27 January 2022

Hon Josh Frydenberg MP
Treasurer
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

By email: josh.frydenberg.mp@aph.gov.au

To the Hon Josh Frydenberg MP,

RE: ADPA PRE-BUDGET SUBMISSION 2022-23

On behalf of the Australian Dental Prosthetists Association (ADPA), we would like to thank you for the opportunity to provide our pre-budget submission for consideration in the preparation of the 2022-23 Budget.

With the impact of COVID-19 on oral health prevention, maintenance and treatment which has significantly declined as a result of the pandemic we feel that now, more than ever, it is critical to implement a ***sustainable, consistent, and adequate dental funding model.*** in a way that is well considered, adequate and delivers the greatest benefits to our communities and to the health of all Australian's. ADPA's pre-budget submission provides recommendations we believe will assist in meeting Australia's growing oral health demands.

THE AUSTRALIAN DENTAL PROSTHETISTS ASSOCIATION (ADPA)

The Australian Dental Prosthetists Association (ADPA) is the peak professional association representing registered dental prosthetists throughout Australia. Our Association's principal purpose is to advance, improve, support, and foster the interests, development, and status of

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dental prosthetists and to increase awareness and recognition of the profession across all sectors of society.

DENTAL PROSTHETISTS

Dental Prosthetists are registered dental practitioners who work as independent practitioners in the assessment, treatment, management, and provision of patient-removable prostheses such as complete and partial dentures, including implant-retained overdentures, as well flexible mouthguards for sports.[1] They are registered nationally with the Dental Board of Australia and are subject to the same registration requirements, guidelines, and codes of practice as other (registered) members of the dental team.[2]

BACKGROUND - AN AGEING POPULATION

Noting Australia's ageing population, with one in every seven people aged 65 years or more[3] have on average 10.8 missing teeth,[4] the services Dental Prosthetists provide (i.e., dentures) is essential in maintaining and meeting the oral health needs of Australia's ageing population.

Unfortunately waiting times for patients requiring dentures are generally longer and are dependent on general dental care needs being met, meaning patients can often wait three years for general care and an additional 12 to 48 months for dentures. In this period patients have significant bone resorption (jaw atrophy) and loss of facial support which can lead to malnutrition and general health decline. This is reflected in the recent Royal Commission into Aged Care Quality and Services Final Report[5] which stated:

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[1] Dental Board of Australia (DBA). (2020). *Guidelines for scope of practice.* https://www.dentalboard.gov.au/codes-guidelines/policies-codes-guidelines/guidelines-scope-of-practice.aspx

[2] Australian Dental Prosthetists Association (ADPA). (2020). *What is a dental prosthetist?* https://www.adpa.com.au/

[3] Australian Bureau of Statistics (ABS). (2017). *2071.0 – Census of Population and Housing: Reflecting Australia – Stories from the Census, 2016.* https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Ageing%20Population~14

[4] Australian Institute of Health and Welfare (AIHW). (2020a). *National Oral Health Plan 2015-2024: performance monitoring report.* https://www.aihw.gov.au/reports/dental-oral-health/national-oral-health-plan-2015-2024/contents/our-oral-health-a-national-perspective/inadequate-dentition-prevalence

[5] Royal Commission into Aged Care Quality and Safety. (2021). *Final report – Volume 1: Summary and Recommendations*. https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-1_0.pdf

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> *Older people are more likely than others to have poor oral health. Many of them cannot afford private dental care and must wait years for public dental health care; others have reduced capacity to undertake oral hygiene routines. The neglect of oral health in residential aged care was among the many terrible stories we heard over months of hearings in 2019. Poor oral health is very serious medically because it can contribute to chronic medical conditions, such as diabetes, respiratory diseases, and cerebrovascular diseases, as well as to severe pain, discomfort, functional impairment and restrict an older person's ability to eat, speak and socialise.*

There is well established evidence highlighting associations between systemic diseases and poor oral health, including links between periodontal disease and pregnancy, diabetes mellitus, preterm and low birth weight babies, chronic obstructive pulmonary disease, renal disease, cardiovascular disease, and stroke.[6] This compounded with the detrimental effects poor oral health has on older Australian's highlights the importance of a ***sustainable, consistent, and adequate dental funding model.***

BACKGROUND: PRIORITY POPULATIONS

The Commonwealth *Australia's National Oral Health Plan 2015-2020* was implemented to 'improve the health and wellbeing across the Australian population by improving oral health status and reducing the burden of poor health'.[7] There are four priority populations identified in this plan, all of whom are treated directly by dental prosthetists.[8]

Priority 1 - *People who are socially disadvantaged or on lower incomes* – specifically pensioners, RACF residents and concession cardholders. People from lower household incomes have more missing teeth than those on higher incomes – generally missing from

[6] Gupta, T., & Stuart, J. (2020). Medicine and Dentistry. *Australian Journal for General Practitioners, 49*(9), 544-548. http://dx.doi.org/10.31128/AJGP-06-20-5482
[7] Council of Australian Governments (COAG). 2015. *Australia's National Oral Health Plan 2015-2024.* http://www.coaghealthcouncil.gov.au/Publications/Reports/ArtMID/514/ArticleID/81/Australias-National-Oral-Health-Plan-2015-2024
[8] *Ibid.*

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8.6 teeth;[9] as a result, they are a key population group requiring partial or complete dentures.

Priority 2 *- Aboriginal and Torres Strait Islander People* – this target population are 2.5 times more likely than non-Indigenous populations to have missing teeth and as a result are another key population treated by dental prosthetists, particularly in regional and remote areas.[10]

Priority 3 *- People living in regional and remote areas* – some patients are required to travel '*up to 12 hours requiring up 3 to 6 visits until treatment is completed'.*[11]

Priority 4 *- People with additional or specialised health care needs* – 82% of older Australian's aged 65 and over have one or more chronic medical condition that '*either impact… oral health or can lead to a decline in oral health*' and overall have higher rates of tooth loss,[12] emphasising the fact that this target population fits the key patient demographics for dental prosthetic services.

Although oral health care is funded through the National Partnership Agreement on Public Dental Services for Adults (NPA),[13] the number of preventable hospitalisations relating to dental continue to rise costing the Australian taxpayer approximately $240 million annually.[14] This is further compounded by the fact that there have been significantly lower dental services accessed during the COVID-19 pandemic.[15] ADPA believes dental services are now in high demand as a result of COVID-19 with some members reporting they are booked six months in advance. ADPA is concerned that patients eligible for access to dental services through the

[9] Australian Institute of Health and Welfare (AIHW). 2020b. *Oral Health and Dental Care in Australia.* https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction.
[10] *Ibid.*
[11] Dental Prosthetist Peter Muller *quoted in* House of Representatives Standing Committee on Health and Ageing, Australian Parliament House. 2013. '*Bridging the Dental Gap: Report on the Inquiry into Adult Dental Services'.* https://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=haa/./dental/report/index.htm.
[12] *Ibid.*
[13] Department of Health. (2020). *Extending the National Partnership Agreement on Public Dental Services.* Ministers Department of Health. https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/extending-the-national-partnership-agreement-on-public-dental-services
[14] Above n 9
[15] Hopcraft, M, Farmer, G. Impact of COVID-19 on the provision of paediatric dental care: Analysis of the Australian Child Dental Benefits Schedule. *Community Dent Oral Epidemiol*. 2020; 00: 1– 8. https://doi.org/10.1111/cdoe.12611

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NPA (the priority populations) will struggle to find private practitioners willing to provide their services (under NPA outsourcing arrangements) due to the high demand for oral health services, limited and inadequate funding and the increase in general dentistry costs. ADPA believes that implementing a ***sustainable, consistent, and adequate dental funding model*** will help ensure the participation of dental practitioners in providing these crucial services under the NPA

THE FUNDING MODELS

Department of Veterans Affairs (DVA)

While Medicare currently covers limited and specific dental services (e.g., Cleft Lip) and the Child Dental Benefits Scheme (CDBS) assists in meeting young Australian's oral health needs there is no comparable Medicare based scheme for older Australians. As a result, state and territory departments typically adopt the Department of Veterans Affairs (DVA) dental and allied health services fee schedules for outsourcing arrangements under the NPA.[16] There are several issues in utilising the DVA fee schedules as they currently exist (*refer to Appendix One*). The key issues include:

- A pause in indexation of 8.5% over five years between 2014 and 2019 – this loss of renumeration in provided crucial dental services has never been recovered.
- DVA dental fees are currently between 41% and 45% below industry rates.
- Dental Prosthetists are paid at a lower rate than their dental colleagues (refer to the *Dentist and Dental Specialist fee schedule*)[17] despite the dental prosthetic industry rate for dental services being 7.82% higher. There should be no differentiation between the fees paid to a Dentist compared with a dental prosthetist for the same service.
- There are limited treatment options available under the DVA scheme such as implant retained overdentures or inadequate funding for aspects of dental prosthetic care including chrome dentures which are currently 35% less than the lowest industry rate.

[16] Department of Veterans Affairs. (2022) *Dental and Allied Health Fee Schedules.* https://www.dva.gov.au/providers/notes-fee-schedules-and-guidelines/fee-schedules/dental-and-allied-health-fee-schedules.
[17] *Ibid.*

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As each state and territory utilise these DVA fee schedules these prevailing issues heighten when the fee schedule is further reduced; Queensland's Metro South for example pay 10% below the DVA rate, the Victorian Denture Scheme is lower still. Additionally, several state and territory departments have removed clinically justifiable treatment options such as chrome dentures or request relines for dentures that evidently require replacement. Dental services as a consequence are often fee focused rather than patient-centred resulting in inappropriate treatment outcomes.

In summary DVA fee schedule rates are severely inadequate, once these are adopted by the states and territory departments for the outsourcing of dental services the issue is compounded with fees set at or below DVA rates and crucial and clinically justifiable treatment outcomes removed from the outsourcing fee schedules. This has resulted in dental prosthetists no longer providing services under both the NPA and DVA. ADPA is concerned the rate of involvement by dental practitioners, particularly dental prosthetists will continue to decline if these issues are not addressed.

National Partnership Agreement for Public Dental Services for Adults

While public dental services are operated by states and territories, there are several inconsistencies across jurisdictions,[18] previous Commonwealth Health Minister Sussan Ley went as far to say the system was 'fragmented' and required an overhaul.[19]

The Commonwealth funding of Dental Services has increased (due to the CDBS), however the funding of the NPA has remained stagnant at $107.8 million for 180,000 patients since 2017.[20] What this funding model assumes is that the cost of dentistry has remained the same over this period, indexation clearly indicates this not to be the case. We recommend the NPA funding model is reviewed urgently with CPI increases applied annually to keep up with the cost of dentistry.

[18] Above n 9
[19] Biggs, A. Parliament of Australia. (2015). *Budget review 2015-16 Dental Health.* https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201516/Dental
[20] Commonwealth of Australia, Budget 2020-21. (2020). *Budget Paper No. 1: Budget Strategy and Outlook.* https://budget.gov.au/2020-21/content/bp1/download/bp1_w.pdf

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Private practitioners are often contracted to provide denture services under the NPA through state-based outsourcing agreements primarily due to a limited public oral health workforce and growing waiting list times. Unfortunately, these outsourcing arrangements are inconsistently applied between states and territories and are financially unviable for most dental practitioners. These issues are more prevalent in Residential Aged Care Facilities (RACF) due to limited access to public oral health services and a lack of service provision for oral health in a RACF setting.

THE SCOPE OF THE ISSUE

ADPA's research on the outsourcing of dentures under the NPA indicates there are significant and compounding issues with the current NPA arrangements. We believe dental practitioners will continue to withdraw from their respective state-based outsourcing schemes so long as these issues remain. It is important to note that some state and territory governments employ dental prosthetists through the public system. The information provided below is limited to the outsourcing of denture services to private practitioners under the NPA only. The below data helps provide context to the scope of the issues related to the current NPA model.

General overview

- 17.78% of dental prosthetists do not provide services under their state/territory based outsourcing scheme identifying the fee structure as the primary reason.
- 84.44% of dental prosthetists indicated the fee schedule was of primary concern followed by lack of treatment options for patients.
- 21.85% noted that due to the complexity of treatment required for public patients and the low fee schedule the ability to appropriately treat public patients is limited.

Specific scenarios

Below are some excerpts of dental prosthetists comments relating to the current NPA framework for the outsourcing of dentures:

"The current fee structure is too low; my practice is in a very much working class area, so my regular fees are reasonably modest. Yet the government sponsored rebate is still about 40-45% lower than my usual fee."

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"We all know there are some disadvantaged members of the community who can't afford to pay for their denture needs privately. I personally have no problems to contribute towards helping them out as a humanitarian duty. But when the scheme has set prices less than half of my private cases it doesn't seem fair to the us. I would prefer to consider some significant discount for the patients and keep the quality as high as possible. In addition, I believe I can only take full responsibility for the dentures I make, if those dentures are what I recommend for the case. For example, when a patient gets referred for relining of a set of dentures that obviously had other major design problems. I already know that the reline is not the solution. But if I do the reline here, I would be held responsible for the failure of the treatment not the clinician who made the decision in the first place."

"A patient has had a chrome denture all their life and now has a voucher for a new denture. However, funding only allows for an acrylic base denture. Patient then (sp?) finds [it] difficult to transition to [an] acrylic base."

"I offer the Hunter New England region vouchers as a service to people who are in need of assistance without being financial able to get such services privately and am happy to do so, I don't change products or procedures in the manufacture of the device but the vouchers are now coming close to half the price of what I charge privately, add in a few adjustments or a difficult patient and the voucher just covers time and cost."

RESIDENTIAL AGED CARE FACILITIES (RACF)

The Royal Commission into Aged Care Quality and Safety (RCAC) found the level of appropriate oral health care and access to services for aged care residents was severely lacking. Recommendation 60 of the final report suggested the need for a Senior Dental Benefit Scheme (SDBS) and specifically listed funding for dentures (maintenance and replacement) as a key requirement.[21]

The ADPA further recommends every resident entering a RACF should have an oral health assessment by a ***registered dental practitioner*** to establish the residents' baseline and develop appropriate and timely treatment plans and referrals.

[21] Above n 5

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Due to the lack of access for residents in receiving oral health care services through the NPA, ADPA recommends the SDBS is implemented as a priority in consultation with Australia's peak professional dental associations including but not limited to the Australian Dental Association, Australian Dental Prosthetists Association, Australian Dental and Oral Health Therapists' Association and the Dental Hygienists Association of Australia, as well as peak alliances such as the National Oral Health Alliance (NOHA). It is crucial dental practitioners have ownership and involvement in such a scheme, by consulting and working with our peak professional associations and alliance we can ensure the scheme is implemented in a way that is most beneficial to residents while at the same time ensuring it is not financial unviable for dental practitioners to participate.

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RECOMMENDATIONS

1. The ADPA recommends the implementation of **a *sustainable, consistent, and adequate dental funding model*** in consultation with Australia's peak dental associations and alliances.

2. The ADPA's recommends every resident entering a RACF should have an oral health assessment by a ***registered dental practitioner*** to inform their ongoing regular oral hygiene measures, schedule regular oral health care, determine efficient referral pathways and provide oral health treatment.

3. The ADPA recommends dedicated funding for aged care residents to adequately cover denture replacements and maintenance.

4. The ADPA recommends the DVA fee schedules are reviewed urgently with an increase that addresses the shortfall and with parity between payment of dental services implemented as a matter of priority.

5. The ADPA recommends the implementation of consistent funding and a consistent approach to the roll-out of outsourcing arrangements (under the NPA) across the states and territories (the DVA dental fee schedules should be the minimum benchmark utilised).

CONCLUDING REMARKS

ADPA has highlighted in its submission the pivotal role dental prosthetists play in meeting the demands of Australia's most vulnerable populations, particularly the ageing community. For dental prosthetists to continue to provide services under the current NPA however, state-based dental outsourcing arrangements need to be aligned at a minimum to the DVA Dentist and Dental Specialist fee schedules and indexation applied within four weeks of Commonwealth implementation. We highlighted the disparity between the current DVA rates with industry rates as the argument for ensuring this Commonwealth fee structure is the minimum benchmark for dental fee schedules. We highlight the complexity and limited treatment options available to patients under the NPA resulting in dental prosthetists being unable to appropriately provide treatment due to outsourcing agreement restrictions, and ask that funding reflects these issues and is available to resolve them.

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We also suggest aligning the treatment options available under the DVA fee schedule with the outsourcing arrangements to help ensure appropriate and adequate treatment options are available to patients.

We have attached for your background and for further information ADPA's Dental Review 2020 submission to DVA (*Appendix One*) of which there has been no response or outcome, a concern that both the Australian Dental Association (ADA) and the ADPA share. We would appreciate this be considered as part of the budget process. You will also find attached a copy of our Oral Health for Older Australian's position statement (*Appendix Two*) which provides further background on our recommendations. Finally, we have attached the National Oral Health Alliance (NOHA) and the Victorian Oral Health Alliance (VOHA's) pre-budget submissions which support the implementation of a Senior Dental Benefits Scheme and highlight the importance of adequate and sustainable funding.

We welcome the opportunity to discuss these issues and recommendations in more detail with you, your Health Minister, Adviser and/or Department with the aim of improving the oral health outcomes of Australian's.

We appreciate your consideration of our 2022-23 Pre-Budget submission and look forward to hearing from you soon.

Yours sincerely,

Jenine Bradburn
National President and Executive Chair
AUSTRALIAN DENTAL PROSTHETISTS ASSOCIATION

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Appendix One: Dental Review 2020

18 December 2020

Ms Robyn Kemp, JP
Assistant Secretary
Program Management
Department of Veterans' Affairs
21 Genge Street
CANBERRA ACT 2601

Email: Dental.Review@dva.gov.au

Dear Ms Kemp,

RE: ADPA SUBMISSION COVER LETTER FOR THE DVA DENTAL REVIEW DECEMBER 2020

Thank you for the invitation to the Australian Dental Prosthetists Association (ADPA) to provide feedback on the current DVA dental review.

ADPA is the peak professional association representing registered dental prosthetists throughout Australia. Our Association's principal purpose is to advance, improve, support and foster the interests, development and status of dental prosthetists and to increase awareness and recognition of the profession across all sectors of society.

Noting the limited scope of the current dental review we would like to take this opportunity to raise additional concerns identified by ADPA members regarding the current dental program. Our submission cover letter is to be read in conjunction with our attached stakeholder submission.

1.0 CONSULTATION AND COMMUNICATION

ADPA has concerns regarding the lack of consultation and communication on the dental program review and the Dental and Allied Health Review (the *Review)*. We have included below a timeline for your reference.

Appendix One: Dental Review 2020

6 November 2017 – ADPA set up a meeting with DVA to highlight some of our members concerns. Attendees included representatives from DVA - Robyn Kemp, Ian Gardner, Lisa Air, Michelle Petroni and Mina Van Dura along with ADPA representatives Martin Dunn OAM and Jasmine Bulman. The following agenda items were raised:

- Indexation which at the time was paused
- Fee parity between Dental Prosthetists and Dentists
- Dental Prosthetists providing implant-retained overdentures as part of their scope of practice and
- Issues relating to Webclaim which have subsequently been resolved.

In this meeting, ADPA was advised that these agenda items and concerns would form part of the *Review.*

8 June 2018[1] **–** Health Providers' Partnership Forum (HPPF) - Discussions began on the *Review* – DVA highlighted future meetings would focus on Element two - the new treatment cycle.

22 August 2018, 27 February 2019, 3 July 2019 and **8 November 2019**[2] – HPPF's –Focussed on the new treatment cycle. This highlights that allied health was a clear focus of the HPPF while dental was secondary.

8 November 2019[3] – HPPF – the meeting summary highlights the following:

> *Trials of new funding approaches, and upgrades to allied health schedules:* ***Consultation on the remaining two elements of the Budget measure will commence early 2020, with implementation expected to commence in 2021****.* ***Further improvements are planned to dental and allied health fee schedules*** *to better reflect contemporary services and better support the workforce providing dental and allied health services.*

At this stage, it was our understanding that Elements three and four of the Review[4] would incorporate dental and would follow a consultative process as outlined above.

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[1] Department of Veterans Affairs, *Health Providers' Partnership Forum – Meeting summaries.* (Department of Veterans Affairs, 2020), https://www.dva.gov.au/providers/notes-fee-schedules-and-guidelines/health-providers-partnership-forum.
[2] *Ibid.*
[3] *Ibid.*
[4] Department of Veterans Affairs, *Review of DVA Dental and Allied Health Arrangements – Final Report.* (Department of Veterans Affairs, 2020), 21 https://www.dva.gov.au/documents-and-publications/review-dva-dental-and-allied-health-arrangements-final-report.

Appendix One: Dental Review 2020

13 March 2020[5] – HPPF – An update on the Review was provided by Chris Reed who noted:

> *The updated fee schedules were pushed back to April 2020. The four fee schedules related to Clinical psychologists, Occupational therapists (mental health), Psychologists and Social Workers (mental health) were updated with telehealth items in response to COVID-19 and for implementation from 13 March 2020. Attendees noted and appreciated the prompt responses from the Health Policy team.*

There was little discussion in this meeting regarding dental.

30 June 2020 – HPPF – Moira Campbell provided an update on the Review. In this meeting Ms. Campbell provided an overview Element four as well as the Dental aspect of the *Review*. It was noted that the consultation process would open late 2020 to early 2021. At this stage there was no indication that the dental aspect of the *Review* was completed. The current dental review and the *Review* were discussed interchangeably, ADPA therefore assumed they were one and the same.

15 September 2020 – HPPF – Ms Campbell noted the *Review* and highlighted that once the review was done the interim paper would be sent to peak associations for feedback.

9 November 2020 – ADPA sent DVA an email asking the *Review* be added as an agenda item for the December HPPF.

16 November 2020 – ADPA received an email from Ben Hay advising of the current dental review and its due date of 18 December 2020.

19 November 2020 – DVA sent an email to industry and veterans asking for feedback on the current dental review.

26 November 2020 –ADPA received an email from Chris Reed in response to questions regarding the Dental and Allied Health Review. In this email, it is highlighted that the *Review* has been completed and that the current dental review was separate to this. This was the first time ADPA was made aware that Element four of the measure was dependent on savings made under Element two despite assurances in previous meetings that consultation would occur in 2020 and 2021 on Elements three and four.

[5] *Above (n 1).*

Appendix One: Dental Review 2020

4 December 2020 – HPPF – ADPA asked Moira Campbell what consultation had occurred in relation to the scope and timeline of the current dental review. This question was put on notice. ADPA was concerned that the current dental review's scope was limited and did not address the concerns raised with DVA on various occasions over a lengthy time period.

It is worthwhile noting that since 2017 ADPA has been a constant participant in the HPPF and has sought an update on the dental aspect of the Review at every meeting. The expectation and understanding was that there would be a thorough review of the dental program under Elements three and four. As highlighted in previous meeting summaries there was an assurance by DVA that 2020 and 2021 would include a review of the dental aspect and that there would be consultation on this. Further, we were assured that the issues ADPA raised from November 2017 would be covered in this review. ADPA believes that there has been insufficient consultation on the scope and timeline of the review with peak bodies.

We have highlighted allied health had a significant focus as part of the review with time dedicated to discussing the new treatment cycle (Element two). What has been lacking is a discussion on Elements one (see below), three and four particularly concerning Dental. While Dental covers a limited aspect of the whole scope of what DVA provides to our veterans there should always be provision for a clear consultative process and defined timelines – there have been neither and unfortunately, our concerns have not been included in the scope of this review. Below we highlight in detail our members specific concerns.

2.0 ELEMENT ONE – TECHNICAL ADJUSTMENTS TO THE SCHEDULES[6]

On the 19 October 2018 ADPA was sent a letter from Matthew Jackson highlighting changes to DVA's dental prosthetist fee schedule to align with the current ADA Schedule of Dental Services and Glossary Twelfth edition. [7] We wish to highlight four primary concerns relating to Element one:

1. ADPA had no involvement in the consultation process for element one, we were simply advised of the technical adjustments which have subsequently had a significant impact on our members.
2. The technical adjustments are not fully aligned with the current schedule (we highlight below in 2.1 the discrepancies or questions arising from the amended DVA fee schedule).

[6] Department of Veterans Affairs, *Review of DVA Dental and Allied Health Arrangements – Final Report.* (Department of Veterans Affairs, 2020), 18 https://www.dva.gov.au/documents-and-publications/review-dva-dental-and-allied-health-arrangements-final-report.
[7] Australian Dental Association, *The Australian Schedule of Dental Services and Glossary – twelfth edition* (ADA, 2017), https://www.ada.org.au/Dental-Professionals/Publications/Schedule-and-Glossary/The-Australian-Schedule-of-Dental-Services-and-(1)/Australian_Schedule_and_Dental_Glossary_2015_FA2_W.aspx.

Appendix One: Dental Review 2020

3. ADPA was advised by DVA that members would not be negatively impacted by these technical adjustments. We provide a detailed account in 2.2 and 2.3 that this has not been the case.
4. The Australian Dental Association (ADA) is currently drafting the thirteenth edition of the Schedule – ADPA would appreciate the opportunity to work with DVA on the transition from the twelfth edition to the thirteenth.

2.1 Technical adjustments alignment issues

POINT OF CLARIFICATION

Provisional Restoration or Prosthesis

"Provisional" refers to a restoration or prosthesis that is intended to be of diagnostic or short-term functional or aesthetic value or awaiting adequate healing before a definitive restoration or prosthesis is placed. For example, this may occur with immediate dentures and subsequent implant prostheses.

Source: Australian Dental Association, *The Australian Schedule of Dental Services and Glossary – twelfth edition* (ADA, 2017), x https://www.ada.org.au/Dental-Professionals/Publications/Schedule-and-Glossary/The-Australian-Schedule-of-Dental-Services-and-(1)/Australian_Schedule_and_Dental_Glossary_2015_FA2_W.aspx.

Refer to item numbers 713, 714, 715, 723 and 724 in the Schedule

Provisional complete maxillary denture	D713 S713	No No	761.80 761.80	This item allows for provisional denture to be relined or replaced within 12 months.
Provisional complete mandibular denture	D714 S714	No No	761.80 761.80	This item allows for provisional denture to be relined or replaced within 12 months.
Provisional complete maxillary and mandibular dentures	D715 S715	No No	1350.90 1350.90	This item allows for provisional denture to be relined or replaced within 12 months.

Source: Department of Veteran Affairs (DVA). (2020). *Fee Schedule of Dental Services for Dentists and Dental Specialists.* https://www.dva.gov.au/sites/default/files/files/providers/feesschedules/dentalfeeschedjul20.pdf.

Question for DVA: *The definition provided in the Schedule indicates Provisional Prosthesis have a short-term function. With this being the case is a reline an appropriate option for a provisional denture?*

Appendix One: Dental Review 2020

DISCREPANCY

721 Partial maxillary denture – resin base

Provision of a resin base for a patient removable dental prosthesis for the maxilla where some natural teeth remain. Other components of the denture such as teeth, rests, retainers and immediate tooth replacements should be appropriately itemised.

722 Partial mandibular denture – resin base

Provision of a resin base for a patient removable dental prosthesis for the mandible where some natural teeth remain. Other components of the denture such as teeth, rests, retainers and immediate tooth replacements should be appropriately itemised.

723 Provisional partial maxillary denture

Provision of a patient removable partial dental prosthesis replacing the natural teeth and adjacent tissues in the maxilla that is designed to last until the definitive prosthesis can be constructed. This item should be used only where a provisional denture is not an intrinsic part of item 721. Other components of the denture such as teeth, rests, retainers and immediate tooth replacements should be appropriately itemised.

724 Provisional partial mandibular denture

Provision of a patient removable partial dental prosthesis replacing the natural teeth and adjacent tissues in the mandible that is designed to last until the definitive prosthesis can be constructed. This item should be used only where a provisional denture is not an intrinsic part of item 722. Other components of the denture such as teeth, rests, retainers and immediate tooth replacements should be appropriately itemised.

727 Partial maxillary denture – cast metal framework

Provision of the framework for a patient removable dental prosthesis made with a cast metal on which to replace teeth from the maxilla where some natural teeth remain. Other components of the denture such as teeth, rests, retainers and immediate tooth replacements should be appropriately itemised.

728 Partial mandibular denture – cast metal framework

Provision of the framework for a patient removable dental prosthesis made with a cast metal on which to replace teeth from the mandible where some natural teeth remain. Other components of the denture such as teeth, rests, retainers and immediate tooth replacements should be appropriately itemised.

Source: Australian Dental Association, *The Australian Schedule of Dental Services and Glossary – twelfth edition* (ADA, 2017), 34 https://www.ada.org.au/Dental-Professionals/Publications/Schedule-and-Glossary/The-Australian-Schedule-of-Dental-Services-and-(1)/Australian_Schedule_and_Dental_Glossary_2015_FA2_W.aspx.

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Partial maxillary denture – resin base	D721 S721	No No	464.70 464.70	**See Note 11.** This item refers to denture base only. The number of teeth are specified in item 733.
Partial mandibular denture – resin base	D722 S722	No No	464.70 464.70	**See Note 11.** This item refers to denture base only. The number of teeth are specified in item 733.
Provisional partial maxillary denture	D723 S723	No No	348.55 348.55	This item refers to denture base only. The number of teeth are specified in item 733. This item allows for provisional denture to be relined or replaced within 12 months.
Provisional partial mandibular denture	D724 S724	No No	348.55 348.55	This item refers to denture base only. The number of teeth are specified in item 733. This item allows for provisional denture to be relined or replaced within 12 months.
Partial maxillary denture – cast metal framework	D727 S727	No No	1360.70 1360.70	**See Note 11.** This item refers to denture base only. The number of teeth are specified in item 733.
Partial mandibular denture – cast metal framework	D728 S728	No No	1360.70 1360.70	**See Note 11.** This item refers to denture base only. The number of teeth are specified in item 733.

Source: Department of Veteran Affairs (DVA). (2020). *Fee Schedule of Dental Services for Dentists and Dental Specialists.* https://www.dva.gov.au/sites/default/files/files/providers/feesschedules/dentalfeeschedjul20.pdf.

Issue: *The definition/s provided in the ADA Schedule for the above item numbers indicate other components of the denture such as '**teeth, rests, retainers and immediate tooth replacements should be appropriately itemised**'. DVA only notes the number of teeth (733) is to be specified.*

Resolution: DVA aligns wording with the ADA Schedule – i.e., teeth, rests, retainers and immediate tooth replacements.

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POINT OF CLARIFICATION

739 **Metal backing – per backing**

An extension of the casting of a cast metal partial denture to provide a backing for the denture tooth. The number of backings should be indicated.

Source: Australian Dental Association, *The Australian Schedule of Dental Services and Glossary – twelfth edition* (ADA, 2017), 35 https://www.ada.org.au/Dental-Professionals/Publications/Schedule-and-Glossary/The-Australian-Schedule-of-Dental-Services-and-(1)/Australian_Schedule_and_Dental_Glossary_2015_FA2_W.aspx.

Metal backing – per backing	D739 S739	No No	9.70 9.70	Can only be claimed with items 716, 727 or 728. Only claimable where a denture tooth has its entire occlusal contact with teeth of opposing arch covered by metal.

Source: Department of Veteran Affairs (DVA). (2020). *Fee Schedule of Dental Services for Dentists and Dental Specialists.* https://www.dva.gov.au/sites/default/files/files/providers/feesschedules/dentalfeeschedjul20.pdf.

Question for DVA: *DVA notes 739 Metal backing can only be claimed with items 716, 727 and 728. Should 716 be removed in this example?*

2.2 Chrome dentures

Before the technical alignment, casting fees (for chrome dentures) were covered by T730 and were based on laboratory invoices. This (T730) was subsequently removed. Unfortunately, the amounts allocated to the amended or added item numbers (see table below) have resulted in dental prosthetists being financially worse off when the alignment came into place. In time this has had a compounding effect.

DESCRIPTION	ITEM	PRIOR APPROVAL	FEE $ (EXCL. GST)	SPECIAL REMARKS
Tooth/teeth (partial denture)	T733	No	34.65	Maximum of 12 teeth per denture base (with partial denture items 721, 722, 723, 724, 727, 728).
Overlays – per tooth	T734	No	42.15	Can only be claimed with items 727 or 728.

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Metal backing – per backing	T739	No	8.80	Can only be claimed with items 716, 727 or 728. Only claimable where a denture tooth has its entire occlusal contact with teeth of opposing arch covered by metal.

The below figures highlight the financial impact the technical alignment change to the calculations for T733 Tooth/teeth. These calculations were made using 727/728 + tooth/teeth and do not include metal backings and/or overlays.

	PRE ALIGNMENT 2018	POST ALIGNMENT 2018	DIFFERENCE
1T P	$366.25	$439.20	$72.95
2T P	$418.25	$472.80	$54.55
3T P	$489.45	$506.40	$16.95
4T P	$550.05	$540.00	-$10.05
5T P	$651.15	$573.60	-$77.55
6T P	$651.15	$607.20	-$43.95
7T P	$651.15	$640.80	-$10.35
8T P	$651.15	$674.40	$23.25
9T P	$651.15	$708.00	$56.85
10T P	$752.75	$741.60	-$11.15
11T P	$752.75	$775.20	$22.45
12T P	$752.75	$808.80	$56.05

We have provided below screenshots of two laboratory invoices that shows that $8.80 for a metal backing is approximately 35% below the industry standard. We note that this was previously covered under the laboratory fee (therefore the dental practitioner was fully compensated for this cost). We are seeking that these fees be reviewed as a matter of urgency.

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/L Trading as THE CHROME LAB
sh St , Campsie,2194.
, 1889

Tax Invoice

Invoice #: 00042747

A.B.N. 68 052 253 586

Bill To:
PHILLIP DALLA
2 FIDLER STREET
COOEE TAS 7320
AUSTRALIA

Patient Name		TERMS	DATE
[redacted]		Net EOM after	31/1/20

QTY.	DESCRIPTION	PRICE	UNIT	DISC	EXTENDED
1	P/- casting	$285.00	ea		$285.00
3	BACKINGS	$25.00			$75.00

PRECISIONDENTAL
CASTINGS

952 Centre Road
OAKLEIGH SOUTH 3167
Ph: 9570 4448
A.B.N. 44 833 910 181

Tax Invoice

Date: 10/08/2020
Invoice No: 00010179
Patient: [redacted]

Bill to:
Signature Denture Studio
24 Mansfield Road
Horfield VIC 3567

QTY	DESCRIPTION	PRICE	DISC	AMOUNT
1	P/- CO CR	$260.00		$260.00
2	Metal backings	$35.00		$70.00

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2.3 Acrylic dentures

The below table again highlights the impact of the new rate for tooth/teeth T733. While we support the move to aligning with the schedule it should not be at the detriment of dental practitioners who are already subsidising their services for DVA patients. These calculations are for partial acrylic dentures (721/722) + the teeth T733 (noting the calculation for 733 was previously calculated differently).

	PRE ALIGNMENT 2018	POST ALIGNMENT 2018	DIFFERENCE
1T P	$366.25	$439.20	$72.95
2T P	$418.25	$472.80	$54.55
3T P	$489.45	$506.40	$16.95
4T P	$550.05	$540.00	-$10.05
5T P	$651.15	$573.60	-$77.55
6T P	$651.15	$607.20	-$43.95
7T P	$651.15	$640.80	-$10.35
8T P	$651.15	$674.40	$23.25
9T P	$651.15	$708.00	$56.85
10T P	$752.75	$741.60	-$11.15
11T P	$752.75	$775.20	$22.45
12T P	$752.75	$808.80	$56.05

3.0 INDUSTRY RATES AND PARITY

The current DVA dental prosthetist fee schedule is currently inadequate and acts as a barrier for dental practitioners to provide services to veterans under the dental program. Indexation to DVA fees was paused for five years from 1 July 2014 to 30 June 2019[8] equating to a loss of approximately 8.5% in indexation rates over the period.[9] Dental prosthetists are impacted on three levels:

1. A significant pause in indexation
2. Are paid less than their dentist colleagues for the same service and
3. DVA rates are exceedingly lower than industry standards.

[8] Productivity Commission (PC), *DVA Review of DVA dental and allied health arrangements* [website], https://www.pc.gov.au/__data/assets/pdf_file/0020/239141/subdr306-veterans-attachment2.pdf. (accessed 10 September 2020).
[9] Reserve Bank of Australia (RBA), *Measures of Consumer Price Inflation* [website], https://www.rba.gov.au/inflation/measures-cpi.html (accessed 10 September 2020).

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This has had a devastating impact on dental prosthetists. It is important to highlight as this stage that DVA fee schedules are widely used as the benchmark for state and territory oral health funding schemes and therefore again significantly impact dental prosthetists.

Table 3.1 compares the current dental prosthetist industry rate to the DVA fee schedule. **DVA rates are currently between 41% and 45% below dental prosthetist industry standards** (calculated as an average of key item numbers). ADPA is aware of members who have had to cease all services to both local oral health services and eligible veterans purely on that basis of it not being financially liable.

3.1 TABLE DVA rates compared to Dental Prosthetist industry rates 2019

Item number	DVA - 1 July 2019 ($)[10]	Dental Prosthetist Median Industry rates 2019 ($)[11]	DVA rate % below Dental Prosthetist Median rate	Dental Prosthetist Mean Industry rates 2019 ($)[12]	DVA rate % below Dental Prosthetist Mean rate
011 - Oral Examination	49.70	56.00	11.92%	52.00	4.52%
711 - Complete maxillary denture	900.75	1405.00	43.74%	1485.00	48.98%
719 - Complete maxillary and mandibular dentures	1597.20	2600.00	47.78%	2797.66	54.63%
721 - Partial maxillary denture – resin base	412.10	800.00	64.00%	878.00	72.23%
727 - Partial maxillary denture - cast metal framework	1206.55	1830.50	41.09%	1885.17	43.90%
731 - Retainer – per tooth	41.50	50.00	18.58%	54.42	26.94%
732 - Occlusal rest – per rest	20.25	45.00	75.86%	46.24	78.18%
733 - Tooth/teeth (partial denture)	34.15	50.00	37.67%	53.71	44.53%
743 - Relining - complete denture - processed	314.35	430.00	31.07%	453.38	36.22%
744 - Relining - partial denture - processed	267.90	400.00	39.56%	408.01	41.46%
Average % difference			**41.13%**		**45.16%**

[10] Department of Veterans Affairs, *Fee schedule of dental services for dental prosthetists – effective from 1 July 2019.* (Department of Veterans Affairs, 2019),
[11] Australian Dental Prosthetists Association, *ADPA Industry Benchmarking survey report*. (ADPA, 2019) https://www.adpa.com.au/documents/item/105.
[12] *Ibid.*

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ADPA has previously raised the fact that dental prosthetists and dentists have comparable industry rates for removable prosthetics. The response from DVA in the past was that dentists have higher overheads and third-party costs however ADPA highlights below in 3.2 that this is no longer the case.

3.2 Statistics[13]

15% of dental prosthetists outsource their laboratory work (excluding chrome dentures)
86% of dental prosthetists outsource their chrome work
49% of dental prosthetists employ other dental practitioners (including dentists)
55% are employing dental support staff
These statistics highlight dental prosthetists similarly have third-party costs and overhead costs like their dentist colleagues.

The below table highlights the **dental prosthetist industry rate is on average 7.82% higher than dentist industry rates.** This supports the premise that the industry has changed significantly since the introduction of fee differentiation. We ask that DVA review this and implement fee parity as a priority – there is no longer an argument for dental prosthetists to be paid lower than their dentist colleagues.

[13] All statistics are sourced from Above (n 11).

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3.3 TABLE Dental Prosthetist industry rates compared to Dentist industry rates 2019

Item number	Dental Prosthetist Mean Industry rates 2019 ($)[14]	Dentist Mean Industry rates 2019 ($)[15]	Mean Dental Prosthetist industry rate % higher than Dentist industry rate
011 - Oral Examination	52.00	65.00	-22.22%
711 - Complete maxillary denture	1485.00	1350.00	9.52%
719 - Complete maxillary and mandibular dentures	2797.66	2448.00	13.33%
721 - Partial maxillary denture – resin base	878.00	805.00	8.67%
727 - Partial maxillary denture - cast metal framework	1885.17	1480.00	24.08%
731 - Retainer – per tooth	54.42	50.00	8.47%
732 - Occlusal rest – per rest	46.24	No data	N/A
733 - Tooth/teeth (partial denture)	53.71	47.00	13.33%
743 - Relining - complete denture - processed	453.38	417.00	8.36%
744 - Relining - partial denture - processed	408.01	381.00	6.85%
Average % difference			**7.82%**

4.0 IMPLANT RETAINED OVERDENTURES

Dental Prosthetists can provide treatment for patients requiring implant-retained overdentures as part of their scope of practice. This is a significant aspect to a dental prosthetists formal training and is a compulsory unit for students wishing to enter the profession. In 2013 the Dental Implant Review Subcommittee recognised this fact and unanimously agreed to the following recommendation:

Recommendation: Include suitably qualified dental prosthetists to provide and maintain implant-supported dentures.

[14] *Ibid.*
[15] *Ibid.*

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At the time DVA determined no change should be made to the existing arrangements. Noting seven years have passed since this review ADPA believes this policy should now incorporate this recommendation.

Dental Prosthetists are not responsible for increases in the number of patients receiving implants (this is outside a dental prosthetists' current scope of practice), instead, they can provide an invaluable service by assisting in the maintenance of existing implant-retained overdentures. This will help ensure positive patient outcomes and assist in reducing the already significant access issues in rural and regional Australia. The below case study provides an example of the access issues impacting older Australian's in regional or rural areas and the benefit of having dental prosthetists provide and maintain implant-retained overdentures.

IMPLANT CASE STUDY – Dental Prosthetist Brett Davis DEN0001050594

Patient A received implants from Prosthodontist located south of Newcastle. Patient A tried to contact the Prosthodontist following treatment and was informed the Prosthodontist no longer worked there. Patient A was a resident of the Hunter region, an area classified as rural/regional by the New South Wales and Federal Governments. Patient A required a reline as part of his ongoing implant maintenance. He had limited access to a local Prosthodontist, the closest being approximately 1.5 hours away (a 150km round trip). As a local dental prosthetist, I had to receive approval from DVA to reline the patient's overdenture in approximately 2008. At the time Mr Davis could have treated any other implant overdenture patient (private) without prior approval and had done so, which raised confusion with patient A as to why he could not receive the same treatment as a standard practice from a Dental Prosthetist.

As highlighted above there are significant benefits in having dental prosthetists provide a service that is part of their scope and is provided to private patients. Additionally, there is no concern regarding an increase/influx of implant patients as dental prosthetists would only assist in the treatment and maintenance of implant-retained overdentures. We highly recommend this policy is amended to reflect what is standard practice.

Concluding remarks

ADPA has highlighted its concerns regarding consultation and communication between DVA and the dental profession, we have also highlighted issues with the implementation of the dental and allied health review. We have requested the fee schedules; fee parity and implant policies are reviewed as soon as possible and highlight the significant impact these have on both veterans and

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dental prosthetists. We have included a number of recommendations on the following page to assist.

We would appreciate your consideration of our submission and look forward to reviewing these areas with you in early 2021.

If you have any questions or require further clarification, please do not hesitate to contact me on 0412 552 730 or jenine.bradburn@adpa.com.au.

We look forward to hearing from you shortly on these important matters.

Yours sincerely,

Jenine Bradburn
ADPA President & Executive Chair
AUSTRALIAN DENTAL PROSTHETISTS ASSOCIATION LTD

Enc.

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ADPA RECOMMENDATIONS

1. DVA and ADPA to meet in early 2021 to discuss the dental and allied health review and the concerns of ADPA members highlighted throughout this submission.
2. DVA aligns their fee schedule with the wording used in the Australian Schedule of Dental Services and Glossary twelfth edition.
3. DVA reviews ADPA's questions in regard to provisional dentures and metal backings.
4. DVA reviews its alignment changes and increases the amounts allocated to 733, 734 and 749 in line with industry standards.
5. DVA review its fee schedule in line with industry rates.
6. DVA to implement a timeline for future fee schedule reviews and incorporating industry rates as part of this review.
7. DVA align the dental prosthetist fee schedule with dentist's fee schedule to ensure fee parity.
8. DVA add dental prosthetists to the implant policy allowing for the treatment and maintenance of implant retained overdentures.
9. DVA to meet with the ADA and ADPA annually to discuss and review the dental program.

Australian Dental Prosthetists Association Ltd

POLICY STATEMENT

Oral Health for Older Australians

PREAMBLE

The Australian Dental Prosthetists Association (ADPA) is the peak body representing the interests of Australian dental prosthetists. Our Association's principal purpose is to advance the profession of dental prosthetists and to support the interests of members.

POLICY STATEMENT

Government should focus on the increased oral health needs of the ageing population through dental practitioner's direct involvement with Residential Aged Care Facilities (RACF) and dedicated, consistent funding for oral health care for older Australians.

BACKGROUND

There is well established evidence highlighting associations between systemic diseases and dental infections, including links between periodontal disease and pregnancy, diabetes mellitus, preterm and low birth weight babies, chronic obstructive pulmonary disease, renal disease, cardiovascular disease, and stroke (Gupta and Stuart 2020, 544-546). This compounded with the detrimental effects poor oral health has on older Australian's highlights the importance of a ***sustainable, consistent, and adequate dental funding model.***

Over the last two decades the proportion of the population aged 65 years and over has increased from 12.4% to 16.3%. This group is projected to increase more rapidly over the next decade (Australian Bureau of Statistics (ABS) 2020).

Within this population 46% have fewer than 21 natural teeth (Australian Institute of Health and Welfare (AIHW) 2020a), the services Dental Prosthetists provide (i.e., dentures) is essential to maintaining and meeting the oral health needs of Australia's ageing population.

Medical status, polypharmacy issues, oral diseases and co-morbidities tend to be more complicated and cumulative in older people.

Diminished capabilities and mobility among aged persons, especially those who are homebound, institutionalised, or hospitalised, may inhibit their access to and the ability to provide them oral health care.

The Royal Commission into Aged Care Quality and Safety (RCAC) found the level of appropriate oral health care and access to services for aged care residents was severely lacking. Recommendation 60 of the final report suggested the need for a Senior Dental Benefit Scheme (SDBS) and specifically listed funding for dentures (maintenance and replacement) as a key requirement (RCAC 2021, 249).

The ADPA's recommends every resident entering a RACF should have an oral health assessment by a registered dental practitioner to inform their ongoing regular oral hygiene measures, schedule regular oral health care, determine efficient referral pathways and provide oral health treatment.

Waiting times for patients under the National Partnership Agreement for Adult Public Dental Services (NPA) requiring dentures are longer and are dependent on general dental care needs being met, meaning patients can often wait three years for general care and an additional 12 to 48 months for dentures (AIHW 2018). During this period a patient's oral health needs can change substantially due to lack of continual and consistent care. Patients generally have significant bone loss, bone resorption (jaw atrophy) and loss of facial support which can lead to malnutrition and general health decline as a result of waiting list times for denture care.

Treatment and waiting times are compounded by the fact that some patients in regional areas will often have to travel '*up to 12 hours requiring up to 3 to 6 visits until treatment is completed*' (House Standing Committee on Health and Ageing 2013, 23-24).

CURRENT FUNDING MODEL

Department of Veteran Affairs (DVA)

The DVA dental prosthetist fee schedule is currently inadequate and acts as a barrier for dental practitioners to provide services to veterans under the dental program.

The pause in indexation to DVA fees for five years from 1 July 2014 to 30 June 2019 (Productivity Commission 2019) equated to a loss of approximately **8.5% in indexation rates** over the period (Reserve Bank of Australia 2021). The DVA fee schedules as a result are significantly below industry rates and have never caught up.

Dental prosthetists are impacted on three levels under the current DVA dental arrangements:

1. A significant pause in indexation has resulted in dental fee schedules not meeting the rising costs of dentistry
2. Inconsistent dental fee schedules have meant dental prosthetists are paid less than their dental colleagues providing the same services and
3. DVA rates are exceedingly lower than industry standards however are generally used as a maximum benchmark for state and territory dental schemes.

This has had a devastating impact on dental prosthetists and subsequently their patients. It is important to highlight as this stage that DVA fee schedules are ***widely used as the maximum benchmark for state and territory oral health funding schemes*** and therefore again significantly impact access and treatment provided to patients by dental prosthetists.

The below table compares the 2019 dental prosthetist industry rates (ADPA 2019) to the 2019 DVA fee schedule (DVA 2019), it shows **DVA rates are between 41% and 45% below dental prosthetist industry standards** (calculated as an average of key item numbers). ADPA is aware of members who have had to cease all services to both local oral health services and eligible veterans purely on that basis of it not being financially viable.

Appendix Two: Oral Health for Older Australians

Item number	DVA - 1 July 2019 ($)[10]	Dental Prosthetist Median Industry rates 2019 ($)[11]	DVA rate % below Dental Prosthetist Median rate	Dental Prosthetist Mean Industry rates 2019 ($)[12]	DVA rate % below Dental Prosthetist Mean rate
011 - Oral Examination	49.70	56.00	11.92%	52.00	4.52%
711 - Complete maxillary denture	900.75	1405.00	43.74%	1485.00	48.98%
719 - Complete maxillary and mandibular dentures	1597.20	2600.00	47.78%	2797.66	54.63%
721 - Partial maxillary denture – resin base	412.10	800.00	64.00%	878.00	72.23%
727 - Partial maxillary denture - cast metal framework	1206.55	1830.50	41.09%	1885.17	43.90%
731 - Retainer – per tooth	41.50	50.00	18.58%	54.42	26.94%
732 - Occlusal rest – per rest	20.25	45.00	75.86%	46.24	78.18%
733 - Tooth/teeth (partial denture)	34.15	50.00	37.67%	53.71	44.53%
743 - Relining - complete denture - processed	314.35	430.00	31.07%	453.38	36.22%
744 - Relining - partial denture - processed	267.90	400.00	39.56%	408.01	41.46%
Average % difference			**41.13%**		**45.16%**

DVA dental prosthetist rates are on average 10% below DVA dentist and dental specialists' rates for ***providing the same service*** (DVA 2021). The below table highlights the **dental prosthetist industry rate is on average 7.82% higher than dentist industry rates** (ADPA 2019 *cf.* Australia Dental Association 2019)**.** This supports the premise that the industry has changed significantly since the introduction of fee differentiation (between dentists and dental prosthetists). ADPA recommends parity in DVA fee schedules for dental services provided to our veteran communities, there is no justifiable reason for dental practitioners providing the same services to be paid at significantly different rates.

Item number	Dental Prosthetist Mean Industry rates 2019 ($)[14]	Dentist Mean Industry rates 2019 ($)[15]	Mean Dental Prosthetist industry rate % higher than Dentist industry rate
011 - Oral Examination	52.00	65.00	-22.22%
711 - Complete maxillary denture	1485.00	1350.00	9.52%
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721 - Partial maxillary denture – resin base	878.00	805.00	8.67%
727 - Partial maxillary denture - cast metal framework	1885.17	1480.00	24.08%
731 - Retainer – per tooth	54.42	50.00	8.47%
732 - Occlusal rest – per rest 733 - Tooth/teeth (partial denture)	46.24 53.71	No data 47.00	N/A 13.33%
743 - Relining - complete denture - processed	453.38	417.00	8.36%
744 - Relining - partial denture - processed	408.01	381.00	6.85%
Average % difference			**7.82%**

National Partnership Agreement on Public Dental Services for Adult (NPA)

While public dental services are operated by states and territories, there are several inconsistencies across jurisdictions (AIHW 2020b), previous Commonwealth Health Minister Sussan Ley went as far to say the system was 'fragmented' and required an overhaul (Biggs 2015).

The Commonwealth funding of Dental Services has increased (due to the Children's Dental Benefit Scheme), however the funding of the NPA has remained stagnant at $107.8 million for 180,000 patients since 2017 (Budget 2020-21, 6-19 - 6-20). What this funding model assumes is that the cost of dentistry has remained the same over this period, indexation clearly indicates this not to be the case.

General dentistry is not funded under the Medicare Benefits Scheme (MBS) except under specific scenarios (e.g., Cleft Lip and Cleft Palate scheme), consequently the DVA dental and

allied health fee schedules are the only Commonwealth fee schedule utilised for general dental (excluding the Child Dental Benefit Scheme). ADPA recommends in the absence of a dental MBS that the DVA fee schedule is utilised as ***the minimum benchmark for state and territory outsourcing arrangements under the National Partnership Agreement.***

Although oral health care is funded through the NPA (Department of Health 2020) the number of preventable hospitalisations relating to dental continue to rise costing the Australian taxpayer approximately $240 million annually (AIHW 2020b). This is further compounded by the fact that there have been significantly lower dental services accessed during the COVID-19 pandemic (Hopcraft and Farmer, 1-8).

ADPA believes dental services are now in high demand as a result of COVID-19 with ADPA members nationally reporting they are booked six months in advance. ADPA is concerned that those covered by the NPA (the priority populations) will be unable to access dental services due to higher demand, limited funding, and the increase in general dentistry costs. ADPA believes that implementing **a *sustainable, consistent, and adequate dental funding model*** will help ensure the participation of dental practitioners and the long-term viability of the scheme.

It is important to note at this stage that it is crucial the NPA is rolled out consistently in each state and territory. For example the Victorian Denture Scheme (VDS) pays on average 20% less than the DVA fee schedules with a co-contribution made my patients, Queensland outsourcing arrangements are different in each jurisdictions some paying DVA rates and others paying 10% below these rates (it is not unusual for our members to be providing services under three separate outsourcing arrangements each with differing rules and payment allocations), in South Australia there is a regional and metropolitan fee schedule (metropolitan rates are 26% below DVA rates) and there is no payment for patient oral examinations (a requirement for dental practitioners to complete under the Dental Board of Australia). The inconsistencies across the states and territories and the continual underfunding of dental services have resulted in an 18% reduction in the number of dental prosthetists providing services in the last five years (DVA 2020) we believe this to be the detriment of Australia's vulnerable populations, particularly older Australians.

ADPA is aware of members who have had to cease all services under this funding model purely on that basis of it not being financially viable. As a result, it is our recommendation that there needs to be a ***consistent approach to funding*** and the DVA fee schedule being held

as a minimum benchmark for all states and territory outsourcing arrangements this will help ensure patients continue to receive crucial oral health services under the National Partnership Agreement.

RECOMMENDATIONS

1. The ADPA recommends the implementation of **a *sustainable, consistent, and adequate dental funding model*** in consultation with Australia's peak dental associations.

2. The ADPA's recommends every resident entering a RACF should have an oral health assessment by a ***registered dental practitioner*** to inform their ongoing regular oral hygiene measures, schedule regular oral health care, determine efficient referral pathways and provide oral health treatment.

3. The ADPA recommends dedicated funding for aged care residents to adequately cover denture replacements and maintenance.

4. The ADPA recommends the DVA fee schedules are reviewed urgently with an increase that addresses the shortfall and with parity between payment of services implemented as a matter of priority.

5. The ADPA recommends the implementation of consistent funding and a consistent approach to the roll-out of outsourcing arrangements (under the NPA) across the states and territories (the DVA dental fee schedules should be the minimum benchmark utilised).

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Commonwealth of Australia

2022-23 Pre-Budget Submission

About the National Oral Health Alliance (NOHA)

Oral health is integral to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. NOHA seeks to improve the oral health of all Australians through a collaboration of consumer, dental and general health member organisations who support action by all levels of government. NOHA endorses the 2015-2024 National Oral Health Plan's four guiding principles: a population health approach, proportionate universalism, integrated oral and general health, and appropriate and accessible oral healthcare services.[1]

NOHA recognises that the social determinants of health have a profound influence on oral health. There are significant oral health inequities in Australia under the existing two-tier public and private dental sector model of dental care. NOHA's immediate priorities are better access to oral healthcare for vulnerable populations in Australia, including Aboriginal and Torres Strait Islander peoples, refugees, people living in rural, regional and remote communities, older people, people with severe mental illness, and people who are socially disadvantaged or on low incomes.

NOHA members supporting this submission

- Australian Council of Social Service
- Australian Dental Association[2]
- Australian Dental and Oral Health Therapists' Association
- Australian Dental Prosthetists Association
- Australian Healthcare and Hospitals Association
- Consumers Health Forum of Australia
- Council on the Ageing (COTA) Australia
- Dental Hygienists' Association of Australia
- National Rural Health Alliance
- Public Health Association of Australia
- Victorian Oral Health Alliance

[1] Council of Australian Governments - Health. Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024. 2015.
[2] Refer to footnote 6.

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National Oral Health Alliance 2022-23 Budget submission

Background

In May 2021, Member States of the World Health Assembly adopted the World Health Organizations' Resolution on Oral health. A Global Strategy on Oral Health is under development using the guiding principles.[3]

- Principle 1: A public health approach to oral health
- Principle 2: Integration of oral health in Primary Health Care
- Principle 3: Innovative workforce models to respond to population needs for oral health
- Principle 4: People-centred oral health care
- Principle 5: Tailored oral health interventions across the life course
- Principle 6: Optimising digital technologies for oral health

Australia is a Member State of the World Health Organization. NOHA urges the federal government to commit to, and make progress towards, the agreed actions of the 2015-2024 National Oral Health Plan, which are consistent with the recommendations of the draft Global Strategy on Oral Health.

Oral diseases can cause pain and discomfort and negatively impact general health and social participation. For people of working age, poor oral health status, especially loss of teeth, can have significant impacts on work capacity or the ability to gain and maintain employment. Poor oral health can have profound implications on self-esteem, mental health and quality of life. Multiple missing 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.[4]

NOHA recognises that the promotion of oral health is the responsibility of both the Commonwealth and State/Territory Governments. The Commonwealth's contribution has reduced significantly in the last eight years. The current 2021/22 Budget includes $107.8m for adult dental care via the National Partnership on Public Dental Services for Adults. This equates to a 44% decrease in crucial oral health funding since 2013-14, yet the population is 9% larger. By comparison, Commonwealth support for dental care via private health insurance grew by 2.7% a year.[5]

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[3] World Health Organization. Draft Global Strategy On Oral Health. 2021. Available from https://www.who.int/publications/m/item/who-discussion-paper-draft-global-strategy-on-oral-health.
[4] Australian Research Centre for Population Oral Health. Australia's Oral Health: National Study of Adult Oral Health 2017–18. 2019. Adelaide: Adelaide University Press. 2019.
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Recommendations

1. **Appointment of a Commonwealth's Chief Dental/Oral Health Officer (CDO).[6]**

Australia is one of very few Organisation for Economic Co-operation and Development (OCED) countries yet to develop and appoint a Commonwealth CDO. In the absence of an appointment, there has been limited national leadership to advance Australia's oral health priorities. This would complement the existing Chief Dental/Oral Health Officer roles currently in place in most states and territories, we would envisage a Commonwealth Chief Dental Officer would work closely with these leaders for the benefit of Australian's oral health.

Refer to footnote 6 in relation to the ADA's position.

2. **Align the National Partnership Agreement (NPA) for public dental services with the National Health Reform Agreement (NHRA).**

The current model of Commonwealth funding of public dental care is via the NPA. This renewal process is costly and inefficient, resulting in significant delays, uncertainty, and interrupted oral healthcare planning and delivery of public dental care. Initially, the Commonwealth funding should be aligned with the NHRA, and indexed according to CPI. This five-year agreement will assist state and territory governments, public dental facilities and private practitioners in achieving patient-centred care and consistent service delivery. The current system's ad-hoc nature has resulted in short term patient outcomes and fragmented continuity of care. In the medium-term, oral healthcare planning should revisit the oral health policy options recommended by the National Advisory Committee on Dental Health.[7]

3. **Scope the establishment of a Seniors Dental Benefits Scheme (SDBS).**

A key recommendation of the Royal Commission into Aged Care Quality and Safety (RCACQS) was to establish a SDBS,[8] which would operate in a somewhat similar way to the existing Child Dental Benefits Scheme. The objective would support people living in residential aged care facilities (RACF), those receiving aged care community packages or those who

[6] The Australian Dental Association (ADA) has an alternative recommendation according to their National Oral Health Policy statement: https://www.ada.org.au/Dental-Professionals/Policies/National-Oral-Health/2-1-National-Oral-Health/ADAPolicies_2-1_NationalOralHealth_V1.aspx. As a result, the ADA does not adopt NOHA's recommendation 1.
[7] Commonwealth of Australia. Report of the National Advisory Council on Dental Health. 2015. Available from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/final-report-of-national-advisory-council-on-dental-health.htm
[8] Royal Commission into Aged Care Quality and Safety. Final Report: Care, Dignity and Respect. Available from: https://agedcare.royalcommission.gov.au/publications/final-report

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receive the aged pension or qualify for the Commonwealth Seniors Health Card – this would ensure some of Australia's most at-risk populations receive adequate and timely oral healthcare. Whilst the RCACQS did not specify the funding requirements, NOHA believes this scheme should focus on essential oral healthcare requirements to maintain a functional dentition as well as to maintain and replace dentures. NOHA views the establishment of the SDBS would be the next step towards universal access to oral healthcare.

Previous research through the Senior Smiles Program targeting RACF residents would generate a cost saving of $3.14 for every $1 spent within Australia's healthcare system.[9] In other words dedicated funding for these at-risk populations will have a direct impact on reducing overall government spending on avoidable hospitalisations and malnutrition issues attributed to poor oral health function.

NOHA urges the Commonwealth government to review its current oral health priorities and recommends implementing a funding model that is long-term focused, sustainable and most importantly patient-focused. The adoption of NOHA's recommendations will help improve the oral health needs of Australia's most at-risk populations.

Should you require additional information or would like to discuss the prevailing oral health issues affecting at-risk Australians, please feel free to contact myself directly.

Yours sincerely,

Tan Nguyen

NOHA Spokesperson

[9] Wallace JP, Mohammadi J, Wallace LG, Taylor JA. Senior Smiles: preliminary results for a new model of oral health care utilizing the dental hygienist in residential aged care facilities. Int J Dent Hyg. 2016 Nov;14(4):284-288. doi: 10.1111/idh.12187.

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Victorian Oral Health Alliance

2022/23 Victorian Budget Submission on public oral health services

This submission is presented by the Victorian Oral Health Alliance (VOHA), a group of 20+ key professional, welfare and consumer organisations and providers (see below VOHA members) committed to improving Victorians' oral health and the current inequities in access to timely dental care.

Victorian Oral Health Alliance

MEMBERS

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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Victorian Oral Health Alliance

Recommendations

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

- **a short-term recovery program for adult care by**
  - Funding a catch-up program in community clinics of $42million to treat an extra 92,000 Victorians in 2022/23 as a first step in future investments
- **facilitating changes in the medium term to enable greater focus on prevention,**
  - enable different value-added and preventive models of care to be included in the DWAU formula for care provided by community health clinics

1. What are the key issues?

1.1 Significant inequity

LONG WAITING TIMES	CONSUMER IMPACTS	GOVERNMENT FUNDING NOT MEETING ADULT NEEDS	AGED CARE ROYAL COMMISSION
2-3 years for at least 50% of clients, and up to 4 years in some rural areas Average was 22.7 months in June 2021, but now longer after winter lockdowns	Tooth decay gap of 7 teeth between HCC holders and the better-off Poor access to care for older Victorians Health, social and employment impacts	44% decrease Commonwealth funding since 2013-14, although population is 25% larger	Found countless stories of suffering from pain and discomfort, poor nutrition, and inability to access timely / affordable dental care

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In addition:

- Public dental care has been restricted to emergency-only during several lockdowns in 2021, especially the winter one. Many services in 2020-21 averaged a ratio of emergency to general care of more than 50%, sometimes over 60%. This severely affected their capacity to treat people on the general lists.
- While VOHA does acknowledge the Government's actions in not financially penalising services for unavoidably underachieving targets during the year, the 2021 lockdowns have undoubtedly increased the waiting lists from the June 2021 average of 22.7 months.
- Waiting times are significantly higher at many rural services but also in the city, e.g., in June 2021 waits for general care were:
    - 48 months @ Maryborough
    - 38 months @ Whittlesea
    - 32 months@ Albury/Wodonga
    - 32 months @ Dandenong/Cranbourne

A more detailed description of the inequalities in access to public dental care in regional Australia is given in a VOHA submission to a 2020 Senate Inquiry[1].

- Waits for dentures were also extremely long in some regions, e.g.
    - 54 months @ Maryborough
    - 36 months@ Latrobe Valley
- Additionally, Victorians in all the following rural and metro electorates have average waiting times over 30 months: Ripon, Yuroke, Broadmeadows, Yan Yean, Mill Park, Thomastown, Mordialloc, Keysborough, Mulgrave, Dandenong, Narre Warren North, Narre Warren South, Clarinda, Bass, Cranbourne, Melton, Bellarine, Gippsland East, Ovens Valley, Benambra and Euroa.[2]
- Finally, for the majority of clients the waiting times quoted do not include the 12 months wait after their last treatment before they can go back on the list. So, 48 months is really 60 months for such clients.

[1] https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Economics/RegionalInequality46th/Submissions

[2] Waiting times as at July 2021 for all Victoria can be found on an interactive map at https://adavb.org/advocacy/campaigns/public-dental-waiting-times

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- The average wait for dentures as at June 2021 was 21.6 months, before the winter COVID-19 lockdown further restricted access to care in a very significant way.
- Whilst services will hopefully well and truly have returned to COVID-safe care by July 2022, they anticipate they will still be working through both the backlog from the 2021 lockdown periods.
- Further there will be increased numbers of adults needing 'urgent care' or simply more chair time as their oral health status has or will have deteriorated during 2021/22 delays and longer waits all round.
- The Smile Squad program is starting to provide care for schoolchildren, but its rollout is still at an early stage and unavoidably hampered by the lockdowns. Services are not expecting that there will be any flow-on freeing up of clinic times for adults in the 2022/23 year, and in any case, this will only apply to the few services that did not already claim CDBS funding.
- Of course, the system has been chronically under-funded for decades with annual funding only allowing for 17% of eligible Victorian adults to be treated in any one year, even pre Covid.
- As a result, poor oral health is already a silent and pervasive epidemic, impacting on people's everyday lives. It disproportionately affects Victoria's vulnerable and disadvantaged people.
- It both prevents people fully participating in society (e.g. getting a job, going to school), and contributes to poor general health e.g. heart disease and diabetes.

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What is needed in the short and long-term?

1.1 Short-term recovery of adult care

For this Budget, VOHA urges the Government to fund

- a catch-up program in community clinics of $42 million to treat an extra 92,000 Victorians in 2022/23 as a first step in future investments.

There is an urgent need to address the backlog of treatment (i.e. those on the waiting list and those whose treatment has been delayed due to Covid restrictions). We need to ensure that the eligible population's oral health status (already much lower than the population average) does not further deteriorate and that associated general health issues do not flow on, e.g. increased need for oral cancer care.

There are approx. 1.5 million eligible Victorian adults but only 175,000 were treated in the year to June 2021 (11.6% or equivalent to treatment every 8.5 years). There were over 154,000 people on waiting lists then and the average wait for general care increased by 3.3 months over the year.

1.2 Longer term investment

While not part of this Budget bid, VOHA will be advocating before the November 2022 election for the parties to commit to seriously addressing the long-lasting inequities in access to oral health care. These are arguably among the very largest and longest ignored inequalities in health status in Victoria, and in Australia more broadly, and specifically affecting the most disadvantaged populations.

VOHA will therefore be advocating for:

- a gradual increase of an additional $40 million on current adult budgets **each** year for the next four years, at an estimated extra $400m over four years, providing a total of 920,000 extra treatment episodes for low income Victorians.

2. Facilitate changes in the medium term to enable greater focus on prevention

The current funding models do not encourage nor effectively reward effective prevention work. In this Budget, VOHA recommends the Government

- enable different value-added and preventive models of care to be included in the DWAU formula for care provided by community health clinics.

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New models of care are emerging from services. For example, some ensure clients receive some health education when joining the list to assist them in preventing any further deterioration of their oral health status while they wait for perhaps 2-3 years for clinical care. This attention is not necessarily fully funded within the current rules but has real benefits for clients, and eventually for services in reducing the damage requiring care and hence reducing chair time.

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Victorian Oral Health Alliance

VOHA Members endorsing this submission

Australian Dental Association Victorian Branch (ADAVB)

Australian Dental & Oral Health Therapists Association (ADOHTA)

Australian Dental Health Foundation

Australian Dental Prosthetists Association (ADPA)

cohealth

Community Information Support Victoria

Dental Hygienists Association of Australia

Health Issues Centre

IPC Health

Public Health Association Australia (Victorian Branch) – Oral Health Special Interest Group

The University of Melbourne Dental School

Victorian Healthcare Association (VHA)

Your Community Health

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Victorian Oral Health Alliance

APPENDIX 1.0

What's needed from the Commonwealth?

Whilst the Commonwealth only provides approximately $27 m p.a. for adult care to Victoria through the National Partnership Agreement, it is acknowledged that this contribution has not kept up with inflation over the last eight years. Nationally the NPA has decreased by 44% over this time, while Australia's population has increased by 9% (and Victoria's by 25%).

VOHA has been advocating for the Commonwealth to take two new steps to address this, namely:

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 2015-16 spending levels, i.e., increase from current $108m to $416m p.a.

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