

ADAVB INC.
VICTORIAN BUDGET SUBMISSION 2002-03

1 Introduction and Executive Summary

The Australian Dental Association Victorian Branch Inc. (ADAVB) is pleased to present this Submission regarding the Victorian State Budget for 2002-03, for consideration by the Victorian Government and the Department of Human Services. The following table summarises the key proposals in our submission and distinguishes them according to their recurrent, one-off or capital expenditure status.

Proposals	Est'd Cost \$m	Recurrent (R) Non-Recurr't (NR) Capital (C)	See Page
2. Reducing inequalities in health service delivery and access to services			
2.1 Reducing waiting times for both emergency and general dental care	30.0	R	2
2.2 Aged Care Services	10.0	R	7
2.3 Rural and Remote Services	0.5	R	8
2.4 Service planning initiatives	5.0	R	9
3. Oral Health Promotion and Disease Prevention Strategies			
3.1 Public Information and Education Campaign	5.0	NR	10
3.2 Extension of Fluoridation	0.95	NR	11
3.3 Smoking Cessation	0.2	NR	12
3.4 Extension of Oral Health Promotion Research Grant Program	0.25	NR	13
4. Workforce recruitment, retention and professional development			
4.1 Attracting and keeping public sector dentists	3.0	NR	14
4.2 Attracting and keeping dental assistants	0.2	NR	14
5. Capital works			
5.1 Decentralised clinics	17.0	C	15
TOTAL	72.1		



The Department of Human Services has identified three flagship projects, which are recognised as setting priorities for planning and service development. We suggest that those associated with Quality in Services and Emergency Demand Management are especially relevant to the dental service area. While some of the proposals outlined within may naturally fall within the DHS Dental Health Output Group, others may more appropriately be addressed within the Aged and Home Care Group and the Primary Health Group.

Quality issues can be related to workforce training and deployment, and therefore to proposed improvements to recruitment and retention of dental personnel. They also encompass disease prevention and health promotion measures, that offer long-term benefits in reducing disease rates, and therefore health service cost burdens. The Emergency Demand Management area on the other hand, may have been targeted at hospitals, but is clearly a continuing problem in dentistry, as more and more people are obliged to seek emergency relief of pain due to being kept on long waiting lists for access to public dental care.

The sections in this submission have been prepared with reference to key objectives set by the State Government and the Department of Human Services. These objectives are laudable in themselves, and we therefore offer the dental profession's views on means by which the desired outcomes may be most effectively achieved.

2 Reducing inequalities in health service delivery and access to services

2.1 Reducing waiting times for both emergency and general dental care

PROBLEM

Objectives set in the Victorian Human Services Budget Estimates 2001-2002 (p.69) included a target of achieving “waiting times for health, community care and housing programs ... at or below national benchmark levels” and reducing “inequalities in health status and well-being, and in access to services”. On the national comparisons we have seen however, disadvantaged Victorians are amongst the most dentally neglected citizens in the country, thus ensuring that in terms of the Department's own benchmark, we are not achieving in this key primary care area.

Similar welcome commitments appeared recently in the publication “Growing Victoria Together” (November 2001), as shown in the following selection of extracts from the section dealing with “High quality, accessible health and community services”:

“The Bracks Government will therefore continue to invest to improve local access to essential health, aged care and community services, particularly in rural and regional communities.”



“There is also clear evidence that early intervention and prevention are vital to keep people of all ages and abilities living healthy and active lives in the community and to break the cycles of inequality, poverty and crime.”



“Priority Actions ... Tackle health issues linked to inequality including mental and dental health.”

“Demonstrating Progress ... Waiting times and levels of confidence in health and community services will improve.”

Regrettably, waiting times have not been reduced to any marked extent over recent years. The average waiting time is now 22 months, which means that many people who went onto the list have by now been treated by doctors, and possibly even been admitted to hospital, because of the general health consequences of their long wait for dental treatment. In some regional areas it is up to three and a half years! (See <http://www.dhsv.org.au/waiting/index.html>). The cost to the Pharmaceutical Benefits Scheme (PBS) and to hospital funding combined, plus an estimated \$6.3m in GP services (AIHW reports that 0.3% of GP attendances relate to oral health problems), would doubtless have paid for the basic dental care they needed in the first place. This failure by the State and Commonwealth to adequately recognise the links between dental and general health, is a continuing blight on the health of the Australian community.

A mere \$1.5m was allocated last year to “make a start on reducing the waiting time for treatment” according to the Department of Human Services (DHS) 2000/01 Budget summary for dental health services. Victoria remains one of the lowest of the States in per capita funding of public dental care. See Fig.2 below.

According to one DHS information sheet, the extra funding in the 2000/01 Budget would “enable the Government’s commitment to make a start on reducing the waiting time for disadvantaged Victorians to access dental services and will treat and additional 3,500 adults”. Another DHS Information Sheet under a title “Improved and Expanded Dental Health Services”, indicated that the extra \$1.5m, “when combined with demand growth funding, will enable an additional 8,250 people to be treated”. Demand growth funding is elsewhere costed at \$1m. In fact the combined \$2.5m increase in dental funding has not reduced waiting time appreciably, and the problem remains as bad as ever.

The Victorian General Dental Scheme (VGDS) and the Victorian Emergency Dental Scheme (VEDS) both have provision for involvement of private sector dentists. Their willingness to assist in provision of treatment to eligible patients within the conditions attached to those schemes, has been eroded in recent times by a failure to adjust fee scales to reflect practice overheads and to adequately fund the provision of public dental care.



Very little use is now made of private sector dentists, since the funding provided is patently inadequate to do more than cover the most pressing emergency cases treated at public centres.

Furthermore, as each new regional clinic is opened, funding from these programs is appropriately diverted to provide a source of operational revenue. Extra funding would enable the VGDS and the VEDS to be expanded, and provide local community service in areas where public facilities do not exist.

The Australian Institute of Health and Welfare (AIHW) has recently published their 447-page report on Australia's Health 2000. Selected extracts regarding dental health follow:

- In a ranking of the most prevalent health conditions in 1996, dental diseases were ranked very high: dental caries (1), edentulism (3) and periodontal disease (5). In a list of most common new health conditions in the same year, dental caries was ranked second, with periodontal (gum) disease seventh in the list of twenty five.
- In all age groups, 15.7% of dentate adults in remote areas and 12.5% in rural areas had a period of 5 or more years since their last dental visit, compared with 9.4% of urban adults. Of urban persons who were not recipients of a government concession card, 58% had made a recent dental visit, compared with 54% of rural dwellers and 47% of those living in remote areas.
- The burden of oral disease is increasingly concentrated in a minority of children. In particular, there remain a significant proportion of children who present with a considerable history of dental caries. The percentage of these high-risk children has decreased only slightly in recent years. Alarming, we note that dental caries are the main cause of child hospital admissions in rural and regional Victoria.

POPULATION VERSUS FUNDING BY STATE - 2001/02

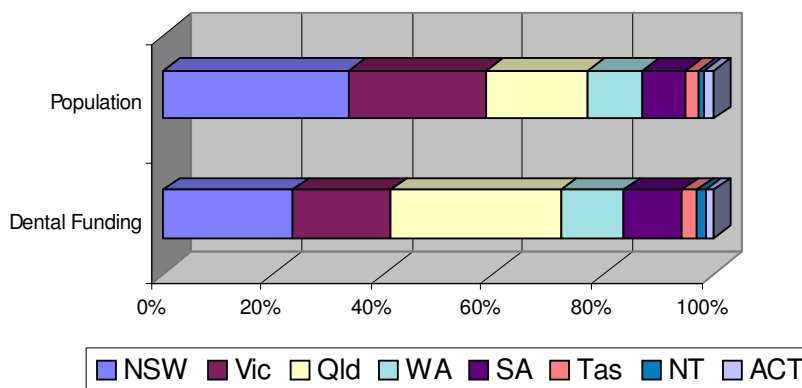


Figure 1 (Source SADS 2001).

Compared with its 25% share of the Australian population, Victoria's share of the public dental funding pool is only 17.7% (Source: SADS August 2001).



A recent media report indicated that the Commonwealth Department of Health and Aged Care estimated that it would require a further \$240m to eliminate dental waiting lists. The Victorian component of that, estimated on a proportion of population basis (i.e. 25%), would be approximately \$60m. This means that double the current State allocation for adult dental care in 2001/02 (\$62.3m*) would be required. A **modest** allocation by the Victorian State Budget to address the proven need, would therefore be \$30m recurrent.

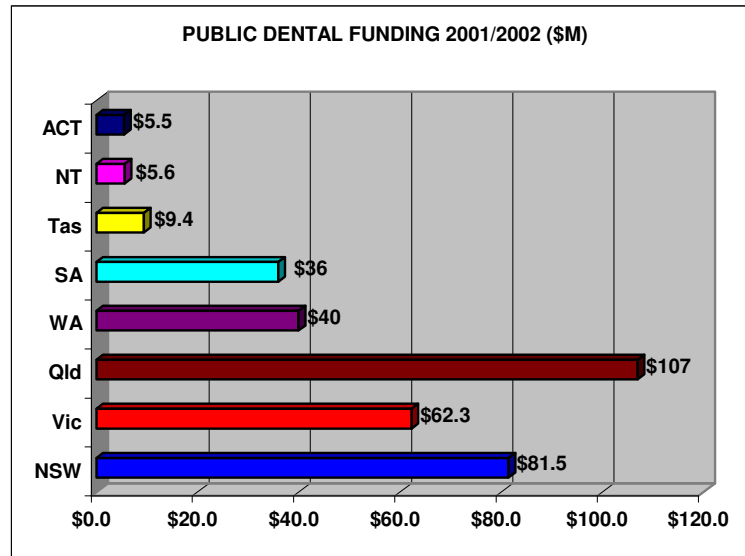


Figure 2 (Source: SADS / DHSV 2001)

Whether we compare the numbers across the States on a proportionate basis, a per capita basis or a total funds basis, Victoria's funding of public dentistry is embarrassingly low. The chart that follows indicates that Victoria spends an average of less than \$10 per eligible adult on their basic dental treatment needs in the current budget - a figure that only Tasmania undercuts.

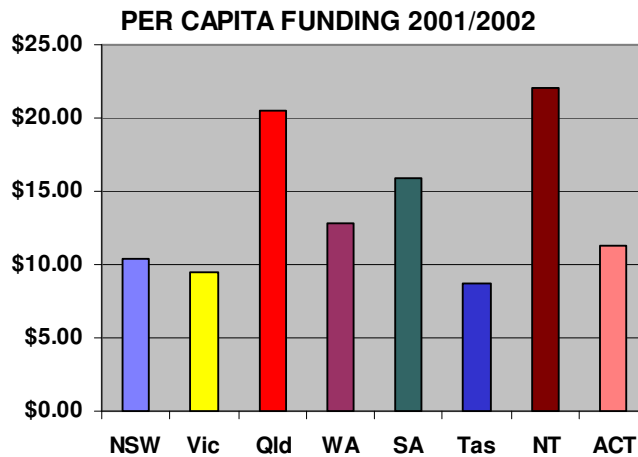


Figure 3 (Source: SADS / DHSV 2001)



COMMENT:

To improve this situation, a dual approach is needed. Firstly, adequate Government funding for treatment (as proposed in this section) is required. Secondly, a strong focus on prevention, with adequate government funding of oral health promotion and disease prevention (see 3 below) including increased availability of fluoridated water (see 3.2 below).

The recent Commonwealth Budget failed to make any allocation for public dental spending, while the Victorian Budget allocated only \$2.5m extra p.a. – which was only just enough to keep waiting lists from getting even longer. This compares with an extra \$9m p.a. and a voucher scheme allowing private sector dental treatment, provided in the NSW State Budget. Both remain lower than Queensland funding levels on a per capita basis, and Queensland was the only State that replaced the lost Commonwealth funds following withdrawal of the Commonwealth Dental Health Program.

Any proposal should ensure that only quality treatments are available to health care cardholders, and that a two-tiered system is not developed.

Victorian waiting lists remain at an average of 22 - 24 months ...

AN UNACCEPTABLY LONG TIME!

PROPOSAL

Victoria should allocate significant additional funding to actually reduce waiting lists and waiting times.

COST: \$30 million

* In preparing this submission, the ADAVB noted that Treasury figures indicate a total of \$83.1m is assigned to public dental programs, yet when we confirmed the actual funding of dental programs run by public agencies, the total available to them was only \$62.3m before co-payments (source – DHSV Annual Report 2000/01). We have independently verified with Departmental and DHSV officials that **the missing \$20.8m is not provided for dental treatment**, but is used instead for various central Departmental services, such as industrial relations, Directors' remuneration, transport services and publications (amongst others).



2.2 Aged care services

PROBLEM

The oral health needs of our aging population are increasing and this should be recognised in the budget. With the fastest growing sector of our age demographic being the over 80 year olds, special efforts are required to take dental treatment to the patients. Residents in nursing homes, whose mobility has become very restricted, require sensible basic care well beyond the capacity of nursing home staff and volunteers to provide.

The School Dental Service has achieved some success over the years in addressing the needs of primary aged school children. The service has an annual budget of around \$10m p.a.. Demand for improved oral health services for the elderly has steadily increased, and will only increase further as the proportion of our population aged over 65 grows in the coming years.

The nature of that need is primarily focussed on oral health maintenance, which will be more readily addressed by an increased workforce of dental hygienists, for whom there is also significant unmet demand in the private sector. (See also workforce proposals below). Recent developments in mobile dental unit technologies make it once again more viable to mount mobile and domiciliary services with confidence that infection control requirements can be met – especially in nursing homes, where some special facilities can also be accommodated without necessarily requiring the installation of a full dental surgery.

PROPOSAL

Just as there was justification for a school dental service, there is now justification for the allocation of funds specifically to obtain the special equipment and workforce (including dentists and dental hygienists) required to treat the elderly. An allocation at least equivalent to that assigned to the School Dental Service would be required.

COST: \$10 million



2.3 Rural and remote services

PROBLEM

Data published by the Australian Institute of Health and Welfare indicates that access to dental services is becoming an increasing problem for people living outside the metropolitan area. Just as medical services have required special promotions to attract and retain medical professionals in regional settings, so too dental services require similar programs.

With an ever-growing proportion of dental graduates being drawn from non-Anglo-Saxon cultural backgrounds, their fear of isolation from close-knit family structures, and of living in a remote smaller community, have mitigated against their relocation to the “bush”.

PROPOSAL

Mirror the rural medical recruitment drive in dentistry or extend the medical program so that it addresses dental undergraduates.

In addition to State funded incentive schemes, we urge the Victorian Government to lobby the Commonwealth for tax relief for practitioners who commit a minimum of two years to remote rural service in particular areas of identified need nominated by Departmental officers. Such an arrangement might see practitioners who undertake to commit two years to service in such communities rewarded with a tax free cash bonus of say \$50,000.

COST: \$0.5 million



2.4 Service planning initiatives

PROBLEM

As additional public clinics have been opened over recent years, funds allocated to the Victorian Emergency Dental Scheme and the Victorian General Dental Scheme have appropriately been reallocated to service delivery costs within those new facilities.

This has reduced the extent to which private dentists have been called upon to contribute to treatment of public patients under the VEDS and VGDS. The Public / Private mix has therefore been diluted, and so disadvantaged those who are not located close to a public facility.

The use of the Department of Veterans' Affairs scale of fees has also eroded the willingness of private dentists to treat public patients, and augmentation of the fee scale is overdue. Private sector dentists would be more willing to treat publicly funded patients where the public sector is fully utilised, if appropriate fees were paid to cover their costs and provide them with a small margin.

PROPOSAL

Expand funding of both the VEDS and VGDS in preference to using additional funds for infrastructure. Using these schemes retains DHSV control over allocation of funds to patients in greatest need and provides local community delivery of services.

COST: \$5 million



3 Oral Health Promotion and Disease Prevention Strategies

The ADAVB was especially pleased to see the assignment of significant funds to support 16 oral health promotion projects over the previous budget period, and we have been actively involved in various of these beneficial ventures. Emerging priorities have been identified for future grants, and these are detailed below.

Poor oral health is a risk indicator for other conditions that are costly to treat. Each dollar invested successfully in prevention, oral health promotion, and treatment, will lead to appreciable savings in medical and pharmaceutical costs.

3.1 Public Information and Education Campaign

PROBLEM

Dental caries and periodontal (gum) diseases are almost entirely preventable. Notwithstanding this fact, our community experiences high rates of decay and periodontal disease (see AIHW statistics on page 3 above). Also, if detected early, they are much simpler and therefore cheaper to treat. Consequently, there are substantial potential savings in reduced treatment costs if decay and gum disease can be prevented or treated early.

Monies spent on educating the public and engaging them in a partnership to self-manage their oral health care, will be well spent. This requires that they develop enhanced understandings about effective oral hygiene and the benefits of regular attendance to enable early intervention and other preventive interaction. As it happens this approach usually involves less discomfort for patients, as well as reduced treatment time and cost.

Public prevention campaigns and programs such as “Slip Slop Slap” have been very effective in changing the behaviours of a large proportion of the community to significantly reduce disease. Such campaigns would also be equally successful for reducing the occurrence of dental caries and gum disease, and thus reduce the demand for treatment, with its associated costs.

PROPOSAL

VicHealth to be funded to conduct an extensive and sustained oral health education campaign focussing on self-managed oral care, and shared responsibility between individuals and their dental professionals for maintaining oral health. Such a campaign should focus on both electronic and print media, and enlist the advice and assistance of the ADAVB and the School of Dental Science.

COST: ~\$5 million



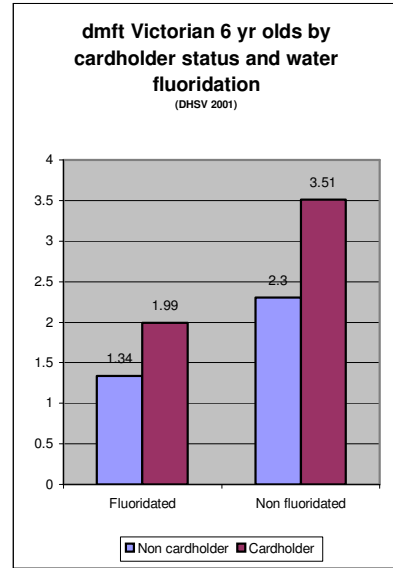
3.2 Extension of Fluoridation

PROBLEM

Around 75% of Victoria’s water supplies are fluoridated, leaving 25% of the State’s population without access to this most cost effective health measure. The mapping done by DHS to overlay fluoridated areas with dental disease and socio-economic data, shows irrefutably that fluoridation is still a highly effective public health policy.

Public attitudes to this excellent public health measure have been influenced by alarmist media coverage of unscientific views about side-effects of fluoridation.

The problem is experienced in most **regional and rural areas of Victoria**, since the metropolitan water supplies have been fluoridated since 1977.



PROPOSAL

A comprehensive and factual information program is required to improve public understanding of the health and economic benefits of fluoridation, and to assist regional water boards to make the required decision to install and turn on their fluoridation facilities. Alternatively, the Government could reclaim the issue from the Boards as it is such a significant public health matter, and given inaction by some Boards over so many years, which seem ill equipped to address the issue.

Essentially, we urge the Government to review its policy to merely allow local water authorities to make the decision, and to take a more pro-active stance on the implementation of fluoridation in communities not now enjoying the public health benefits of this measure.

A PR firm should be engaged to devise a media campaign for delivery primarily via regional TV, and designed to provide scientific and health expert support for the extension of fluoridation to those rural communities not yet enjoying the preventive benefits. The TV component should also be supported by targeted online material on the Health Channel and other measures.

COST: \$0.95 million



3.3 Smoking cessation

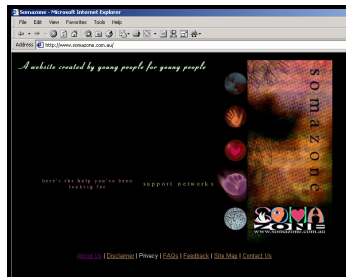
PROBLEM

One of the very commendable oral health promotion projects during 2000/01 involved the ADAVB and Quit in preparing smoking cessation training resources for dentists and their staff. This successful project highlighted the dearth of resources to inform adolescents about oral health risks associated with smoking.

Standard print materials are no longer 'credible' for most adolescents, and special web publishing and interactive resources are required to make the required meaningful connection with the younger audience. Additional resources have been allocated to the School Nursing Program in order to address drug and alcohol issues especially, and School Nurses require training and access to these new smoking and oral health resources.

PROPOSAL

To assist dentists, school nursing personnel and other health service providers to inform students about the **oral health risks of smoking**, a further grant of \$200,000 is sought to develop and deliver targeted Internet resource materials for adolescents.



Such funding would be complimentary to the Commonwealth funded project on tobacco education resources for schools, and the work being done to provide addiction prevention material on CD-ROM. It would also update the somazone website material produced with Departmental support in 1999/2000.

The proposed funding would need to allocate approximately \$50,000 to research and evaluation, with the remainder being required for web site development and hosting costs.

COST: \$0.2 million



3.4 Extension of Oral Health Promotion Research Grant Program

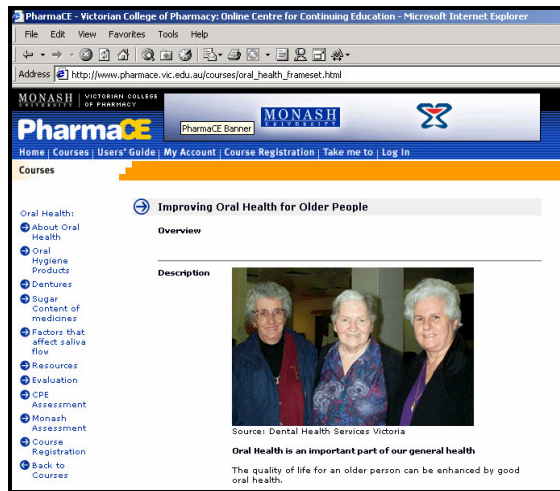
PROBLEM

The 16 oral health promotion projects made possible by a special grant scheme established by the Department during 2000/2001 were a welcome shift in funding emphasis away from high cost restorative areas towards lower cost disease prevention and health promotion activity. As seeding grants, they have the capacity to significantly reduce demand for health service delivery, and to make permanent changes to both consumer and provider perspectives.

PROPOSAL




Extend the grants scheme for a further year to enable a wider range of projects to be conducted, with consequent beneficial impact on the oral health of more Victorians.

COST: \$0.25 million



Just say 'A-A-A-A-A'.

The 5As
a model for dentists
to help patients to quit smoking.



4 Workforce recruitment, retention and professional development

4.1 Attracting and keeping public sector dentists

PROBLEM

Wastage rates of around 40% have been recorded for the last three years in succession, so that the number of experienced and committed dentists working in the public sector is now one of the lowest levels recorded. A workforce strategy was to have been implemented in the previous budget year, but the industrial problems were allowed to fester for months rather than bringing the dentists' terms and conditions into line with their medical counterparts.

Wage fixing principles have been used to stifle a just claim for catch up, and in the meantime, the public sector keeps losing almost half its workforce each year! Salaries have not advanced at the same rate as in comparable health occupations.

The DHS Key Future Directions list includes the objective to “develop and implement an Oral Health Workforce strategy”. A major report was completed for the Department in mid 2000, and this has still not been released over a year later. Given the projections that there will be a shortage of all dental operatives by 2010, demand for dentists in the private sector will continue to grow while the public sector recruitment and retention problem remains unattended.

PROPOSAL

Give public sector dentists wage parity with other health professionals with similar education and responsibility. Refer to the Lochtenberg report for appropriate rates and recognition levels.

Incentive schemes are required to attract dentists into public service and to locate them in areas of greatest need.

COST: ~\$3 million

4.2 Attracting and keeping dental assistants

PROBLEM

There has been a growing problem in attracting dental assistants to work in both public and private practice – especially in metropolitan areas. The crisis previously identified in general nursing appears now to have extended to this special field, and to warrant similarly focussed efforts to recruit and retain dental assisting staff.

PROPOSAL

Career promotion and wage and benefit reviews to be conducted to increase the rate of employment for dental assisting personnel.

COST: \$0.2 million



5 Capital works

The continuing commitment to build the new dental hospital (initiated by the previous Government) is greatly appreciated as these modernized facilities for public dental care and training of dental care providers are long overdue. The ADAVB recognises that the commitment of \$52m to this venture is a significant and positive contribution to public dental infrastructure. The new hospital and school form the hub for the “hub and spoke model” adopted by DHSV in its capital plan. That plan was prepared in 1997 and remains the most recent capital plan recognised by the Department of Human Services.

5.1 Decentralised clinics

PROBLEM

The mobile dental vans are obsolete and present both OHS risks for staff and infection control risks for staff and patients. Some regions remain poorly served by public dental infrastructure, whilst others need major upgrade of their facilities to provide an efficient and safe treatment and working environment.

The ADAVB understands that stages 1 and 2 of the DHSV Capital Plan have been implemented, and that stages 3 and 4 remain to be addressed. The original funding projection for those stages required \$15m, which would now translate into a figure closer to \$17m.

PROPOSAL

Increase the rate at which new decentralised clinics are commissioned at community health centres – particularly in rural and regional Victoria, and ensure use of private clinics where possible to reduce the need for capital works whilst maintaining local service delivery for the communities concerned.

COST: \$17 million





ABOUT THE ADAVB Inc.

PURPOSES

The objectives of the Branch are to promote the:

- improvement of the dental health of the public;
- art and science of dentistry; and
- highest standards of professional dental care

MEMBERSHIP

- Approximately 2050 Dentists in private and public practice
- 95% of registered private practitioners
- 10 suburban and 7 country groups

MEMBER SERVICES & FUNCTIONS

- Continuing Education (including Professional Development Program)
- Dental health education programs (eg. Dental Health Week, Megabite)
- Community Relations – dispute resolution
- Code of Ethics (Conduct)
- Recent Graduate support
- Dental Assistant Training update seminars
- Member Service Plans (eg Professional Insurances; preferred suppliers)
- Industrial relations advice and representation
- Defence and legal support
- Advice on Practice Management
- Quality Assurance (including Doctors Health Advisory Service)
- Benevolent Fund
- Library and resource collection
- Representation to Government and statutory bodies
- Superannuation (Professional Provident Fund)
- Sports and social functions
- Publications – Newsletter, Journal, Award details, Manuals etc.
- Home Page (find us at <http://www.adavb.com.au>)

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