen significantly.

7. **There is a significant spatial maldistribution of dental practitioners** which highlights not only the substantial access issues regional Victorian's deal with but also the recruitment and retention issues public oral health facilities and private clinics face. In 2017, 93.2% of all dental practitioners worked in either major cities or inner regional locations. [18] The below table emphasises the disparity between dental practitioners per 100,000 in major cities compared with inner regional, out regional, remote and very remote areas.[19]



As is well-known, regional and rural Australia has much greater trouble recruiting and retaining the health workforce generally, and this is equally true of the oral health workforce. For example one Health Service CEO in Western Victoria informed VOHA that, alongside inadequate funding to meet demand, attracting and retaining oral health workforce remains the other key constraint facing regional and especially rural oral health services. City based professionals are

[18] https://hwd.health.gov.au/webapi/customer/documents/factsheets/2017/Dental%20Practitioners.pdf
[19] https://www.ruralhealth.org.au/sites/default/files/publications/fact-sheet-dental.pdf

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difficult to entice to the country. Rural community health service managers report that it would appear that the great majority of students enrolling at one rural schools of health and dentistry are still metro students who do not subsequently apply in sufficient numbers to rural positions once graduated.

Regular changes to government funding formulas and levels also exacerbate this, for example the general decline in Commonwealth funding for oral health care since 2014.[20] Over time this means fewer positions can be afforded, especially for smaller (typically rural) services.

Whilst recognising that there needs to be some economies of scale in dental clinics, more use of hub and spoke models from the nearest regional centres is seen by rural services as a realistic model. The Grattan Institute also recommend that governments provide a loading to the funding for rural services to accommodate the extra expenses in workforce retention.[21]

According to Grattan:

> *Indigenous people are also more likely to face cost-related barriers to dental care than other Australians. According to the Commonwealth Fund's International Health Policy Survey, 32 per cent of Indigenous Australians skipped dental care due to the cost, compared to 21 per cent of non-Indigenous people. Indigenous people may also face non cost barriers to dental care, including the absence in some areas of culturally-sensitive dental practitioners.*[22]

It is worthwhile noting that rural GPs often see patients with a range of oral health problems, however many acknowledge they are not equipped, appropriately trained or confident when dealing with oral health problems and on most occasions provide short-term pain relief.[23] Patients require not only short-term pain relief but preventative oral health measures and access to restorative dentistry if necessary (e.g. dentures for missing teeth) which is why it is essential to have a suitably equipped and spatially distributed dental workforce in regional areas.

[20] https://www.aihw.gov.au/reports/den/231/oral-health-and-dental-care-in-australia/contents/costs
[21] Duckett, S., Cowgill, M., and Swerissen, H. (2019). Filling the gap: A universal dental scheme for Australia. Grattan Institute.
[22] https://grattan.edu.au/wp-content/uploads/2019/03/915-Filling-the-gap-A-universal-dental-scheme-for-Australia.pdf
[23] https://www.mja.com.au/system/files/issues/204_01/10.5694mja15.00740.pdf

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WHAT IS NEEDED?

In the short-term, there is an urgent need to address the backlog of treatment (i.e. those on the waiting list and those whose treatment has been delayed due to COVID-19 restrictions). At the Commonwealth level, this means ensuring there is sufficient funding allocated to the Child Dental Benefits Scheme and to the National Partnership Agreement on Public Dental Services with the States to meet this pent-up demand. Long term there is a need for an increased and assured allocation of funding at both Commonwealth and State levels to reduce the vastly inequitable and costly long waiting lists for care with a dedicated focus to meeting rural and regional demands. Further, funding needs to be long-term focused and more flexible to facilitate a more preventive and integrated (with other allied and general health services) approach to oral health care.

VOHA believes this inquiry provides an opportunity to factor in the significant access, funding and dental practitioner recruitment issues affecting regional Australians in respect to oral health care in the Committee's final report and recommendations.

Should you require additional information or would like to discuss the prevailing oral health issues affecting regional Australians please feel free to contact VOHA spokesperson Tony McBride at oralhealth@tanjable.net or on [redacted].

Yours sincerely,

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Tony McBride

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SUBMISSION SIGNATORIES

- Australian Dental Association Victorian Branch (ADAVB)
- Australian Dental and Oral Health Therapists' Association Victoria (ADOHTA Vic)
- Australian Dental Prosthetists Association (ADPA)
- cohealth
- COTA Victoria
- Dental Hygienists Association of Australia (DHAA)
- Health Issues Centre
- Oral Health SIG, Public Health Association Australia
- IPC Health
- North Richmond Community Health
- Star Health Group
- Victorian Healthcare Association
- Network for Integration of Oral Health

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Australian Dental & Oral Health Therapists Association (ADOHTA)

Australian Dental Prosthetists Association (ADPA)

Brotherhood of St Laurence

cohealth

Community Information Support Victoria

COTA Victoria

Dental Hygienists Association of Australia

Health Issues Centre

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La Trobe University

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North Richmond Community Health

Star Health

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