AMBULATORY CARE FRAMEWORK

SUBMISSION
TO THE DEPARTMENT OF HUMAN SERVICES
BY AUSTRALIAN DENTAL ASSOCIATION VICTORIAN BRANCH INC.
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ACF Consultation
Level 11
555 Collins Street
MELBOURNE 3000

Via Email to: acffeedback@dhs.vic.gov.au

Dear Sir / Madam

AMBULATORY CARE FRAMEWORK

The Australian Dental Association Victorian Branch Inc. (ADAVB) appreciates the opportunity to present the attached submission regarding the Ambulatory Care Framework.

The ADAVB represents over 90% of private practitioner dentists and about 60% of public sector dentists in Victoria. One of our key objectives is to promote the oral health of all Victorians, and so we are pleased to make this submission in support of the inclusion of dental services in the Ambulatory Care Framework.

We make these representations on behalf of our members to highlight concerns that the overall climate for health practice which is being created by the Government militates against the laudable objectives of the ACF being achieved.

Yours sincerely

Garry Pearson
Chief Executive Officer
INTRODUCTION

This submission focuses on support for the integration of dental services into the full range of health care services provided to patients on a “right care, right place, right time” basis. Dental services are ideally suited to self-management, as most dental conditions and diseases are entirely preventable.

In reality of course, even relatively simple oral health measures are not used or understood by large sections of the community, and indeed for many special needs groups, self-managed care is not appropriate.

Regrettably, oral health promotion is unlikely to ever receive funding support at even 10% of the cost of the total dental services budget, much less the 20% or higher rates applied to health promotion in numerous other areas. The demand for basic dental care continues to outstrip capacity by such a large extent that it is hard to increase spending on disease prevention while so many people require basic restorative care.

The Government’s commitment to the fluoridation of water supplies is a key preventive measure and is warmly supported by the ADA.

The assignment of dental therapists to an extensive preventive role within the School Dental Service has been one of its strengths over recent years, and it is a matter of concern to the ADA that this is being undermined by current moves to expand the duties of these operatives to treat all age groups. The ADA warned that allowing dental therapists to work outside the public sector would be contrary to the public interest, and we can now see that large numbers of them work either full time or part-time in the private sector, thus reducing the effectiveness of the early intervention program which had been so well targeted through the School Dental Service. While co-location of the School Dental Service with Community Dental Services in regional centres makes logistical and resource management sense, the dental profession fears that erosion of the Service’s focus on children will lead to a long term increase in dental disease patterns as the children who miss out on preventive care mature and develop.

The ADAVB strongly supports measures to enhance the provision of oral health promotion and oral health care (including oral hygiene care) to homebound people and residents of nursing homes, and indeed we recently sought significant increases in funding for the Domiciliary Unit to extend the number of bases operating throughout Victoria.

In addition, the Federal ADA policy on Allied Dental Personnel was modified in 2003 to support the role of dental hygienists in the provision of preventive oral health care in non-dental facilities, such as residential care. Dental hygienists are viewed as an essential part of the dental team, particularly in providing ongoing maintenance preventive programs.
The DPBV Code of Practice for Dental Auxiliaries notes:

“This Code requires a team approach in the delivery of dental services, with a registered practicing dentist or dentists adopting the role of clinical team leader(s) with overall responsibility for patient care. The dental therapist and dental hygienist work with the dentist(s) in a consultative and referral relationship to provide any or all of the following: preventive, periodontal, restorative and orthodontic dental services. A dental auxiliary may not engage in independent practice.”

It is clear that the responsibility for dental examinations and treatment plans rests solely with a dentist. It is important that dental therapists and dental hygienists gain an understanding of these clinical decisions, and indeed are involved in clinical decisions during maintenance programs. However, in terms of deciding on a course of care, it is the dentist who takes responsibility according to a written agreement.

“People and community
Access to health care will be timely, provided predominantly in community-based settings and informed by patient choice.
Care will be ‘person-centred’, focusing on the needs of the whole person as these change over time.
Health care will be provided in community-based settings (including in people’s homes), where it is safe and cost-effective to do so.
People will have equitable, timely and appropriate access to health care regardless of where they live.”

Given the well known resource constraints, this language of “access and equity” is sounding more and more like it is wishful thinking. The debate seems now to be much more about eligibility criteria and demand management, and coveys a sense that public health officials have to be given the means by which to say “no”. This is very similar to the approach being taken by private health insurers, who are constantly adjusting the schedule of services they will rebate, and the level of rebate they will pay, due to the profitability pressures within their businesses. Premiums keep rising, rebated services and percentages are declining, and all the ‘I feel better now’ jingles are beginning to ring hollow.

We suggest rewording the second principle to read “Health care will be provided in community-based settings (including in people’s homes), where it is safe, a high quality of care can be achieved, and it is cost-effective to do so.” Offering people second rate care which happens to be safe and cost-effective is not a worthy aspiration for our health system.

Over a number of years now the Victorian community has watched dental waiting list get longer and longer. Recently, we have seen some signs of improvement, and the 30% increase in funding to dental services announced in the 2004 Victorian Budget has been a key factor in this. Regrettably, waiting lists, even in large regional centres like Ballarat and Moe remain unacceptably long.
According to the Your Hospitals section of the Department of Human Services website, patients in Ballarat will still have to wait 54 months for general care and 31 months for dentures, while those at the Latrobe Community Health Service in Moe have to wait 61 months for general care and 46 months for dentures (as at June 2005).  

It doesn’t matter how you define “equitable access” and “timely access”, nobody in these two significant regional communities could accept these waiting times as reasonable.

- **How can we improve consumer involvement to ensure effective service planning and delivery?**
- **What barriers to ‘person-centred’ care need to be overcome?**
- **What is required to build stronger integration between primary care and specialist services?**
- **What are the barriers to population health based care?**
- **Which existing ambulatory care services will be able to be provided in community-based facilities? Which ambulatory services must continue to be provided on hospital sites, and why?**

Integration of dental services with primary care is being trialed at Goulburn Valley Health, and the co-location of a coordinated community dental service with medical and acute facilities is clearly a key factor in the potential success of this exercise.

The biggest barrier to effective referral of patients for dental care is the lack of resources to ensure that those patients would in fact receive the care in a timely and appropriate manner.

When medical practitioners have tried to use the enhanced primary care funding under recent changes to Medicare, they have found the funds available are so small and the paperwork so onerous, that it is not worth the effort. This Commonwealth program is insulting to those patients with complex medical conditions that are further compromised by poor dental health.
“Service delivery
Health care will be evidence-based, will address broad determinants of health and will ensure that information about people’s health care is well managed.

The delivery of health care will be based on the best evidence available and will be planned on an area basis to meet the needs of defined populations.

The delivery of health care will incorporate a population-based health approach that recognises the social determinants of health and promotes prevention and early intervention. Information about people and the services they receive will be consistently managed and coordinated across health care services, to protect privacy and support integrated service delivery and continuity of care.”

The ADAVB supports health care being evidence based, especially given the limited resources available for service delivery. We have no comment on other principles listed as they seem to be applicable to larger health care systems and to be of little relevance to dental services.

• What mechanisms are needed to effectively plan for integrated ambulatory care services at a population level?
• How might the current range of population-based planning approaches be re-cast in light of the needs of the ambulatory care system? (Consider PCP, Primary Care and Population Health Advisory Committees and local government roles.) How could area-based planning be integrated with other planning requirements (for example, metropolitan health service strategic plans)?
• Appendix 1 provides an example of a potential schema for classifying ambulatory care services. How useful is this schema for guiding planning of ambulatory care services? How could it be improved?

The description of dental services as a specialized ambulatory care service correctly indicates that special facilities are required either in major regional centres or via additional domiciliary services, to permit care to be offered in home settings. It will also require more specialist Special Needs Dentists to deal with the complex treatment requirements of medically compromised patients, whose circumstances are such that allied dental personnel would only be able to meet little or none of their treatment needs. Specific training initiatives and incentives are required in this area.

Capability
Health care will be delivered by a skilled workforce resourced to deliver services in a planned and coordinated way.

The workforce will be configured to deliver integrated health care.

There will be a consistent, planned approach to developing the infrastructure for the delivery of integrated health care, including information and communications technology, standard tools and protocols, facilities and equipment.

A mechanism for integrating health care services will be through co-location or clustering within health precincts.
The recent push by the Victorian Government and the Department of Human Services to use workforce substitution in a range of health services involving professionals has alienated key groups whose cooperation and participation will be vital to the effective integration of services as envisaged by the ACF. Characterising those who have dedicated their lives to development of the skills and knowledge necessary to provide the most appropriate care to the community as ‘protectionist’ and ‘inflexible’ devalues their efforts, and contradicts the community’s expectation that they will receive safe and high quality care. Such proposed substitution will lead to further fragmentation of dental care – the opposite of the stated aim.

The recent Bundaberg hospital case, on which a Commission of Inquiry has recently been conducting hearings, illustrates the contradictions inherent in public policy which advocates that we need more lower trained health workers along with specific registration for overseas trained practitioners to avoid them having to meet local educational standards (albeit for a limited period of time),

The roles of health workers need to be clearly defined so that the public can be confident that the person they are seeing is competent to provide the treatment they require.

When some commentators seek expansion of duties for auxiliaries they are also seeking additional remuneration in recognition of their allegedly greater skills and responsibilities. This necessarily undermines the economic arguments in favour of greater use of such operatives. Given the high overheads currently involved in the delivery of dental care, such arguments are already problematic. We also see public sector managers resist the concept of clinical supervision, especially where this involves having senior professionals on site to provide opportunity for direct intervention in the event an auxiliary encounters a problem that is beyond their skills to handle.

Independent practice rights are already being sought by the associations representing these allied dental personnel, with the argument that dentists are holding them back from achieving the recognition they should be given. The more auxiliaries are encouraged to become independent practitioners the less dentists are going to be willing to accept legal liability for the outcomes of treatment completed by those operatives. If the Government wants them to be independent, then it will have to deal with all of the consequences of this, including increased rates of treatment failure and complaints, and therefore higher insurance premiums and other on costs that independent practice will necessarily bring.

As this ‘credential creep’ and the push for independence promotes the interests of allied dental personnel over those of the public, the cost of their labour will rise, while the overall standard of care offered to the community will fall as the more highly skilled workforce are replaced or “substituted” by less skilled operatives.

These developments do not occur in a policy vacuum. While these debates occur, we also have a bureaucracy in overdrive creating an ever increasing regulatory burden on health professionals and distracting them from their clinical work with more and more red tape and paperwork. In an apparently contradictory trend we also see Governments blithely legislating away (for lengthy periods) obligations for overseas trained personnel to have to meet minimum educational standards, and arguing that we should expand the duties of auxiliary personnel without necessarily undertaking the required additional education and training.
The Government’s moves to de-regulate the health professions by establishment of lay controls which disenfranchise those who are expert enough to know when a practitioner is providing unscientific treatment, will ultimately produce the same damage to public health. Unregulated areas of health practice lend themselves to quackery and abuse.

Victoria’s Small Business Statement (2005) comments on a range of factors influencing the willingness of private practice owners to remain in Victoria:

“Creating a competitive business environment that makes Victoria an attractive location to invest in is critical to small business and the State’s prosperity.

Key elements to a competitive business environment include low business costs, quality infrastructure, access to markets and capital, a skilled workforce and minimal regulatory barriers.

Bureaucratic red tape continues to be a major concern for small business. As they do not have the administrative and support systems of larger businesses, small businesses can face disproportionately higher compliance costs.

Increasing the red tape and bureaucracy required to be addressed by dentists by virtue of new public dental schemes is one sure way to alienate the private sector and making public schemes look and sound like managed care is likely to ensure that proposals for public / private partnerships will not succeed.

This de-regulation of auxiliary personnel and overseas dentists is occurring at the same time as locally trained and fully registered dentists are complaining of unprecedented levels of regulatory activity and heavy compliance costs, most notably due to the red tape requirements they have to attend to in their back office, which distract them from providing the dental treatment they are there to deliver.

Private practitioners are also currently being subjected to a heavy handed and intrusive program of third party control over the services they provide, with Government supporting the activities of health funds in their encroachment on the clinical and business independence of practitioners.

The Ambulatory Care Framework will not integrate private dental services effectively if all private dentists have been so alienated by Government policies and regulations that they are unwilling to contribute to public health service delivery.
• What needs to be done to ensure that there is an appropriate workforce available to support the expansion of community-based ambulatory care?
• Under the ACF, capital planning would be done on a geographical basis, for defined populations. What are the implications of this for partnering between agencies?
• What are the most important capabilities to focus on? What can be achieved quickly? What will bring the most benefit?

Dental services are affected by the same long term workforce problems as are other health services, and there is an inadequate number of HECS places offered in Victoria for Bachelor of Dental Science students. The Victorian Government has inexplicably favoured funding for additional dental therapist and hygienist places, but illogically argues that only the Commonwealth is responsible for funding of dentist training. This abdication of responsibility for funding an extra 25 places means that Victoria will be significantly disadvantaged compared with other States which have been adding extra training places to their dental courses.

We note that the Department has supported some rural dental workforce initiatives, as reported on the Dentistry in Victoria website:

“In 2003 the government awarded six undergraduate dental scholarships to students demonstrating a commitment to rural public practice upon graduation. Up to $21,000 pa is paid to rural agencies in the form of a rural allowance to help them attract dentists. The amount depends on the distance the agency is from Melbourne and translates into a higher salary and/or relocation costs, accommodation, a car or other benefits.”


While these measures, and the scholarships provided by the ADA, offer some hope for improvement, to date they have had limited impact, and they leave a significant shortfall between demand and supply. Dentists are the most suitable dental care providers for regional rural and remote areas, as they are trained to provide all dental treatment. In order to ensure community based dental service therefore, the system requires more dentists.

**Collaboration**

Health care will be based on funding and accountability arrangements that foster a partnership approach.

The provision of health care will be based on partnerships among levels of government and public and private health care services.

Funding and accountability arrangements for the delivery of quality health care services will support the provision of the right care, at the right time, and in the right place.

Defining “right care, right time and right place” for dental services requires an open community debate. The profession sees signs of a shift in Government rhetoric about the services it feels obliged to provide, and is concerned that this will have the effect of downgrading the dental care offered to the community. The diffusion of the School Dental Service amongst Community Dental Clinics, and potentially the same loss of coordinated and focused service planning and delivery for domiciliary services are of particular concern in this regard.
The community should be able to expect basic restorative care designed to preserve functional dentition to the maximum extent possible. Extraction rates have been too high for too long, and more emphasis needs to be placed on both preventive and complex restorative care.

For many of the people targeted by the ACF, domiciliary care will be required, and this specialized service requires central coordination rather then diffusing energies by use of isolated and limited local resources around the State.

- How can changes to existing relationships, service coordination, organisational structures and funding facilitate a more person-centred ambulatory care system?
- How can funding models support service integration, flexibility and coordination?
- What kind of incentives can be put in place to encourage innovation, increase transparency and build trust?
- How can the ACF foster new or improved public–private partnerships?
- What is required to support a ‘virtual organisation’ between co-located public, private and not-for-profit providers?

Case management models that include dental services would be required in order to make services more person-centred. It is difficult to see adequate resources being assigned to this however, given the existing resource limitations in dental and rural health services generally.

The continued use of dentists as the primary care provider in dentistry will ensue a more person-centred ambulatory care system. The more such care is proposed to be done by allied dental and other personnel, the more fragmented and less person-centred the treatment will become.