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EXCL
ABN 98 729 112 634
Mr Tan Nguyen
Executive Director
PO Box 217
BULLEEN VIC 3105
AUSTRALIA
0432 715 420
tan.nguyen@unimelb.edu.au

Committee Secretary
Standing Committee on Health and Ageing
House of Representatives
PO Box 6021
Parliament House
CANBERRA ACT 2600
AUSTRALIA
haa.reps@aph.gov.au

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To the Committee Secretariat,

I am writing on behalf of DEXCL as the Executive Director. I am grateful for the opportunity to make a submission, and comment on the inquiry regarding 'Adult Dental Services in Australia'.

I am a registered oral health therapist working in Melbourne, with 4 years experience employed in the public dental sector since graduation in 2008. I have recently resigned in February 2013 to pursue full-time study with the Master of Public Health at the University of Melbourne, and am a clinical supervisor to the 3rd final year Bachelor of Oral Health students at the Melbourne Dental Clinic, the University of Melbourne. I am the current President of the Victorian Dental and Oral Health Therapist Association Incorporated. Our vision at DEXCL is to deliver dental excellence in evidence-based public health research, and provide leadership for innovation in dentistry.

The demand for adult dental services through the public dental system is substantial, and requires a significant multifactorial investment in workforce retention, continuing professional development, evidence-based health promotion, and research and innovation. The current adult waiting list for many community dental health services in Victoria is 2-3 years, and the majority of dental treatment provided is emergency and restorative dental care. Waiting lists are further amplified due to the loss of productivity for high rates of non-attendance for dental appointments. For rural and remote communities, access to public dental care is made worse by the lack of retained dental workforce working in these locations, including metropolitan regions[1]. Disadvantaged socioeconomic populations are unlikely to afford private dental care, and are more likely to delay in seeing a dental practitioner[2]. For patients who have access to primary general dental care through public dental services after the waiting period, the consequential appointments can be up the 3 months from their first dental examination, and treatment planning are usually confounded by complex dental needs. In addition, the continuity of care for patients is absent as the patients are placed again on the 2-3 year adult waiting list when their general course of care complete. Many oral diseases are chronic

[1] Teusner et al, 2007
[2] Chrisopoulos et al, 2011

and dietary related, thus it is necessary to establish an appropriate dental recall system for adults which do not currently exist in Victoria.

It is clear that an insufficient workforce hampers access to dental care in the public dental system; however, the affordability for eligible patients is excellent. Adult patients in Victoria have a capped maximum payment of $102 per for a general course of care, which includes all dental treatment. There are bioethical issues that need to be considered and examined. Should unmotivated adult patients be 'compensated' through the public dental service, where they have access to infinite appointments as required to complete their dental care, thereby reducing the resourcing for other patients? Can the private practice funding arrangement be a useful model to implement in a public dental system? And what about the middle-income population group who are ineligible for public dental services but cannot afford private dental care? Is a government funding arrangement really suitable for private practice to address the concerns of access and affordability for the disadvantaged adult populations for dental care with a public health agenda?

I recommend a co-payment arrangement where patients should pay a partial cost towards their dental care. This funding arrangement model is likely to be beneficial long-term for both the patients and the finite public funds through enhanced financial resourcing, and the potential to offer specialist treatment options including crowns, bridges and dental implants, which would otherwise not be unavailable within the existing public dental service model, The co-payment model is likely to reduce the reliance on dental practitioners to provide a 'treatment' since common oral diseases are manageable with optimal home care maintenance, namely dental caries and periodontal disease. Patient autonomy to make informed decisions of their care is promoted by addressing the social determinants of health, and greater attention in developing personal skills and health literacy. Any funding arrangement whether through the Commonwealth or the State should be directed exclusively to the public dental system.

The clinical education and certification in dentistry including the delivery of dental care are varied due to the nature of rapidly emerging evidence-based research. Continuing professional development is an essential investment for dental practitioners not only as a mandatory requirement for registration with the Dental Board of Australia, rather it is professional ethics responsibility to offer our patients the most appropriate treatment and enable informed decisions. Many dental practitioners will agree there is diverse range of procedures to address oral diseases, and this is very evident from my own experiences. Patients will often be seen by multiple dental practitioners within the public dental system, and this can sometimes cause frustration to both the patient and the dental practitioner due to the lack of consistency in the continuity, and differing philosophies of dental health treatment planning. A recent research publication shows that inconsistencies in dental caries detection can have a tendency for dentists to 'over-treat'[3]. In dentistry, there is too much emphasis on treatment, and too focused on patient centred-care. Dental practitioners should have sound foundations on the social determinants of health.

The existing model of public dental services is a primary care medical model that focuses on the curative treatment yet dental caries and periodontal disease has no such cure. The shortage of investment in health promotion initiatives and prevention strategies simply saturates the provision of public dental services into this model. The demand and expectation by patients to receive a 'treatment' such as fillings further exacerbates the growing concern on the reliance on dental practitioners to provide 'treatment'. Priority is necessary in primary prevention strategies in shifting the locus of control for patients to develop self-care management given common oral diseases are largely preventable. Further public education to support and increase water fluoridation is also of paramount importance. I refer to the amended changes in Queensland which has empowered local councils make their own decisions[4]. The choice to cease water fluoridation to save cost rather than to prevent and reduce the burden of dental caries to all population age groups is a significant

[3] da Silva et al, 2012
[4] Queensland Government, 2012

concern. The poor informed decision making of this 'cost saving' will be associated with an increase in oral disease burden, greater demand for dental care, and compounded costs of treatment in the future. Water fluoridation is considered one of the top 10 greatest public health achievements in the 20th century[5], and has strong evidence for cost effectiveness[6].

Past dental schemes have generally ignored the dental services provided by dental hygienists, dental therapists and oral health therapists. It highlights the poor recognition of their profession in Australia, and their professional status is suppressed by the absence of a Medicare provider number, and has a noteworthy impact to patient choice seeking the services of other dental professionals. It is concerning that patients are unable to make a claim from private health insurers or from Medicare for dental services provided by these professions, unless a dentist's provider number is provided, which has been standard practice. We currently experience these issues when I am supervising Bachelor of Oral Health students at the Melbourne Dental Clinic. Should patients be financially disadvantaged if a dental practice incidentally did not have a dentist on-site to sign a declaration for a claim? And if the dentist's Medicare provider number is used on behalf of a dental hygienist, a dental therapist or an oral health therapist, is this theoretically fraudulent where the claim is a 'criminal deception intended to result in financial or personal gain'[7]?

Research and innovation in dentistry has been given low preference in all areas of health funding grants, and is yet to become a priority area for public health for the Australian National Preventive Health Agency and the National Health and Medical Research Council. This is despite the emerging evidence of oral diseases having associations with other chronic health conditions including cardiovascular disease[8], diabetes mellitus II[9], and preterm and low weight babies[10]. Furthermore, the recent publication of the 'Evidence-Based Oral Health Promotion Resource' recommends the needs to pilot and evaluate interventions targeting high-risk populations groups, and to improve the evidence base in upstream interventions to target the social determinants of oral health inequities and inequalities[11]. There is good evidence to incorporate oral health into general health promotion initiatives, however, there lacks vigorous evaluation and monitoring in oral health terms[12].

I warmly commend the Commonwealth Government's initiative to have an inquiry into the adult dental services in Australia, and I look forward to an appropriate and informed funding agreement, which will benefit all Australians. If there is a need for any further clarification, I am contactable by email.

Yours sincerely,

Mr Tan Nguyen
Oral Health Therapist
BOralHlth (Mel)
Executive Director
DEXCL

[5] Centers for Disease Control and Prevention, 2001
[6] Pizzo et al, 2007
[7] Oxford Dictionaries 2010
[8] Scannapieco, 2003
[9] Lamster et al, 2008
[10] López et al, 2002
[11] Roger 2011
[12] Satur et al 2010

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