**Budget Submission February 2021 on public oral health services**

The Victorian Oral Health Alliance (VOHA) is a group of key professional, welfare and consumer organisations and providers, committed to improving Victorians' oral health and access to dental care.

This submission presents a case for urgent action to address the short and long-term impacts on Victorian's oral health caused by the COVID-19 pandemic. It then proposes a series of measures for the May 2021 Victorian Budget to address these key issues and pressures faced by both consumers and services.

**In short, VOHA believes this Budget should focus on both:**

- **short-term recovery and**
- **facilitating changes in care in the medium term to enable greater access to care and a greater focus on prevention.**

***Why is there a need for urgent action?***

- Waiting times were already very long pre-Covid: 23 months on average at 31st March 2020 (up from 15 months in 2015-16), with some services experiencing wait times for service care of over 40 months.
- Waiting times are significantly higher at many rural services, e.g. in June 2020 waits for general care were:
    - 42 months @ Maryborough
    - 33 months@ Wangaratta and Benalla
    - 30 months@ Baw Baw and Latrobe.

  A more detailed description of the inequalities in access to public dental care in regional Australia is given in a VOHA submission to a Senate Inquiry this year (attached as an appendix).
- Lack of timely primary dental care creates costs in the hospital system, e.g. it leads to preventable use of expensive hospital care, including emergency departments (about 17,000 preventable admissions p.a. in Victoria).
- The COVID-19 pandemic necessarily led to a severe constriction of oral health care at public services to 'emergencies only' for many months in 2020. Some services estimate that up to 70-80% of expected clients during most of 2020 were left unable to be treated.
- Whilst services by the end of the year had resumed Covid-safe care (and VOHA acknowledges the Government's actions in not financially penalising services for underachieved targets during the year), services were facing greater demand from:
    - a backlog of half-completed care for the many clients whose treatment had been interrupted and re-examination required
    - increased numbers of adults needing 'urgent care' as their oral health status had deteriorated during both their pre 2020 wait and then 2020 delays


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  - the pent-up demand from those still on the long waiting lists (already around 125,000 one year ago and comprising predominantly low-income adults) plus those who normally would have wanted to join the list has been exacerbated by new demand from Victorians who have lost jobs and are now eligible for public care (potentially another 300,000).
- But at the same time services have constrained capacity to address this, namely:
  - the increase in emergency or urgent care (noted above) reduces the number of appointments available each day to treat those on the general waiting list, and
  - some services are unable to provide the full scope of services or as many appointments per day under Covid-normal conditions, depending on the severity of the aerosol generation procedures or physical size and layout of their facilities
- This has led to less capacity to address the growing demand, and hence growing waiting lists - a vicious cycle.
- Of course, the system has been chronically under-funded for decades with annual funding only allowing for 17% of eligible Victorian adults to be treated in any one year, even pre Covid.
- As a result, poor oral health is already a silent and pervasive epidemic, impacting on people's everyday lives. It disproportionately affects Victoria's vulnerable and disadvantaged people.
- It both prevents people fully participating in society (e.g. getting a job, going to school), and contributes to poor general health e.g. heart disease and diabetes.

***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). We need to ensure that the eligible population's oral health status (already lower than average) does not further deteriorate and that associated general health issues do not flow on, e.g. increased need for oral cancer care.

VOHA urges the Victorian Government to undertake the following.

- Articulate how it aims to meet the large unmet demand for public dental care.
- Encourage and fund statewide oral health promotion activities and advertising as good oral hygiene practices will delay the progress of disease.
- Increase funding to community clinics in 2021-22 to fund a catch-up program (to treat 125,000 Victorians, and then an additional 15% increase on current budgets each year for the following three years.
- Encourage and fund services to offer more extended (after-hours) hours operations to facilitate management of the backlog and optimise capacity efficiencies.
- Deliver this growth through funding existing public services (including utilising spare capacity) and by outsourcing care to the private sector, where appropriate, to speed up service delivery and support the Victorian economy.
- Acknowledgement of the increased costs of providing care post-pandemic and associated increase in funding for continuing dental care (e.g. reduced throughput and increased costs of extra PPE). This should apply to both public agency funding agreements and the funding of voucher schemes. (Incidentally, it should be noted that the Victorian voucher schemes


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have consistently remained the lowest in the country and are in dire need of review). (Estimated cost $10 million p.a.).

- Funding requirements to allow services to be much more flexible in how they provide care in their own contexts, including teledentistry, an increased focus on prevention (noting that oral disease is the most prevalent preventable disease in Victoria), and the expansion of outreach work that can enable many disadvantaged groups to access necessary care (when they still show reluctance to recontact services or are residents in medium to high dependency aged care).
- Immediately commence planning to ensure services have access to sufficient secure, stable and affordable PPE supplies from a wider range of credible suppliers to cope with future unpredictable emergencies.
- Urgently address workforce availability in rural Victoria, a key constraint in providing accessible services outside the metro areas, through: better funding to attract public dental clinicians and outsourcing care to the private sector, where appropriate; funding graduate positions and further incentives for them to stay beyond 2 years; and boosting funding to support clinical teaching of students in rural areas.
- Fund an evaluation of the current models of public oral health care to assess those that create the best outcomes for consumers, and link to value-based care approaches.

Lastly VOHA believes there is a strong need for further transformation and bolstering of the public oral health system. VOHA will provide a range of proposals for this further stage in a submission this year.

***VOHA Members endorsing this submission***

- *Australian Dental Association Victorian Branch (ADAVB)*
- *Australian Dental and Oral Health Therapists' Association (ADOHTA)*
- *Australian Dental Prosthetists Association (ADPA)*
- *Australian Network for Integration of Oral Health*
- *Brotherhood of St Laurence*
- *cohealth*
- *Community Information and Support Victoria*
- *COTA Victoria*
- *Dental Hygienists Association of Australia (DHAA)*
- *Health Issues Centre*
- *IPC Health*
- *Public Health Association of Australia Victorian Branch*
- *Star Health Group*
- *Victorian Alcohol and Drug Association*


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## APPENDIX: VOHA SUBMISSION TO THE SENATE 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.

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 population, 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.

[1] https://www.aihw.gov.au/getmedia/df234a9a-5c47-4483-9cf7-15ce162d3461/aihw-den-230.pdf.aspx?inline=true
[2] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Socio-Economic%20Advantage%20and%20Disadvantage~123


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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]

   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*

[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.

[6] Australian Institute of Health and Welfare (AIHW) (2018b). *Patient Experiences in Australia: Summary of Findings, 2017-18,* Cat. No. 4839.0, Canberra.


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*$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
   - Baw Baw – 30 months
   - Latrobe – 30 months
   - East Grampians – 24 months
   - Albury Wodonga – 23 months
   - Portland - 22 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

[7] https://grattan.edu.au/wp-content/uploads/2019/03/915-Filling-the-gap-A-universal-dental-scheme-for-Australia.pdf

[8] https://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=haa/./dental/report/index.htm.


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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]

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.6F[12] This indicates a decline in oral health that not only affects dental waiting lists, potentially preventable hospitalisations due to dental conditions7F[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]

[9] https://www.ruralhealth.org.au/book/health-card-holders
[10] Data source: Dental Health Services Victoria, obrained via FOI
[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

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 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.12F[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.13[19]

[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
[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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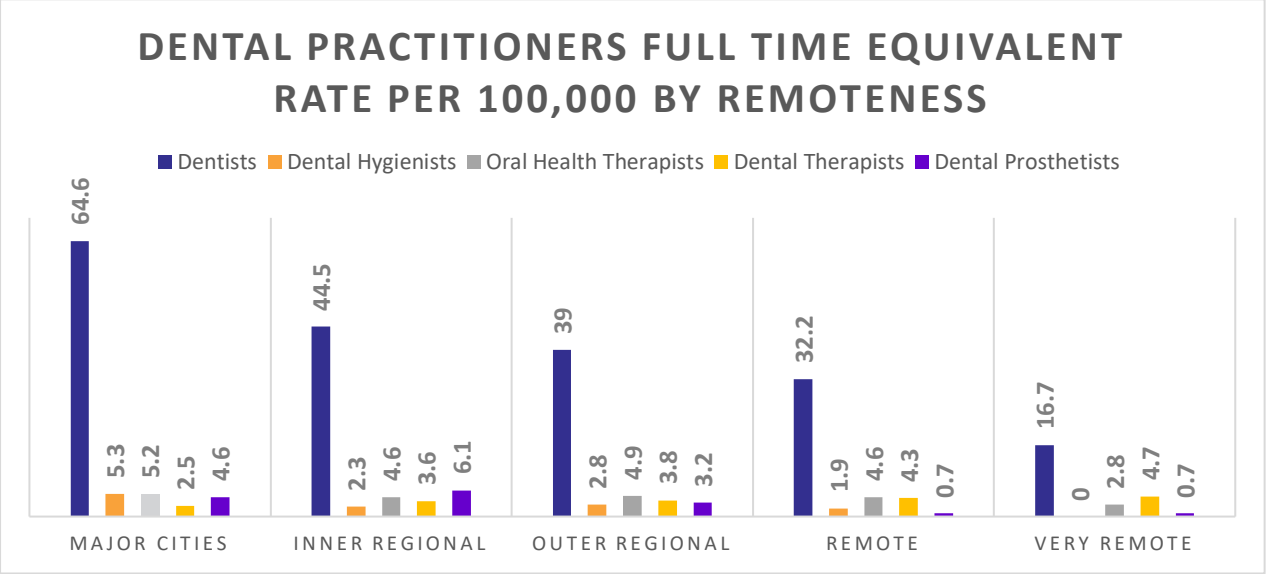


As is well-known, regional and rural Australia has much greater trouble recruiting and retaining the health workforce generally, and this is equally true of the oral health workforce. For example one Health Service CEO in Western Victoria informed VOHA that, alongside inadequate funding to meet demand,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

[20] https://www.aihw.gov.au/reports/den/231/oral-health-and-dental-care-in-australia/contents/costs


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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.

## 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

[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

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 0407 531 468.