



VICTORIAN STATE BUDGET SUBMISSION 2010-2011

Purpose

The Victorian Branch of the Australian Dental Association (ADAVB) is pleased to present this submission on the Victorian State Budget for 2010-2011 with a view to assisting the Government to identify priority areas requiring additional funding support over the coming months.

Representing over 90% of registered dentists in Victoria, the ADAVB is the peak professional body for dentists, and has a long history of acting in the public interest as well as representing our members. The ADAVB mission statement reads:

"The ADAVB is an association of dentists committed to advancing the art, science and ethics of dentistry, the care of the oral health of all Victorians, and the professional lives of its members."

We highlight the ethical and community dimensions here because health professions are sometimes characterised (unfairly we believe) as being simply 'vested interests'. Our view of professional obligation continues to place patient welfare first, and that means we hold strong views about the way State budgets need to be framed to promote the oral health and safety of the public.

Summary and Recommendations

1. Capital and workforce plans need to be reviewed to build capacity to address the requirements for delivery of universal access to dental care via Denticare, the proposed dental intern program, and expanded clinical placement facilities.
2. Funding of \$18m is required to support the establishment of an 80 chair specialist training facility at the Melbourne Dental School.
3. Health care policy planners must recognise that the provision of oral health care is an integral part of the concept of accountability to the community, comprehensive care to patients, and the standard of care for many disease processes and medical diagnoses.
4. A capital plan is required to ensure that all public dental clinics are fitted with ISO 11143 compliant amalgam retention filters to prevent mercury bearing waste entering the sewerage system.
5. Changing population demographics and disease patterns are increasing the numbers of patients who face barriers to accessing basic oral health care in the traditional dental office setting. Hospital dental programs serve the special needs of these patients, and also provide a safety net for indigent patients. These programs should continue to receive State Government funding. Estimated cost - \$200k

6. The critical interface with medicine, so essential to the changing face of dental education and clinical practice, cannot be provided solely within the dental school environment, underscoring the importance of hospital rotations for all undergraduate dental students and the value of hospital-based postgraduate general practice residencies. These educational programs need to receive State funding. Estimated cost - \$400k
7. The establishment of hospital-based dental services at public hospitals with more than 200 beds. With the hospitals having the necessary healthcare facilities (from access ramps to staff training), what is required is a dental surgery and equipment, documentation, a dental team and appropriate and adequate funding. Initially establishing a dental unit at St Vincent's at an estimated cost of \$1.5m.
8. Consideration be given to establishing a nursing home program where private practitioners treat residents and are paid by DHSV on a special fee schedule (essentially DVA rates, but with special item codes specific to nursing homes). The service involves setting up portable equipment, writing notes in nursing home records, travel to the residences etc. Estimated initial cost - \$0.5m.
9. Funding for several research projects:
 - Reducing hospital admissions for dental treatment
 - Interdisciplinary preventive and health promotion activities
 - Estimated cost - \$200k
10. Funding for the teaching of the Diploma and Masters courses on Victim Identification thereby ensuring that Victorian based forensic odontologists are available in the event of emergencies. Estimated cost - \$211k.
11. Continue the very successful program of fluoridating Victorian towns.

Background to preparation of this submission

This submission has been prepared in the context of an unprecedented range and scale of health reforms currently occurring nationally. A huge increase in workforce and public dental infrastructure would be required for some of the reforms to be delivered as promised.

The context of this submission includes these national reforms:

- National registration and accreditation scheme - a single national registration and accreditation system for the health professions accompanied by new and updated registration standards.
- Denticare – a proposed scheme to provide universal access to preventive and restorative dental care and dentures, regardless of people's ability to pay which has resulted in the ADA proposing an alternative scheme targeting the most disadvantaged in our community. The Denticare scheme, as proposed by the NHHRC, could possibly result in a reduction in access to care for health care cardholders when waiting lists are swelled by the inclusion of people who were previously not eligible for publicly funded care.

- Medicare Select – if implemented, the Federal Government would be the sole funder of health services and health insurers would top up the basic cover offered to everyone by means of customised dental plans. US style managed care administration arrangements would be likely to ensue.
- Practice accreditation and related measures as proposed by the Australian Commission on Safety and Quality in Health Care.
- e-Health – electronic record keeping, patient controlled records, and other e-Health measures will be challenging for many practices – even those that currently use dental software. This will be driven by requiring e-health systems to be installed in every practice if it is to be paid by social insurance agencies under Denticare and proposed pay for performance measures.
- State – Federal responsibilities in flux. Proposals for the Commonwealth to take over responsibility for policy and funding of primary health care are likely to impact on dental services also.
- New dental funding model proposed for Victorian public dentistry– with a move away from itemised treatment to courses of care.
- Award modernisation changing the terms and conditions for employment of dental practice staff, and increasing costs for opening surgeries on Saturdays. Effective 1 January 2010.
- National OHS model implementation leading to new obligations to meet modified OHS standards.
- National Primary Care Strategy - promoting evidence-based management of chronic disease; supporting patients with chronic disease to manage their condition; addressing the growing need for access to other (non-medical) health professionals, and encouraging a greater focus on multidisciplinary team-based care.
- Health Workforce Australia initiatives aimed at creating “effective, streamlined and integrated clinical training arrangements” and supporting “workforce reform initiatives”.
- National Health Promotion and Preventive Agency providing an opportunity for the dental profession to partner with diabetes, heart and cancer programs to achieve adjunct benefits for oral health.
- Henry Tax Review leading to new business obligations. Implementation dates unknown.
- Cooper Superannuation Review leading to changed employee superannuation administration arrangements. Implementation dates unknown.

The UN Environment Program Global Mercury Partnership will also impact on dentistry. This is an intergovernmental negotiating committee with the mandate to prepare a global legally binding instrument on mercury, commencing its work in 2010 with the goal of completing it prior to the 27th regular session of the Governing Council/Global Ministerial Environment Forum, in 2013. Thanks to the continuing support of EPA Victoria and the water authorities, the *Dentists for Cleaner Water* program is an outstanding success with more than one third of the target of 1000 dental surgeries having installed ISO 11 143 compliant amalgam separators. (ADAVB is also actively encouraging members to be environmentally socially responsible.)

Dental waiting lists

Waiting times reported via the Your Hospitals website appear to have improved over the last two years, and Government action to support this has been greatly appreciated. Eligible patients in a number of areas are still experiencing unacceptably long waiting times however, and further action remains to be taken.

Should the Commonwealth Government introduce Denticare, and allocate the extra funding to extend basic dental care to the entire community, the infrastructure and workforce required to deliver the additional services will need significant upgrading. The Commonwealth may propose to take up both funding and policy responsibilities but the Denticare proposal appears to expect that State Governments would continue to administer the delivery of public dental services. The State's share of funding responsibility for infrastructure under the proposed reforms is not clear to the ADAVB.

If the Commonwealth proceeded with a national dental intern scheme for all new dental graduates, the infrastructure and staff required would also need to be assessed, especially the adjustment of productivity targets for the senior public dentists who will mentor and supervise the interns. This is a significant industrial issue and the State Government will need to ensure that the Commonwealth takes this into account when determining the allocation of the additional funds required to administer the new schemes - Denticare and the Intern program.

Whether the responsibility lies with the State or Federal Governments, we draw attention to the unrealistic expectations that will fall upon public dental services when the entire community is advised that they are entitled to free or subsidised dental care. The Victorian public dental services treat approximately 300,000 people of the currently eligible population of only 1.5 million Victorians, so its capacity is limited to about 20% of the potential demand in any one year. Increasing that demand by the inclusion of everyone else in the community will significantly extend dental waiting lists, even though many will opt for private cover.

If about 35% of the community cannot afford access to dental care, then **at least another 500,000 Victorians who were not previously eligible for public dentistry will be joining the queues for public dental services** under Denticare. This is because these people are no more likely to pay for additional private dental insurance than they do now.

The Victorian Government needs to establish the actual level of likely demand for access to public dental services in liaison with the Commonwealth Government. In the light of the finding, public clinics throughout the State should then be assessed for their ability to deliver on the promise of 'universal access'. The ADAVB expects that the Department of Health and Dental Health Services Victoria will have completed modelling of the impact of these major changes to public dental services, but we have not been reassured by the agency about the impact assessments.

Our concerns echo those of Prof John Spencer, who has been one of the key advisors to the National Health and Hospitals Reform Commission – the architect of the health reforms - and Minister Roxon regarding Denticare. In a 'Policy Bite' published by the Australian Research Centre for Population Oral Health on 10 September 2009, he said:

"A fundamental rationale for Denticare Australia is to attract and retain people in regular use of dental services and for those services to be more comprehensive and preventively oriented. Inescapably this involves an increase in 'demand' from a dental labour force which is struggling to meet existing demand. Therefore, improved dental services can only be accommodated from within growth in the labour force. Labour force growth is in the pipeline, but there is an imperative for the benefits of Denticare Australia to be made available in parallel that growth.

Therefore Denticare Australia needs a phased implementation over many years."

Source: <http://www.arcpoh.adelaide.edu.au/policy/Policy%20Bite%20Denticare%20Australia.pdf>

The ADAVB makes no specific suggestion concerning the level of funding to bring the infrastructure and staffing levels into alignment with the policy aspirations of the Denticare and Intern schemes, but suggests that it will require many millions of dollars over a number of years. The Victorian Government therefore needs to have capital and human resources plans to deal with the issue.

Public dental infrastructure

In addition to the infrastructure problems outlined above, the ADAVB recognises that capacity to support undergraduate clinical placements is also of concern in both Melbourne and LaTrobe Dental Schools. This is an issue both from the perspective of the availability of chairs and mentoring support. The problems are expected to grow as increased intakes lead to additional accommodation requirements. Final year students needing to be accommodated in clinical placement programs are projected as:

2010	120	
2011	125	
2012	175	(LaTrobe commences its fifth year program)
2013	180	
2014	190	

Concern about the capacity to provide for this undergraduate demand was noted as one of the reasons public agencies and dental schools were reluctant to support the National Dental Intern Year proposal where first year graduates would do an internship, thereby providing greater dental services throughout Victoria and giving these young dentists considerable professional experience.

Referring back to the UN Environmental Program Global Mercury Partnership, we reiterate¹ our call for the Victorian Government to bring public dental practices into alignment with the ISO 11143 standard on amalgam separation. A capital plan is required to ensure that all public dental clinics are fitted with ISO 11 143 compliant amalgam retention filters to prevent mercury bearing waste entering the sewerage system.

¹ Refer previous correspondence to Minister Andrews dated 2 June 2009 and the ADAVB's submission to the Victorian Government's Climate Change Green Paper dated 29 September 2009.

In May 2008, the Victorian Department of Health (DH; the Department; formerly the Department of Human Services; DHS) commissioned the *Best Practice Clinical Learning Environments* project. The primary objective of that project was to develop a framework that would underpin consistency and excellence in clinical education and training across the state. This was part of a comprehensive strategy developed by the Department aimed at enhancing the capacity and quality of clinical education in medicine, nursing and allied health in Victoria. The ultimate aim is the creation of a sustainable health service workforce.

The second draft of the framework published in December 2009 identifies four key principles which must be adhered to if best practice is to be achieved for clinical learning environments:

- Principle 1: Patient (or client) care is an integral component of quality clinical education.*
- Principle 2: Learning in clinical environments is an essential component of training all health professionals.*
- Principle 3: Registration, accreditation or competency standards set down by professional bodies (where these exist) are the appropriate mechanism for ensuring that clinical education arrangements meet minimum standards for educational or training outcomes.*
- Principle 4: Many different models of clinical education and training exist and successfully produce health professionals of required competency and standard.*

The ADAVB commends these principles to those responsible for allocation of funds for health professional training infrastructure, and we draw attention specifically to the highlighted text in the following extract from the framework

“Capital infrastructure is the most problematic category to address, since space is a relatively fixed resource and once buildings are built, it is difficult to incorporate new facilities. Therefore, it is important that educational requirements are taken into account in the planning phase for new buildings and that educational facilities are not always the first to be eliminated when budget constraints bring about a review and modification of the plans.” (2009:11)

Expansion of the Melbourne Dental School (MDS)

The University of Melbourne has awarded the MDS \$20m and reassigned a property to permit the establishment of a specialist training facility, the Melbourne Oral Health Training and Education Centre (MOHTEC).

Regrettably the Commonwealth has reneged on the provision of an additional \$18m for an 80 chair pre-clinical training centre to be established along with facilities to support the hands-on continuing education program.

The dental profession acknowledges that much more of the mandatory CPD offered to dentists needs to be hands-on training, rather than hotel-style courses involving a passive audience listening to PowerPoint presentations. Amenities of this kind are therefore most valuable and serve the important purpose of improving the safety and quality of dental health care.

This facility will proceed without the Commonwealth funding, but it will be restricted to only 40 chairs. These facilities potentially offer part of the solution to the infrastructure problem highlighted above, in that they are to be used to provide treatment for those who were not previously eligible for public dental services, but who could not afford private dental care. Fees are to be charged at 50%-60% of customary private sector fees for equivalent services.

The establishment of this specialist training facility will also take pressure off the chairs in the Dental Hospital, so that more are available for the increased numbers of undergraduate students and interns who will need access to clinical training facilities.

This venture needs strong support from the Victorian Government, recognising that all of the students enrolled in programs at this centre will be local residents and none of the graduates will be overseas full fee paying students, thus ensuring that virtually all the graduates will enter the local workforce rather than returning to their home country as so many of the undergraduate population have done. We urge the Victorian Government to allocate the \$18m that was to have been provided by the Commonwealth to permit MOHTEC to reach its full capacity.

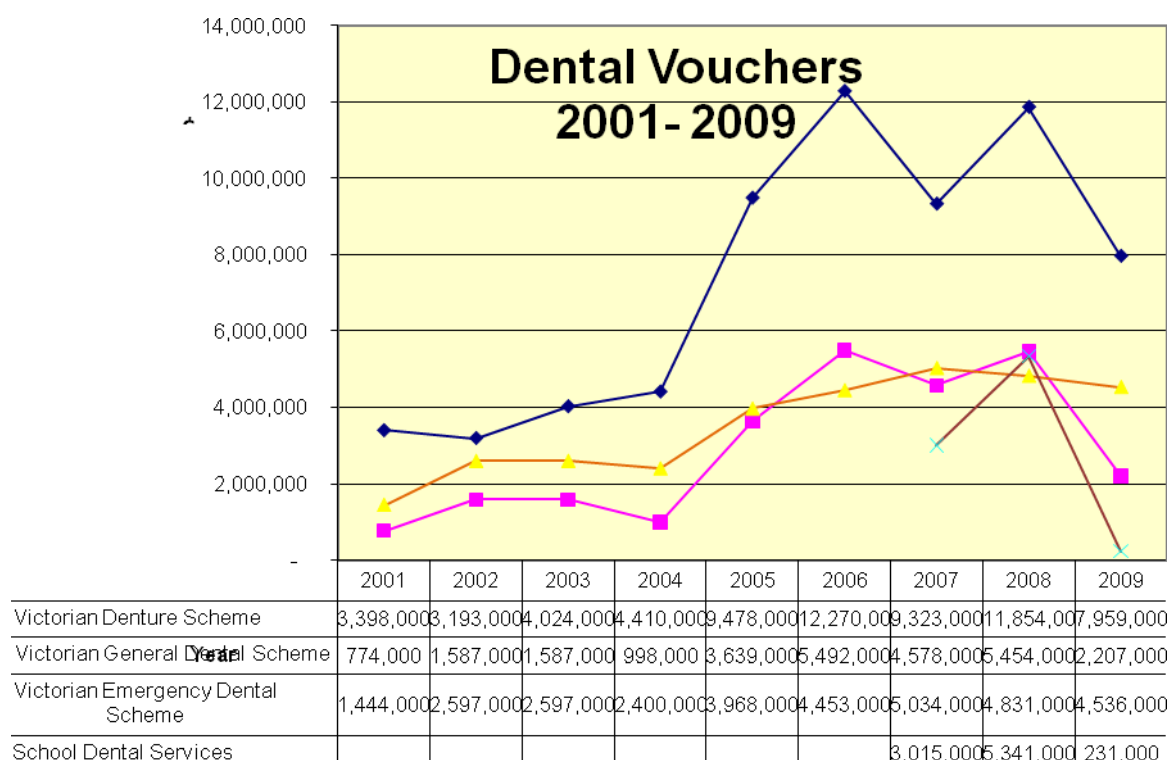
Declining use of vouchers

In a submission to Dental Health Services Victoria (DHSV) in December 2007 we urged that the dental voucher scheme rates be aligned with those of Department of Veteran Affairs (DVA). At that time of 34 treatment items which appear on both the DVA and Victorian General Dental Scheme (VGDS) schedules, only four of the VGDS items were within 15% of the DVA rates, and a staggering 27 VGDS items were more than 20% below the DVA rates. There were even three VGDS items that are more than 30% below DVA rates. Item 114 - removal of calculus - is amongst the most basic and common preventive measures, yet it has the greatest differential from the cost of service, and so appears to highlight the lack of understanding of the significance of this treatment and importance of prevention. This situation has not changed since 2007.

Last year we highlighted that Victorian voucher schemes were no longer using private dentists as much, and fee schedules for these remain out of date. The graph below shows the decline in use of the voucher schemes (source DHSV financial statements 2001-2009).

We once again urge that the Government increase funding for greater use of voucher schemes so that private dentists can help provide dental treatment to patients on public waiting lists and for voucher fees to be aligned with the Department of Veteran Affairs schedule of dental fees. (The Western Australian Department of Health works to the DVA schedule of dental fees.)

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E-Health

The Federal Government, as part of its health reforms, has embarked on the development and implementation of national electronic health records – e-Health. A report by the National Health and Hospitals Reform Commission earlier this year recommended a national e-Health strategy which would include every Australian having an electronic health record by 2012. To obtain this goal, a national policy and technical standards framework is needed by 2011 or 2012.

Although e-Health is a Federal initiative, Victoria has a direct involvement in this electronic records system through COAG and AHMAC. The State will also have to make budget allocations for its introduction to the public dental agencies and services. For this reason, ADAVB requests that the Government start making suitable allocations for e-Health – not only for the software and its installation, but also for adequate training of dental personnel in its use.

The Government should also consider data management issues and possible cost savings by aligning Denticare and Medicare Select and overcome some administration bottlenecks through an integrated e-Health model.

Our national body has made representations to the Department of Health and Ageing on matters relating to healthcare identifiers, privacy, and financial support for surgeries putting in place software and training for staff.

Hospital Dental Programs

Currently restricted to several Melbourne public hospitals, hospital-based dental programs should be extended to give state-wide coverage for patients with special needs. This would be done by public hospitals with more than 200 beds each having a dental unit.

Dental Care for Special Patients

The important role of these dental programs is increasing because of changing demographics, disease patterns and people with medically-compromised problems requiring special dental treatment.

There are also important adjunctive roles for the hospital dental program in the management of patients receiving other medical or surgical services. This ranges from treatment of incidental dental complications or emergencies arising during hospitalisation (e.g. toothache, dental trauma during anaesthesia intubation, etc.) to the provision of essential dental treatment that is a central component of the overall standard of medical care for a number of serious medical disorders.

Preventive and interceptive dental measures are an important and cost-effective means of preventing morbidity and mortality in these patients. These patients are best managed in a hospital-based dental program because, depending on their pre-chemotherapy blood counts, special management procedures may be required to prevent haemorrhagic or infectious complications associated with dental treatment.

There is also an important, cost-effective role for hospital dental services in the management of patients undergoing organ transplantation. The risk of infection in these patients, who are immune-suppressed to prevent transplant rejection, is a serious one.

The goal of basic dental intervention, before and after organ transplantation, is the identification and treatment of oral foci of infection which can give rise to bacteremia and serious systemic infections in these individuals. The cost of basic dental assessment and interceptive care is minimal, when considered in the context of the overall cost of the preoperative work-up, transplantation, follow-up care, and immunosuppressive medications for these patients (heart \$149,000, lung \$147,000, liver \$134,000).

In addition the immunosuppressive therapy that these patients receive as part of their transplant management can result in severe oral complications with almost 50% of these patients experiencing periodontal side effects as a result

Undergraduate and Postgraduate Education

Changes in demographics and patterns of disease have led to an increase in the number of people who will present to the new graduate with various complicating health problems that will have an impact on the management of complex dental treatment needs.

It would be advantageous to regional and remote communities and the community at large if dental faculties could develop hospital-based components to their undergraduate curricula. This would provide unique educational experiences in the hospital setting including training in the dental treatment of medically compromised, physically

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handicapped, and mentally handicapped patients in an ambulatory setting; training in medical risk assessment of dental patients; training in the management of dental and medical emergencies; training in the use of conscious sedation techniques for the provision of comprehensive dental care to anxious patients; and experience in managing hospital dental inpatients from admission through discharge, including experience in standard operating room protocols.

Aged care

Elderly people living in residential aged care facilities have difficulty accessing dental care. With an ageing population who are retaining more of their natural teeth, this problem will grow. The Federal Government's recent initiative of training one staff member in each nursing home on basic oral health for residents is welcomed, but dental treatment really needs to be taken to aged care facilities.

ADAVB urges the Victorian Government to look at a very successful program run in South Australia. Operating since 2003, the South Australian Dental Service's nursing home program is simple and cost-effective. It started with four dentists and now has eight dentists and one hygienist.

These private practitioners treat residents in nursing homes and are paid by SADS on a special fee schedule (essentially DVA rates, but with special item codes specific to nursing homes). The service involves setting up portable equipment, writing notes in nursing home records, travel to the residences etc. All nursing home residents are eligible for an examination (regardless of health care card status), but only those with normal public eligibility (health concession cards etc.) can access treatment paid for by SADS.

There is a patient co-payment of about 15%. SADS has four sets of portable equipment that they maintain and courier to each nursing home when it is required. Most of the dentists work about one session per fortnight, but they all do it in their own way - one dentist visits about 30 homes and mostly deals with emergencies; several dentists and their hygienist predominantly look after several homes, see nearly all residents and have a regular recall, seeing high risk residents about every three months.

SADS spends about \$340,000 a year on the program. About 1000 patients are seen at an average cost of about \$340 per patient, which is less than the average of about \$600 for patients in SADS's adult public sector. SADS has a waiting list of dentists wanting to participate in the program but can't due to lack of funds.

Victoria has about 45,000 residents in some 850 nursing homes. ADAVB acknowledges that providing such a service to all nursing home residents in the State may be fiscally and logistically impossible, but urges the Government to consider such a scheme and to progressively phase it in, especially in regions such as Gippsland and the Wimmera.

Research projects

ADAVB calls for several research projects – reducing hospital admissions for dental treatment and interdisciplinary preventive and health promotion activities.

Reducing hospital admissions for dental treatment - ambulatory care sensitive conditions (ACSC)

In 2004-05 the Department of Human Services analysed hospital admissions in Victoria caused by dental ACSC. It was found that dental ACSC admissions had risen across the State since 1994 with dental caries or associated conditions accounting for more than 80% of all dental ACSC admissions, and 95% of ACSC admissions for 0–9-year-olds. These admissions were treated with removal of teeth in more than 75% of cases. These extractions could all have been prevented with earlier intervention. There is a significant difference in ACSC admission rates between and within regions across Victoria. Access to fluoridated water was found to be a significant predictor of the difference. That is, ACSCs were found to be significantly higher in catchment areas with lower access to fluoridated water. The analysis demonstrated the value of providing fluoridated water supplies in reducing dental disease and subsequent need for treatment, especially for treatment in hospitals.

With around 90% of Victorians now benefiting from fluoridated water, ADAVB believes that another study of ACSC is warranted, as the findings would help identify areas in the State where hospital admissions for dental treatment could be further reduced.

Interdisciplinary preventive and health promotion activities

Lifestyle behaviours – such as diet, exercise, smoking, alcohol consumption and drugs such as “meth mouth” (a term used to describe the mouth of a methamphetamine user because of the rampant tooth decay that often occurs with the use of this dangerous drug) - have significant health and economic consequences. (The health system is being weighed down by cases involving obesity and diabetes.) Dentists, as primary care providers, play an important role in promoting positive health behaviours. This study would compare the performance of primary care models in health promotion and identify practice factors associated with its delivery.

Disaster Victim Identification (DVI)

One of the primary roles undertaken by forensic odontologists within the Centre for Human Identification is to provide positive identification for unknown deceased people who cannot be visually identified. Investigations range from single cases to multiple victims, e.g., ‘Black Saturday’ bushfires.

On 7 February 2009 the most devastating bushfires in Victoria’s history claimed 173 lives. More than 60% of the victims were either identified by dental means alone or with a strong dental input. The entire forensic odontology expertise of the State of Victoria (10 people) was called upon and assistance from a further 32 odontologists from Australia, New Zealand and Indonesia was utilised. At the peak of the investigation, 20 fully trained forensic odontologists were either at the fire scenes or involved in mortuary examinations and data gathering.

It is essential that future disaster management preparation for Victoria is adequately maintained and funded. The existing body of expertise and all future training of new personnel for succession planning must be supported so reliance upon expertise from outside our borders is minimised.

Victoria was well served by the Graduate Diploma in Forensic Odontology since its inception in 1990. However, this is no longer operating, despite a strategic need to maintain expertise and continued interest in the program from both local and overseas dentists (e.g. New Zealand, Indonesia, Fiji and Nepal). This is due largely to financial constraints experienced by both the Victorian Institute of Forensic Medicine and the Melbourne Dental School. There is an urgent need for ongoing financial support to develop capacity building strategies, training and research strengths, to re-invigorate the Diploma program and initiate a fully recognised Masters program and to assist in continuing educational programs both nationally and internationally.

This project would extend over a two-year period aiming:

- To reinvigorate the Diploma program and to develop a Master's program with the co-operation of ADAVB, Monash University, and the VIFM
- To evaluate the Diploma/Masters programme with regard to course content, body of knowledge base, strength of research objectives
- To evaluate the international significance of the course.

DVI Budget

	\$
Salary of Course Coordinator to oversee: <ul style="list-style-type: none"> • The development of syllabus • The development of core dental curriculum • The development of relevant and sustainable teaching modules 	100k
Administration assistance to enable: <ul style="list-style-type: none"> • Compilation of an Australian database of all relevant reference material • Compilation of a resource base of published material for use of practitioners and students • Compilation of teaching resource from all disciplines involved in forensic odontology 	84k
Production of course manual; course notes and relevant teaching material	15k
Integration of IT infrastructure including: <ul style="list-style-type: none"> • AQnet access and licence costs • iCMS access facilitation • Computer stations 	7k
Fees for visiting lecturers; travel incidentals, accommodation costs	5k
TOTAL	\$211K

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Fluoridating Victoria

Proud to be a partner of the fluoride program, the ADAVB congratulates the Government on providing fluoridated drinking water to 90% of the State's population – a remarkable achievement, especially over the last five years.

The Branch urges the Government to continue the fluoride program to more regional and rural towns, thereby providing health benefits and further redressing the inequity enjoyed by metropolitan Victorians and helping to reduce the public dental waiting lists.

There are still a number of towns to be fluoridated, such as Maryborough and those in western Gippsland. The Branch also encourages the Government to monitor a program in the Northern Territory which aims to bring fluoridated water to towns with populations of only 600. If successful, this program may show how to economically fluoridate similar sized towns in Victoria.

ENDS

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