Victorian Oral Health Alliance

# Revised Position Paper
# Key options for Commonwealth to improve Australia's oral health[1]

This short document outlines the case for a range of new Federal-level policy decisions which would address one of Australia's greatest health inequities – the long waits (commonly two to three years) to access to oral health care for disadvantaged and lower income Australians, including older people.

## 1.0 Executive Summary

### The Problem - Significant inequity

| LONG WAITING TIMES | CONSUMER IMPACTS | GOVERNMENT FUNDING NOT MEETING ADULT NEEDS | AGED CARE ROYAL COMMISSION |
|---|---|---|---|
| Commonly 2-3 years, and up to four in some places, especially rural.<br>Now longer after the impacts of COVID-19 lockdowns | Tooth decay gap of 7 teeth between those with a Health Care Card and those without<br>Poor access to care for older Australians<br>Health, social and employment impacts | 44% decrease since 2013-14, although population is 9% larger<br>By comparison, subsidy for private health insurance grew by 24% | Found countless stories of suffering from pain and discomfort, poor nutrition, and inability to access timely / affordable dental care |

[1] Note this paper builds on VOHA's July position paper.


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### What's needed?

The Commonwealth needs to increase its contribution to addressing the huge inequities in access to adult dental care through two avenues.

**Establish a Seniors Dental Benefits Scheme**

- As a matter of urgency, make oral health/dental care more accessible to all older Australians on Health Care Cards, as recommended by the recent Royal Commission into Aged Care Quality and Safety. Estimated cost $2.84b over first three years

**Provide a sustainable and higher-level long-term funding model for adult care**

- Replace annually agreed National Partnership Agreement with ongoing model of funding (as per hospital agreements) to state/territory public dental services. Increase Commonwealth contribution to planned Gillard Government spending levels, i.e. increase from current $108m to $416m pa, and increased annually by CPI, reviewed every three years.

## 2.0 Why is change needed?

Oral diseases can cause pain and discomfort and negatively affect general health and quality of life. For people of working age, poor oral health status, especially loss of teeth, can have significant impacts on work capacity or ability to gain employment, as well as on self-esteem and social life. And poor teeth can be literally one of the most in-your-face indicators of poverty and disadvantage in Australia. Some indicators suggest there is a seven teeth decay gap between Health Care Card holders and others – a gap that has doubled in the last 15 years.[2] Of

[2] Australian Research Centre for Population Oral Health. Australia's Oral Health: National Study of Adult Oral Health 2017–18. The University of Adelaide: Adelaide, Australia. 2019.
Slade GD, Spencer AJ, Roberts-Thomson KF. Australia's dental generations. The national survey of adult oral health. 2004;6(2007):274.


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course it is also well-known that those who live with greater social and economic disadvantage are more likely to experience health inequalities more generally.
Poor oral health has also been associated with a range of illnesses and diseases, while the impact of poor oral health can also create a financial burden, both for individuals and within the broader health system. So there is a major inequity that needs to be addressed.

Some groups are at greater risk of poor oral health. The National Oral Health Plan identifies four priority population groups that have poorer oral health than the general population and experience barriers to accessing oral health care. These include:

- people who are socially disadvantaged or on low incomes
- Aboriginal and Torres Strait Islander Australians
- people living in regional and remote areas
- people with additional and/or specialised health care needs.

Despite the above, oral health/dental care is one of the least governments supported areas of health care, costing Australian consumers on average five to ten times more in out-of-pocket costs than hospitals or general medical practitioners (see Appendix).[3]

There is a strong need for public dental services, yet they are generally highly under-funded with long waiting lists in many parts of Australia. For example, in Victoria, the average waiting time for general dental care is 22.7 months (but more than 30 months at many public dental services and up to 48 months in one rural area). Patients must then wait 12 months wait following treatment before they can go back onto the waiting list for ongoing treatment. *That means some Australians wait for longer than a Federal Parliamentary term for basic dental care.*

In Victoria there are more than 1.4 million Victorian adults who are eligible to receive public dental care, but only around 250,000 adult patients are funded to receive care each year, contributing to the long waiting times.

[3] AIHW 2018

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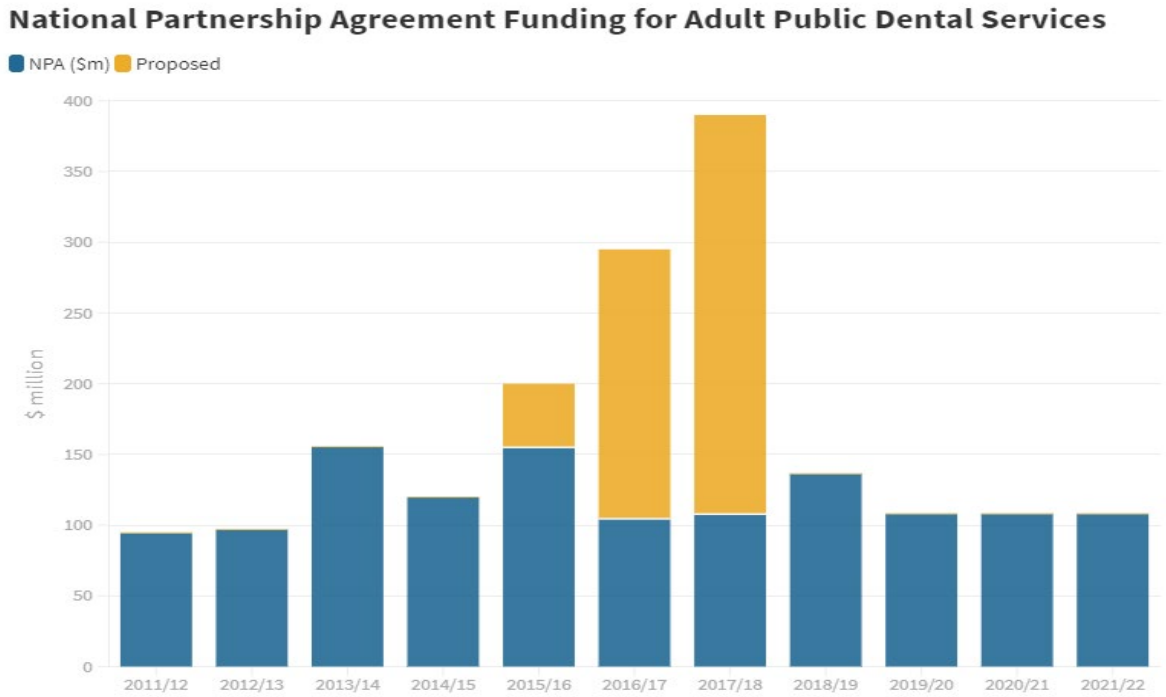
Lack of timely primary dental care not only affects individuals – it also creates costs in the hospital system. Poor oral health leads to otherwise avoidable and preventable hospital admissions, which adds to the cost of care and leads to worse outcomes for patients. In Victoria alone, there are an estimated 17,000 preventable admissions annually, at an approximate cost of $70 million.

Despite the above, the Commonwealth contribution has shrunk significantly in the last eight years. The current 2021/22 Budget includes $107.8m for adult care via the National Partnership Agreements to the States. This equates to a 44% decrease since 2013-14, yet the population is 9% larger. By comparison, Federal support for dental care via private health insurance grew by 2.7% a year[4] – 24% increase over that period.




[4] Australian Institute of Health and Welfare 2019. Health Expenditure Australia 2017-18. Health and welfare expenditure series no.65. Cat. no. HWE 77. Canberra: AIHW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***For older adults:***

Older people experience higher levels of oral disease than younger people. This is associated with general health problems such as diabetes, changes in diet, increased use of medication, and the breakdown of heavily restored teeth. Poor oral health makes it difficult to eat a nutritious diet. This is a particular problem for those who are receiving Commonwealth support at home or in residential aged care facilities.

More than 220,000 Australians live in residential aged care, and many more receive assistance to live at home. For too long, the most basic oral care needs of these residents have been neglected. The Royal Commission into Aged Care Quality and Safety highlighted countless stories of residents who suffered from pain and discomfort, poor nutrition and an inability to access timely and affordable dental care. This has a significant impact on their general health and quality of life.

It's time to prioritise oral health and stop the neglect.

Many senior Australians who cannot afford private care have no choice but to languish on public dental waiting lists, where, as noted above, the average wait for care can be years.

## 3.0 Two key proposals to address these gaps

A higher level sustainable oral health funding model with the States

The current model of Commonwealth funding of public dental care is via a National Partnership Agreement (NPA) which provides roughly $100 million-annually across Australia. While this is only a minority share of the funding of public care (for example it represents roughly 15 per cent of funding in Victoria) it still funds essential care for an estimated 250,000 Australians each year. This is critical when:

- total State and Commonwealth funding only enables a small proportion of eligible Australian adults to be treated in any one year (e.g. 17 percent in Victoria), and
- providers face increased care costs post-pandemic (e.g. increased safety measures such as increased costs of extra PPE, and space constraints at times reducing throughput, further increasing wait times).

However, the crucial constraint imposed by the NPA mechanism is that it is only extended on an annual basis. In recent years this extension typically occurs towards the very end of the funding period and leaves services unsure until the last moment of their funding for the new financial year. This has significant impacts on staff contracts, affecting both the recruitment and retention of good staff. This is particularly true in rural locations, as workforce issues are the key constraint in providing accessible services outside metropolitan areas. At a minimum, public dental services need the commitment of longer-term sustainable funding to assist in workforce planning and service delivery. But more realistically, funding needs to increase again to the levels planned 8 years ago.

**VOHA recommends:**

- Shift from the NPA to an ongoing model, similar to that for hospitals. Such a multi-year agreement would provide recurrent funding and hence certainty for services. Negotiations with the States could include future reform priorities.
- Return funding levels to those promised in the 2013-14 Budget, after the recommendations of the National Dental Health Advisory Committee. That is provide 2022/23 funding at the equivalent level promised for 2017-18, then $390m, now $410m pa, and increase annually by CPI, reviewing every three years.

## A Seniors Dental Benefits Scheme

A key recommendation of the Royal Commission was to establish a Seniors Dental Benefits Scheme, which would operate in a somewhat similar way to the existing Commonwealth Child Dental Benefits Scheme. The proposed Senior scheme would:

- fund dental treatment for people living in residential aged care or who live in the community and receive the aged pension or qualify for the Commonwealth Seniors Health Card
- include benefits set at a level that minimises gap payments, and include additional subsidies for outreach services provided to people who are unable to travel, with weightings for travel in remote areas
- focus and fund dental treatment required to maintain a functional dentition, and to maintain and replace dentures.

Such a scheme would ensure that the most vulnerable older people (residents and seniors receiving community support) could access dental care in either the public or private dental system, including in their homes. It would also allow older Australians to have a regular and local dental care provider (private or public), which is important for quality healthcare. It could potentially also have a more preventive focus, such as the inclusion of regular screening and oral health promotion.

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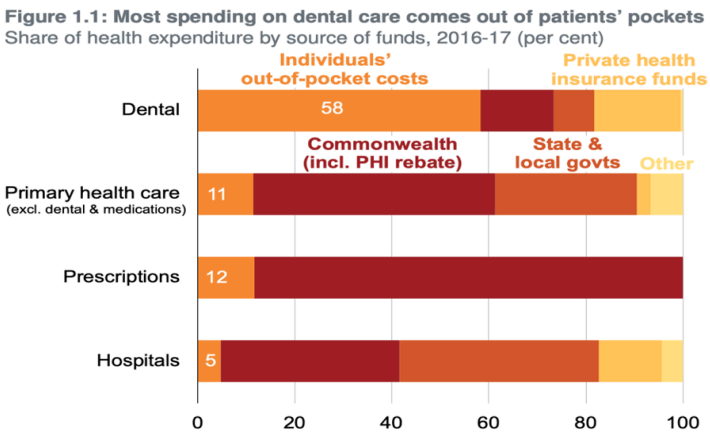
# APPENDIX – useful background information

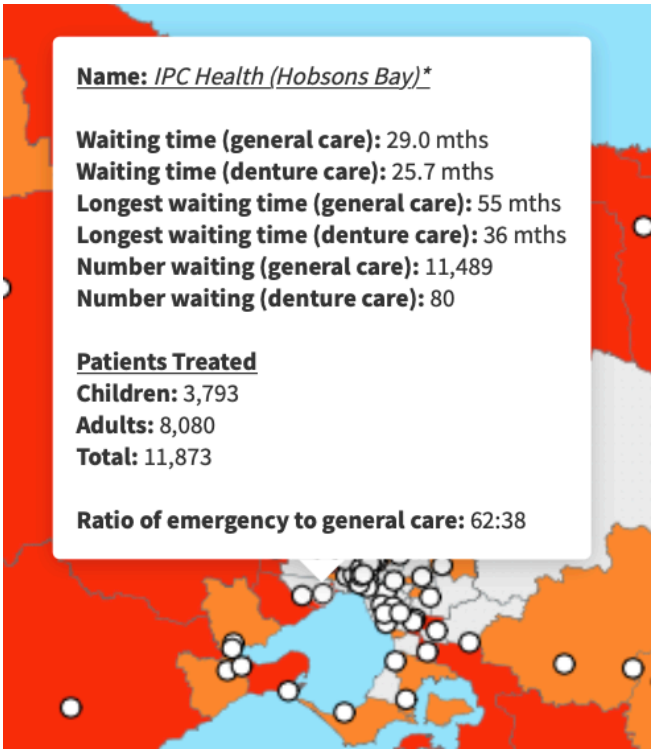
## Consumers pay most of the dental bills in Australia




Data from the Grattan Institute's analysis 'Filling the Gap' 2019 report.[5]

Note – the 58% consumer out of pocket amount does not include consumer payments to cover their private health insurance – the Australian Institute of Health & Welfare estimate the total at **81%,** up from 77% in 2015-16.

## Example of Victorian waiting times for general care, June 2021




This screen shot comes from the ADAVB's interactive map[6] (relating to access to public oral health services.

NOTE: *Remember to add 12 months for existing clients who cannot register to go back on the waiting list for a year after last treatment.*

[5] https://grattan.edu.au/report/filling-the-gap/
[6] https://adavb.org/advocacy/campaigns/public-dental-waiting-times



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Victorian Oral Health Alliance

The Victorian Oral Health Alliance (VOHA) is a group of 19 key professional, welfare and consumer organisations and service providers, committed to improving Victorians' oral health and access to dental care.

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## MEMBERS

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|---|---|---|---|
| ADA Victoria | Australian Dental Association Victorian Branch (ADAVB) | ipc Health | IPC Health |
| ADOHTA | Australian Dental & Oral Health Therapists Association (ADOHTA) | north richmond community health Wulempuri - Kertheba | North Richmond Community Health |
| ADA Australian Dental Health Foundation | Australian Dental Health Foundation | Peninsula Health | Peninsula Health |
| ADPA | Australian Dental Prosthetists Association (ADPA) | Public Health Association Australia | Public Health Association Australia (Victorian Branch) – Oral Health Special Interest Group |
| NIOH Australian Network for Integration of Oral Health | Australian Network for Integration of Oral Health | StarHealth | Star Health |
| Brotherhood of St Laurence | Brotherhood of St Laurence | The University of Melbourne Melbourne Dental School | The University of Melbourne Dental School |
| cohealth care for all | cohealth | Uniting AgeWell | Uniting Agewell |
| CISVic helping local communities help local people | Community Information Support Victoria | vaada Victorian Alcohol & Drug Association | Victorian Alcohol and Drug Association (VAADA) |
| COTA Victoria | COTA Victoria | Victorian Healthcare Association Vision • Value • Voice | Victorian Healthcare Association (VHA) |
| DHAA | Dental Hygienists Association of Australia | your COMMUNITY HEALTH | Your Community Health |
| Health Issues Centre Consumer voices for better healthcare | Health Issues Centre | | |

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