Access to Public Dental Services in Victoria

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VAGO
Victorian Auditor-General's Office
Auditing in the Public Interest

The Hon Bruce Atkinson MLC
President
Legislative Council
Parliament House
Melbourne

The Hon Telmo Languiller MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my report on the audit *Access to Public Dental Services in Victoria*.

Yours faithfully

Andrew Greaves
Auditor-General

7 December 2016

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Audit overview

Good oral health is important for general health and wellbeing. Poor oral health has a significant impact on individuals, the health system and society.

Most oral diseases can be prevented, and access to preventive oral health care can promote good oral health and minimise oral disease.

A preventive approach to oral health care is widely recognised as the most cost-effective approach to improving oral health outcomes. Also known as minimal intervention dentistry, this approach involves early identification and assessment of a person's risk of developing tooth decay, eliminating and minimising risk factors, early intervention to stop and reverse the development of tooth decay, and fillings and tooth extraction as a last resort. It also requires patients to visit the dentist regularly for check-ups rather than episodically to treat a problem. Good leadership and long-term planning are needed to achieve a preventive approach to oral health care in the public dental system.

Economically and socially disadvantaged Victorians, who are eligible for public dental services, are most likely to experience poor oral health. At June 2015, about 41 per cent of Victorians were eligible for public dental services. Only one in four eligible people accesses public dental services, with another 6 per cent of eligible people waiting for access. Some people eligible for public dental services seek oral health care through the private sector instead—for example, about 80 per cent of all outputs delivered for the Child Dental Benefits Schedule in 2014–15 were from the private sector.

In this audit we assessed the extent to which people eligible for public dental services have access to oral health care that effectively meets their needs. We also assessed whether public dental services are accessible in a timely manner and whether agencies effectively facilitate timely access. For the purpose of this audit, we considered access to the broad continuum of care provided by Victorian community dental agencies (CDA)—prevention, early detection and intervention, treatment and oral health promotion.

With state oral health plans due for renewal in 2016 and 2017, this audit is timely.

Conclusion

The current model of public dental services in Victoria, with its focus on treatment, is demonstrably less cost-effective than a preventive approach to oral health care. There is a need for change to break the cycle of poor oral health among eligible people and build on more recent preventive approaches to managing the health of the population.

Getting the balance right between prevention and treatment is a longer-term objective that involves a fundamental change to the way public dental services are currently funded, delivered and overseen. Poor oral health shares common risk factors with other general health problems, and health services must be integrated to improve access pathways and optimise patient outcomes.

Although achieving this change is challenging, if CDAs fail to adopt a more preventive approach to delivering public dental services, they will be unable to address existing inequalities in oral health in Victoria .

Findings

Current access to a continuum of oral health care

The Department of Health & Human Services (the department) and Dental Health Services Victoria (DHSV) are primarily responsible for preventive oral health care and oral health promotion activities. They have delivered on these responsibilities through a range of interventions. These include adding fluoride to public water supplies to help prevent tooth decay across the population, and introducing programs targeted at pregnant women and children with the aim of preventing or addressing bad oral hygiene habits as early as possible.

CDAs have only been able to carry out oral health promotion activities when these have been a local priority and supported by resources.

CDAs are primarily responsible for treating oral diseases. Their traditional focus on treatment is due to high levels of oral disease in the population over the past two to three decades. There remains a backlog of people with oral disease requiring treatment due to:

- poor dental visiting patterns among eligible people who are more likely to access services for emergency rather than preventive care
- the link between socio-economic status and higher levels of sugar, tobacco and alcohol consumption, which have an impact on oral health.

About 40 per cent of public dental courses of care are for emergency or episodic care to treat a problem. In Victoria, targets for delivering emergency care were exceeded between 2014–15 and 2015–16. However, access to routine care has not been timely and varied widely across CDAs and regions—for example, in 2015–16, wait times for general care varied from 1.04 months to 28.42 months.

It is internationally recognised that tooth decay can be managed through a more preventive approach, known as minimal intervention dentistry. Currently CDAs have limited ability to deliver more preventive dental care due to the current funding model, which promotes a focus on treatment.

We are encouraged by DHSV's commitment in its new strategic plan for 2016−2021 to develop new models of care that 'support the right interventions at the right time at the right place'.

Barriers to a preventive approach

DHSV and CDAs have limited ability to develop and put in place a preventive approach to delivering public dental services that provides access to minimal intervention dentistry. This is due to:

- a funding model that rewards outputs, such as more complex and time-intensive treatment activities, rather than optimal patient outcomes
- a workforce predominantly made up of dentists—using dentists rather than other oral health professionals is not a cost-effective method of delivering oral health education and support to patients to help them better manage their oral health
- lack of coordination between oral health and general health services, resulting in reduced likelihood of a person receiving a holistic assessment of their needs at the first point of contact and earlier detection and referral to the most appropriate health service
- a need for stronger strategic leadership and transition planning.

The Commonwealth Government has contributed funds to address the pressure on waiting lists under two National Partnership Agreements. States are required to meet agreed output targets to receive funding. In 2013, Victoria's former Department of Health aligned the current state funding model for public dental services with the Commonwealth funding model. It did this to reduce the administrative burden of reporting for the public dental sector, as well as the risk of inaccurate reporting arising from the complexity of operating under two different funding models.

The public dental sector has become reliant on this Commonwealth funding to meet demand. The uncertain and time-limited nature of these funds limits the capacity of the department, DHSV and CDAs to plan strategically to meet demand in the long term. It also creates a risk that increases in demand for services will not be matched by ongoing financial support, adding further pressure to an already overwhelmed system.

DHSV's *2016–2021 Strategic Plan* states that it will design purchasing agreements with CDAs—agreements that outline the service and access performance targets—to drive improved health outcomes and integrate oral health into other relevant programs.

Addressing barriers to access

With finite resources for delivery of public dental services and demand outstripping supply, DHSV and the department have understandably been primarily focused on addressing, rather than increasing, demand. Nonetheless, they have worked with CDAs to address the most likely factors—financial, cultural and geographical barriers.

Although the department and DHSV have introduced initiatives to increase access by targeted population groups, they do not have a mechanism for identifying the specific barriers that result in low take-up of public dental services and cannot show the impact of these initiatives on improving oral health.

Current activities CDAs use to address barriers have not been as comprehensive as those delivered collaboratively as part of regional oral health networks. Nonetheless, initiatives by DHSV and CDAs have resulted in a 40 per cent increase in access by priority groups from 2012–13 to 2015–16.

We are encouraged that DHSV's *2016–2021 Strategic Plan* commits to identifying barriers to access, implementing strategies to overcome them, and collaborating with CDAs on opportunities for improvement. However, this does not address the need for a way to measure how effectively such strategies improve patient outcomes.

Monitoring and reporting on accessibility

Current performance monitoring and reporting on the delivery of public dental services is output-focused and lacks indicators for improved oral health outcomes. As a result, agencies are unable to show whether delivery of public dental services has been effective. The department's *Victorian Public Health and Wellbeing Outcomes Framework*, released in October 2016, and DHSV's *2016–2021 Strategic Plan* identify future outcome measures that could address this gap.

Recommendations

We recommend that the Department of Health & Human Services and Dental Health Services Victoria work with community dental agencies to:

1. identify and pilot models of care that redress the current imbalance between treatment and prevention services for eligible people by increasing access to the broader continuum of care, while maintaining the focus on addressing demand for treatment (see Section 2.5)
2. carry out a cost-benefit analysis of the long-term outcomes of adopting a model of care for public dental services (see Section 3.5).

Recommendations – *continued*

We recommend that the Department of Health & Human Services and Dental Health Services Victoria work with community dental agencies to:

3. review and improve the current approach to managing waiting lists, including prioritising need and assessing the risk of people placed on the waiting list (see Section 2.5.4)
4. identify where collaboration between regional public dental services could address barriers to access and pilot related projects to test their effectiveness in improving oral health and in identifying resourcing requirements (see Section 4.2.2)
5. identify how community dental agencies can take greater responsibility for promoting oral health, supported by adequate funding (see Section 2.3.3)
6. collect data on people who are eligible for public dental services as a subset of its broader oral health outcomes measures based on the whole population (see Section 5.2.2).

We recommend that the Department of Health & Human Services, in consultation with Dental Health Services Victoria:

7. review the most appropriate and effective funding model to deliver public dental services to achieve the government's goals—this will include an assessment of the value of applying the Commonwealth funding model (see Section 3.2.4)
8. when developing the funding model, consider including loading for variables that affect how services are delivered, such as remoteness and client complexity (see Section 3.2.4)
9. develop an implementation plan for introducing a consistent Dental Weighted Activity Unit rate for all community dental agencies while the Dental Weighted Activity Unit funding model is in place, informed by a sound analysis of reliable data (see Section 3.2.4)
10. review the relevance and appropriateness of current key performance indicators in the Statement of Priorities and identify more relevant indicators for providing a comprehensive picture of the impact of the dental health program (see Section 5.2.1)
11. review the usefulness of the current key performance indicators in *State Budget Paper 3: Service Delivery* and identify more relevant indicators for providing a comprehensive picture of how public dental services are delivered (see Section 5.3.2).

Responses to recommendations

We have consulted with the Department of Premier & Cabinet, the Department of Health & Human Services (the department) and Dental Health Services Victoria (DHSV) and we considered their views when reaching our audit conclusions. As required by section 16(3) of the *Audit Act 1994*, we gave a draft copy of this report to those agencies and asked for their submissions or comments.

The following is a summary of those responses. The full responses are included in Appendix A.

The department and DHSV responded, accepting the recommendations. The department provided a detailed action plan on how it will address our recommendations and the time frames for these activities, and also noted where it has started acting on our recommendations. Both the department and DHSV noted the potential impact of future funding decisions on time frames for implementing recommendations.

1 Audit context

1.1 Oral health

Good oral health is an important part of general health and wellbeing, enabling people to eat, sleep, socialise and work without pain or embarrassment. Poor oral health can lead to psychological and social problems including poor self-esteem, anxiety and depression.

Dental problems are common but preventable. In 2012, the World Health Organisation reported that the most common oral diseases in the world were dental cavities, gum disease and oral cancer.

Victoria's Health: The Chief Health Officer's report 2014 identified dental problems as the single largest cause of all avoidable hospitalisations for Victorians under 25 and the second largest for Victorians as a whole.

However, dental disease is distributed unevenly in Australia and is strongly linked to low socio-economic status. According to the Australian Institute of Health and Welfare's *National Survey of Adult Oral Health 2004–06*, a higher proportion of people eligible for public dental care in Australia had untreated tooth decay (32.9 per cent) than those who were ineligible (22.9 per cent). The proportion of people with untreated tooth decay was also higher at lower levels of household income. The highest proportion was for people living in households earning less than $12 000 per year (35.4 per cent), while the lowest was for people living in households earning $100 000 or more per year (16.5 per cent).

1.2 Policy and legislative framework

1.2.1 Commonwealth framework

The *Dental Benefits Act 2008* establishes a legislative framework for the payment of dental benefits and provides the legislative framework for the Child Dental Benefits Schedule from 1 January 2014. The Child Dental Benefits Schedule provides children aged 2–17 years, who are eligible for Medicare and who satisfy the means test for the program, access to benefits for basic dental services up to a cap of $1 000 within two consecutive calendar years. The *Dental Benefits Rules* establish the operational framework for the payment of dental benefits under the *Dental Benefits Act 2008*.

The Commonwealth's oral health plan *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–24* sets the national direction for oral health over a 10-year period. Its goal is to improve health and wellbeing across the Australian population by improving oral health and reducing the burden of poor oral health.

The Commonwealth and state governments have entered into two National Partnership Agreements on oral health with the following objectives:

- The National Partnership Agreement on Adult Public Dental Services for 2015−16 aimed to reduce pressure on adult public dental waiting lists. This one-year agreement provided $38.5 million to Victoria if the state achieved set output targets based on measuring delivery of dental care activities.
- The National Partnership Agreement on Treating More Public Dental Patients aimed to improve access to services by reducing wait lists. This agreement provided $85.4 million to Victoria from January 2013 to March 2015 for achieving set output targets.

1.2.2 State framework

Legislation

The *Victorian Public Health and Wellbeing Act 2008* provides the legislative framework for preventive health. The objective of the Act is to achieve the highest attainable standard of public health and wellbeing for all Victorians by:

- protecting public health and preventing disease, illness, injury, disability and premature death
- reducing inequalities in public health and wellbeing.

The *Health (Fluoridation) Act 1973* regulates the safe and effective addition of fluoride into drinking water supplies in Victoria.

Plans for improving oral health

Three key statewide plans, shown in Figure 1A, inform the oral health care system in Victoria, including the state's public dental program:

- *Victorian Public Health and Wellbeing Plan 2015−19*
- *Healthy Together Victoria: Action plan for oral health promotion 2013−17*
- Dental Health Services Victoria (DHSV) Strategic Plans.

Figure 1A
Plans for improving oral health

Plan	Details
Victorian Public Health and Wellbeing Plan 2015−19	The plan's vision is a Victoria free of the avoidable burden of disease and injury so that all Victorians can enjoy the highest attainable standards of health, wellbeing and participation at every age. It acknowledges that many chronic diseases and injuries are preventable and has a particular focus on improving the health and wellbeing of disadvantaged Victorians.
Healthy Together Victoria: Action plan for oral health promotion 2013−17	The objective of the plan is to improve the oral health of all Victorians, including those at higher risk. It emphasises partnerships to build a prevention and early intervention system for oral disease. The government allocated $14.9 million in funding to the plan.
DHSV *2013−2016 Strategic Plan*	This strategic plan aimed to lead improvement in oral health for all Victorians, particularly vulnerable groups and those most in need. In September 2016, DHSV released a new strategic plan for 2016−2021, which has a stronger focus on improving outcomes.
DHSV *2016−2021 Strategic Plan*	Released in September 2016, this strategic plan aims to use a population and life course approach to improve health outcomes and develop a new model of care. It contains a strengthened commitment to improving oral health by: • embedding preventive models of care within a population health framework throughout the public dental sector • delivering high-quality and high-value care • reducing health inequalities through extending DHSV's reach to more of the eligible population, especially priority groups.

Source: VAGO.

1.3 Responsibility for public dental services

1.3.1 Department of Health & Human Services

The Department of Health & Human Services (the department) has overall responsibility for the public dental program. It has lead responsibility for negotiating National Partnership Agreements with the Commonwealth government, capital planning for public dental services, and population health planning. It funds DHSV to purchase and deliver public dental services through community dental agencies (CDA) and monitors its performance.

The department also has overall policy, funding and program responsibility for public health and wellbeing under the *Public Health and Wellbeing Act 2008* and for water fluoridation under the *Health (Fluoridation) Act 1973*.

1.3.2 Dental Health Services Victoria

DHSV has statewide responsibility for negotiating purchasing agreements with CDAs, monitoring and managing CDAs' performance, workforce development, oral health promotion and clinical governance of public dental services.

1.3.3 Community dental agencies

At 1 June 2016, DHSV funded 52 CDAs and the Royal Dental Hospital of Melbourne to provide dental services in Victoria. These agencies operate under three distinct legal and governance arrangements:

- 30 are established under the *Health Services Act 1988* (Vic) as public or metropolitan hospitals or public health services
- 21 are independent companies limited by guarantee and established under the *Corporations Act 2001* (Cwlth)
- one is an incorporated association established under the *Associations Incorporation Reform Act 2012* (Vic).

1.4 Funding for public dental services

1.4.1 Commonwealth funding

Although both the state and the Commonwealth fund public dental services, the responsibilities of state and Commonwealth governments for oral health care and promotion are unclear.

Successive Commonwealth governments have differed in their views about the Commonwealth's role in oral health care and promotion. This has resulted in ongoing changes to national oral health policies, Commonwealth contributions and uncertainty in funding arrangements.

Commonwealth policy has included a direct role in funding targeted dental health programs. At various times, it has had an indirect role providing limited assistance through Medicare and offering subsidies to encourage the wider use of private health insurance.

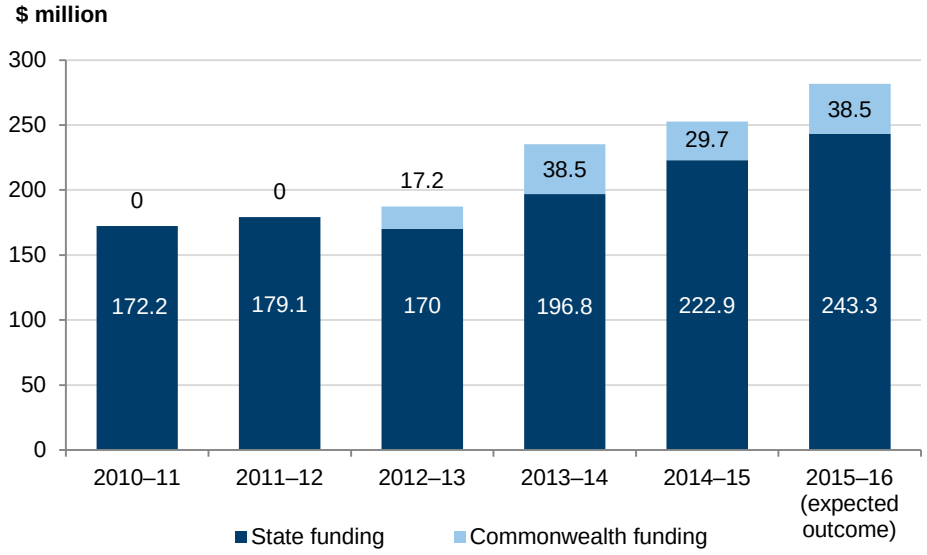
Commonwealth-funded initiatives have included the School Dental Program in the mid-1970s, the Commonwealth Dental Health Program in the mid-1990s, and the current Child Dental Benefit Schedule. However, the funding stream for these initiatives is not certain as the Commonwealth can discontinue them at any time. For example, on 23 April 2016, the Commonwealth Government announced its intention to close the Child Dental Benefit Schedule from 1 July 2016. As the legislation was not passed by Parliament before the Commonwealth Government entered into caretaker arrangements on 9 May 2016, the Child Dental Benefit Schedule remains open. On 31 August 2016, the Commonwealth Government reintroduced legislation to close the Child Dental Benefits Schedule from 31 December 2016 and establish the Child and Adult Public Dental Scheme from 1 January 2017.

1.4.2 State funding

Historically, the state government has provided the majority of funding for public dental services, with a focus on providing a safety net for socially and economically disadvantaged Victorians.

Since 2013, the Commonwealth Government has provided top-up funding through National Partnership Agreements. This is illustrated in Figure 1B.

Figure 1B
State and National Partnership Agreement funding for public dental services



Note: Figure 1B excludes the cost of direct reimbursements to CDAs through rebates under Commonwealth dental programs, such as the means-tested Child Dental Benefits Scheme, which provides children aged 2–17 years with access to basic dental services capped at $1 000 per child over two calendar years. The department does not hold this data.
Source: VAGO analysis of information in Victorian *Budget Paper 3: Service Delivery* and the National Partnership Agreements.

State-funded care focuses primarily on courses of treatment provided by CDAs. In 2015–16, 71 per cent of funding went to community dental care and 19 per cent to the Royal Dental Hospital of Melbourne for emergency and specialist care.

Promoting good oral health

The state also provides some early detection, prevention and oral health programs, but devotes less than 10 per cent of funding to these interventions. In 2015–16, around 1 per cent of funding was allocated for oral health promotion. In addition, a range of community health services receive funding for integrated health promotion. These agencies typically work within a catchment in a collaborative manner using a mix of health promotion interventions and capacity-building strategies to address priority health and wellbeing issues. Forty-two CDAs were part of community health services or primary care partnerships—networks of health and humans services providers—that received this funding.

In Victoria, promoting good oral health is generally targeted in the following ways:

- **a population health approach** to improve oral health of the whole population and reduce oral health inequalities across population groups through evidence-based strategies and actions, such as fluoride programs
- **targeted oral health promotion activities** that focus on specific population groups identified as having higher risk of oral disease or that have the potential to achieve long-term preventive effects, such as activities targeted at pregnant women
- **early intervention for individuals** to encourage them to improve their oral health through understanding their oral health needs and environment, such as their oral hygiene habits, and the effects of diet and smoking.

1.4.3 Eligibility and fees for public dental services

Medicare does not comprehensively cover oral health care, although in recent years several targeted programs have provided rebates for particular services to specific groups of people.

Access to public dental services is not universal. Victoria's public dental system aims to increase access by providing services at reduced or no cost to people who meet strict eligibility criteria targeting people who are disadvantaged.

At June 2015, an estimated 2.46 million Victorians were eligible for public dental services. However, data indicates that a significant proportion of eligible people seek private dental care. For example, about 80 per cent of all outputs delivered for the Child Dental Benefits Schedule in 2014–15 were from the private sector.

The department's *Eligibility and priority access for public dental services policy* identifies those who are eligible to access public dental services and those who have priority access. Priority access groups are specific population groups recognised to be at greater risk of poorer health than the general population. This includes children, homeless people, and Aboriginal and Torres Strait Islander people.

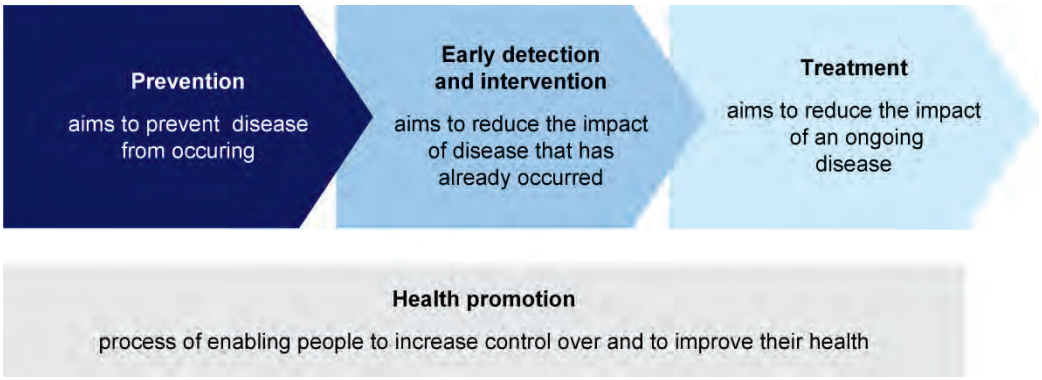
The department's *Public dental fees policy* outlines the fee schedule. Among the eligible population, most priority access groups do not have to pay fees for public dental services. Appendix B outlines eligibility and fee requirements for accessing public dental services.

1.5 Victoria's continuum of oral health care

As most oral diseases can be prevented, focusing on patient awareness and prevention rather than treatment is the most cost-effective approach to improving oral health. While treatment is important in responding to oral disease, effective preventive measures will minimise the need for more costly treatment interventions.

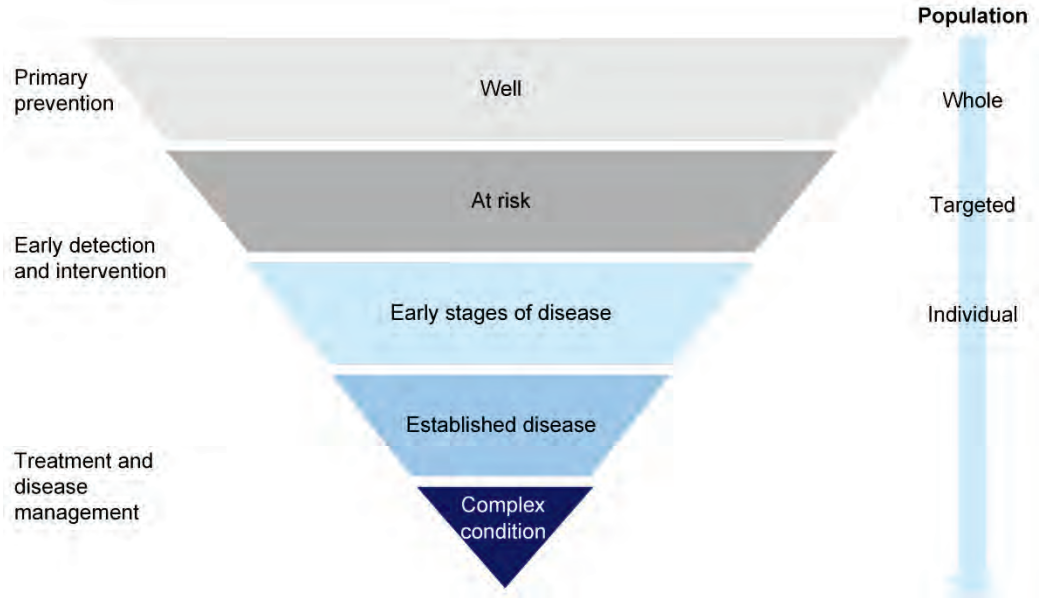
Providing people with access to a continuum of care is therefore important to achieve positive oral health outcomes. Figure 1C outlines the continuum of care, and Figure 1D outlines the population focus within the continuum of care.

Figure 1C
Continuum of care for positive oral health outcomes



Source: VAGO, adapted from information from the Institute for Work and Health, 2015.

Figure 1D
Population focus in the continuum of oral health care



Source: VAGO, adapted from the former Department of Health, *Healthy Together Victoria: Action plan for oral health promotion 2013–17*.

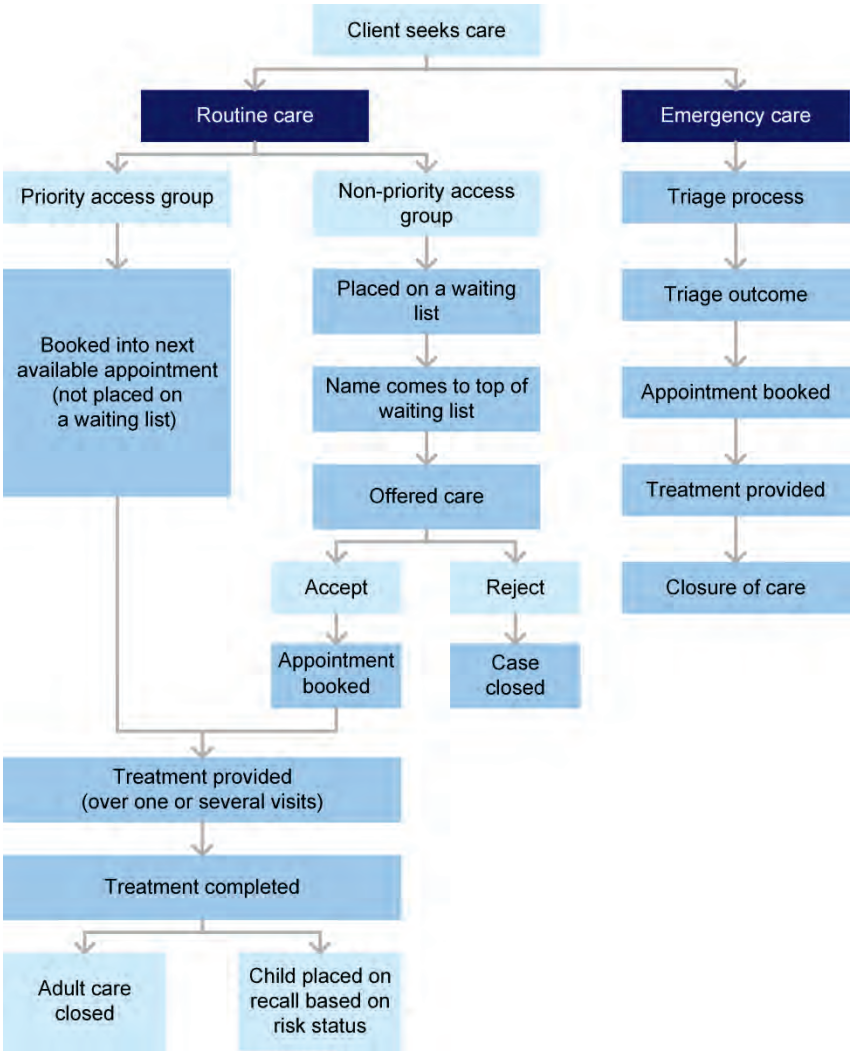
Public dental care includes the following treatment and early detection interventions:

- general dental care—such as examinations, cleaning, fillings and extractions, and check-ups every one to two years
- denture and priority denture care
- emergency care
- specialist care—such as oral surgery, treatment of severe gum disease or treatment for children with complex dental, medical and other needs.

1.6 Model of care

A model of care describes how health services are delivered. Under the current model of care for public dental services, there are two pathways to accessing care, shown in Figure 1E. The pathway will depend on whether care is routine or urgent.

Figure 1E
Pathways to access care in community dental agencies



Source: VAGO, adapted from information from DHSV.

Generally, patients seeking routine general or general denture care will be put on a waiting list, whereas patients from a priority access group will get the next available appointment and will not be placed on the waiting list. The next available appointment usually involves a wait time of two to four weeks across CDAs.

1.7 Why this audit is important

Access to public dental services is important for people who are economically and socially disadvantaged. DHSV has highlighted that people who access public dental care:

- have more disease and fewer teeth than the general population
- are less likely to access services than the general population
- have to wait on average a year to get routine care with no recall arrangements (but this varies across the state)
- receive care that is not always focused on achieving better health outcomes.

In our 2002 audit *Community Dental Services* and our 2005 follow-up audit, we identified long waiting lists, workforce changes and a complex and inequitable funding model. In this audit, we assessed the progress made over the past decade to improve timely access to the public dental system and achieve the state goal to improve oral health for those Victorians most in need.

1.8 What this audit examined and how

We examined whether public dental services are accessible in a timely manner and whether agencies effectively facilitate timely access. Specifically, we examined whether:

- people eligible for public dental services have timely access to dental services
- the department and DHSV have a sound, evidence-based understanding of access issues facing people eligible to access public dental services
- the department and DHSV have coordination and governance arrangements in place to effectively facilitate access to public dental services
- the department and DHSV have sound policies, programs and strategies to effectively identify and respond to any barriers for eligible people accessing public dental services
- the department and DHSV undertake effective performance monitoring of accessibility, underpinned by sound data, to monitor performance against objectives.

As part of the audit, we visited five CDAs across three regions.

We conducted this audit in accordance with section 15 of the *Audit Act 1994* and Australian Auditing and Assurance Standards. The total cost of this audit was $510 000.

1.9 Report structure

The remainder of this report is structured as follows:

- Part 2 looks at how access to a continuum of oral health care is currently provided
- Part 3 looks at barriers to implementing a preventive approach that would provide access to a continuum of care
- Part 4 looks at the effectiveness of strategies to address barriers to accessing public dental services
- Part 5 looks at the adequacy of the performance monitoring framework for public dental services.

2 Current access to the continuum of oral health care

Victoria's Health: The Chief Health Officer's report 2014, published in 2016, states that dental conditions are the highest cause of all preventable admissions to hospital for Victorians under 25 years of age and the second highest for all ages. The main cause of this in children is tooth decay.

Access to a continuum of care that encompasses prevention, early detection and intervention, treatment and oral health promotion is necessary for achieving positive oral health outcomes. Access can be targeted at the whole population, specific groups at higher risk of poor oral health compared to the general population, or individuals. Good oral health requires ongoing maintenance for life.

Although Australians' oral health has improved over the past three decades, largely through the introduction of fluoridation in the 1960s, poor oral health among adult Australians is still widespread. Across the population as a whole, three out of 10 adults have untreated tooth decay. The rate more than doubles among adults on low incomes and Aboriginal and Torres Strait Islander people. Rural and remote populations are also at greater risk of poor dental health. In addition, children from low socio-economic areas have 50 to 70 per cent more decay-affected teeth than children in the most advantaged areas.

This Part of the report examines how the Department of Health & Human Services (the department), Dental Health Services Victoria (DHSV) and community dental agencies (CDA) currently provide access to the continuum of oral health care.

2.1 Conclusion

Although there have been some improvements in the overall oral health of the general population, poor oral health is still widespread in Australia and more likely to be present in people eligible for public dental services due to historically poor oral health and unfavourable visiting patterns. There is still therefore demand for affordable dental treatment services through the public dental system.

The current focus of public dental services on addressing this backlog of treatment and the high demand for services mean that CDAs are unable to provide more preventive oral health care to help patients better manage their oral health. As a result, people seek treatment for conditions that could be prevented and potentially return for re-treatment. This is not a cost-effective way of delivering public dental services. If adults are not encouraged to attend regular preventive check-ups, then efforts to instil good oral health habits in the early years will not be maintained.

Changing the delivery of public dental services in the long term is essential to meet future needs, to improve oral health and to reduce pressure on the public dental system. Currently, with finite resources and uncertain Commonwealth funding, the state government is limited in its ability to build greater capacity to meet growing demand. In order to be able to meet demand from the total eligible population, the department and DHSV have to address the upstream social determinants of poor oral health and encourage a shift in public dental services from emergency to general care and from treatment to prevention.

2.2 Access to prevention

The department and DHSV take a 'population health approach' to preventing oral disease. This approach aims to improve the health of the entire population and to reduce health inequities among population groups. It acknowledges a wide range of systemic factors—social, economic and environmental—that influence the development and progression of oral disease. A population health approach is one of the guiding principles of *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024*.

A key population health strategy pursued in Victoria is increasing access to fluoride—a mineral found naturally in rocks, air, soil, plants and water—which helps to prevent tooth decay when added to drinking water, toothpastes or other products applied directly to teeth.

2.2.1 Fluoridation programs

Only communities with access to a reticulated (public) drinking water supply can potentially have access to fluoridated water. In Victoria, 95 per cent of the population has access to a reticulated water supply. The remaining population get drinking water from other sources, such as water tanks.

Between 2004 and 2010, the department carried out a water fluoridation program that funded the building of 30 water fluoridation plants in 26 towns, providing fluoridated water to an additional 700 000 Victorians. This increased the percentage of Victorians with access to fluoridated water from 74 per cent in 2004 to 90 per cent. Since then, the department has continued to extend fluoridation by:

- providing fluoridated water to an additional 20 000 Victorians in Kilmore and Maryborough in 2015
- providing fluoridated water to an additional 7 000 Victorians in Ararat in 2016.

The department is also working with Regional Development Victoria and Goulburn Valley Water to continue works to extend fluoride to the Cobram system, serving a population of 5 970. Works are expected to be completed in 2017.

There remain 60 rural communities with a non-fluoridated reticulated drinking water supply. The department has advised that any future work to extend the fluoridation program will depend on successful budget bids through the expenditure review and estimates process.

The impact of water fluoridation has been significant. The most recent Australian evidence shows that water fluoridation reduces tooth decay by about 35 per cent in children, and increases the proportion of children who have no tooth decay by about 15 per cent. In addition, a recent study in Victoria identified that young children living in areas without community water fluoridation had 59 per cent higher rates of admissions to hospital for dental treatment compared with children living in fluoridated areas when controlling for access to dental health professionals and socio-economic status.

Both DHSV and the department have worked to improve access to fluoride in other forms in communities without access to fluoridated water.

2.2.2 Access to fluoride varnish

Fluoride varnish is a highly concentrated gel form of fluoride that is applied to teeth using a soft brush. Studies internationally and in the Northern Territory have shown that applying fluoride varnish every six months substantially reduces tooth decay in children.

The *Drugs, Poisons and Controlled Substances Regulations 2006* restrict the use of fluoride varnish to:

- dentists, dental and oral health therapists and hygienists
- medical practitioners and pharmacists.

In May 2015, in response to an invitation to provide possible amendments to the *Drugs, Poisons and Controlled Substances Regulations 2006*, DHSV asked for an amendment to authorise anyone with suitable qualifications and training to apply fluoride varnish, with a view to encouraging innovative delivery of this preventive service and expanding its use. The request was unsuccessful. The Chief Officer, Drugs and Poisons Regulation, considered that broadening the authorisation to apply fluoride varnish to other trained personnel was beyond the scope of the Regulations.

The department is exploring a potential pilot project to demonstrate the effectiveness of fluoride varnish application by oral health professionals targeting children living in communities without access to fluoridated water and vulnerable children living in communities with fluoridated water.

2.3 Access to oral health promotion

Although increased access to fluoridated water has improved Victorians' baseline oral health, this is only one factor in maintaining good oral health. Oral health promotion is important for improving people's health literacy and their ability to protect and improve their own oral health.

Healthy Together Victoria: Action plan for oral health promotion 2013–17 (the action plan) identifies a range of actions to improve the oral health of all Victorians. DHSV is the lead agency responsible for overseeing and delivering the goals of the action plan. Two key initiatives that the department funds DHSV to deliver under this action plan are the Healthy Families, Healthy Smiles program, targeting children under four years old and pregnant women, and Smiles 4 Miles, which targets four-year-old children in kindergarten.

DHSV targets prevention, early detection and intervention efforts at these two cohorts due to the fact that despite the improvements outlined in Section 2.2.1:

- dental admissions are the third-highest cause of preventable hospital admissions in Victorian children under five years old
- nearly half of six-year-old children have had decayed baby teeth
- early childhood is a critical time when lifetime habits are established and early childhood dental decay influences long-term oral health
- pregnant women are at increased risk of gum disease, and links exist between advanced gum disease and premature and low-birth-weight babies
- poor oral health of mothers is linked with early childhood tooth decay in their children.

2.3.1 Healthy Families, Healthy Smiles

The Healthy Families, Healthy Smiles program aims to improve the oral health of children aged under four and pregnant women by building the knowledge and skills of health and early childhood professionals to promote oral health. Key achievements included:

- delivering oral health professional development activities to 3 000 health and early childhood professionals from 2012 to 2016
- developing joint position statements on oral health between DHSV and:
  - the Dietitians Association of Australia
  - the Pharmaceutical Society of Australia.

A 2015 evaluation of the program by the Centre for Applied Oral Health Research showed that it was achieving its objectives. However, the impact of this program on promoting referrals to oral health services for pregnant women and reducing tooth decay in children under four has yet to be determined.

2.3.2 Smiles 4 Miles

Smiles 4 Miles is an oral health promotion program based in early childhood settings, mainly kindergartens, that focuses on increasing children's access to dental services by improving partnerships with public dental agencies in high-risk areas. It also encourages and promotes good oral health habits and healthy eating. Achievements of Smiles 4 Miles include:

- reaching 29 460 children in 510 services in 2016
- participation by nine Aboriginal early childhood services in 2016
- formalising an agreement with the Victorian Aboriginal Community Controlled Health Organisation so that all Aboriginal early childhood services registered in Smiles 4 Miles will be offered additional support from the organisation.

A 2013 evaluation of the program found that children from participating kindergartens were more likely to have seen a dentist in the last 12 months (61 per cent compared with 53 per cent for all children).

The ongoing impact of the program on increasing referrals to public dental services has yet to be determined. In 2015, DHSV added a new data field to its electronic patient management system that allows it to track referrals from the Smiles 4 Miles program. This data source should allow DHSV to better evaluate the impact of this program. Extending this data field would allow DHSV to track referrals from other professionals, such as midwives, maternal and child health nurses and pharmacists, to provide insight into the impact of these programs on referrals and take-up of dental care.

2.3.3 CDAs' oral health promotion activities

Of the five CDAs we visited during this audit, all were involved in oral health promotion activities. Examples of their activities included:

- taking part in the Smiles 4 Miles program (three CDAs)
- taking part in the Healthy Families, Healthy Smiles program (one CDA)
- visiting and presenting to specific cohorts, such as a special needs school, a local primary school and a group for new parents
- carrying out education programs at preschools, primary schools and community events, including Aboriginal and Torres Strait Islander cultural events.

The ability of CDAs to carry out oral health promotion activities depends on available resources. CDAs can potentially receive funding to support oral health promotion if they are part of a community health centre or primary care partnership (PCP) that receives funding for integrated health promotion and identifies oral health as a priority area. Four CDAs we visited are part of a community health centre or PCP that receives such funding. Of these:

- one CDA is part of a PCP that did not identify oral health promotion as a priority, however, this CDA had its own oral health promotion action plan
- two CDAs are part of PCPs that included oral health promotion, specifically delivery of the Smiles 4 Miles program, within the priority area of 'healthy eating'
- one CDA is part of a community health centre that identified oral health promotion as a standalone priority.

Resourcing varied across CDAs and was influenced by the extent to which oral health promotion was a local priority for the region, or governing hospital or health service. Of the CDAs we visited, one allocated a senior dental nurse educator at 0.6 EFT to the role, while another CDA had a full-time clinical project officer in the dental services team who coordinated eight 'health promotion champions' (Certificate IV nurses and oral health therapists). The governing hospital subsidised the CDA's oral health promotion activities, which enabled it to allocate a full-time position.

When oral health is not a local priority, oral health promotion activities can be seen as competing with activities that meet productivity targets. This affects CDAs' availability or willingness to carry out such activities, which often occur outside normal clinic hours.

To increase the level of responsibility CDAs have for delivering oral health promotion activities within their catchments, DHSV will need to collaborate with CDAs to identify ways to deliver oral health promotion effectively and efficiently, and allocate the necessary resources.

2.4 Access to early detection and intervention

Early detection and intervention is important for reducing the progression and impact of tooth decay, and the need for more costly treatments. Early detection of tooth decay and gum disease can occur through regular visits to the dentist for teeth cleaning and applying fissure sealant to prevent decay. This is discussed in Section 2.5. Early detection can also occur when people are prompted to visit their public dental service as a result of screening or outreach programs carried out by CDAs or other professionals in key settings.

Examples of screening programs in Victoria are:

- **Maternal and Child Health Service**—this universal primary care service is for Victorian families and children from birth to school age. In 2009, the service's maternal and child health key ages and stages framework was revised to include oral health, resulting in maternal and child health nurses performing a full oral assessment at the eight-month, 18-month and 3.5-year consultations.
- **Birthing Outcomes System**—this database stores data that midwives are required to collect on pregnant women. Two questions on oral health were introduced in 2015.

Three of the five CDAs we visited also demonstrated screening activities they use to increase awareness of public dental services and to encourage access. This included oral health screening and education programs in primary schools, community events such as a local children's fair, and events specifically for Aboriginal and Torres Strait Islander people. Again, the ability of CDAs to carry out such activities depended on available resources and whether oral health was a priority for the hospital or region.

2.5 Access to treatment

Traditionally, dental care has focused on the treatment of oral disease in patients. This has been partly due to the high levels of disease present in the population over the last two to three decades.

A report by the Australian Institute of Health and Welfare (AIHW), based on findings from the *National Survey of Adult Oral Health 2004–06*, found that:

- the generation born before 1930 experienced widespread oral disease and were frequently treated by extraction of teeth
- two intermediate generations, born between 1950 and 1970, were more likely to retain teeth, but experienced historically high rates of decay
- the generations born since 1970 have been exposed to more dental prevention than any preceding generation, particularly through fluorides in toothpaste and drinking water.

However, while there have been some improvements in the overall oral health of the general population, poor oral health is still widespread in Australia and more likely to be present in people eligible for public dental services. This is partly due to poor dental visiting patterns being more common among eligible people as well as the link between socio-economic status and higher levels of sugar, tobacco and alcohol consumption that impact on oral health.

AIHW identifies visiting patterns as a good indicator of oral health—the frequency and reason for dental visits indicate the likely pathway for treatment or service. Visiting patterns can be defined as favourable, unfavourable or intermediate. People with favourable visiting patterns generally have good oral health, visit the same dentist once a year and visit for a check-up rather than a problem. People with unfavourable visiting patterns do not usually visit the same dentists, do not visit yearly, are often seeking treatment for a problem rather than visiting for a check-up and tend to have poorer oral health. According to AIHW, 34.7 per cent of people across Australia who are eligible for public dental services had favourable visiting patterns compared to 47.3 per cent of ineligible people.

Data from the AIHW's *National Dental Telephone Interview Survey 2013* in Figure 2A shows that favourability of dental visiting patterns is linked to socio-economic status and annual household income.

Figure 2A
Dental visiting pattern by annual household income, 2013

Annual household income ($)	Dental visiting pattern (per cent)		
	Favourable	Intermediate	Unfavourable
<30 000	27.4	37.5	35.1
30 000–<60 000	38.6	32.7	28.7
60 000–<90 000	42.4	33.1	24.5
90 000–<140 000	52.1	28.7	19.2
140 000+	57.1	30.5	12.4

Note: Data is for people aged 18 and over.
Source: VAGO, based on the AIHW *National Dental Telephone Interview Survey 2013*.

With better understanding of the tooth decay process and improvements in dentistry, there is international recognition that tooth decay can be managed through a more preventive approach known as minimal intervention dentistry (MID). MID involves:

- early identification and assessment of the risk of developing tooth decay through lifestyle analysis and saliva testing
- eliminating and minimising risk factors by altering diet and lifestyle habits and improving oral health
- early intervention to stop and reverse the development of tooth decay
- fillings and tooth extractions as a last resort.

MID has a focus on building people's ability to manage their oral health so that they only need minimum intervention from public dental services.

2.5.1 Use of public dental services

About 41 per cent of Victorians are eligible for public dental services. According to the Australian Bureau of Statistics, the estimated resident population of Victoria at June 2015 was 5.94 million people. According to the Commonwealth Department of Social Services, the total estimated population eligible for public dental services in June 2015 was 2.46 million people.

Figure 2B illustrates that overall there has been increased access to public dental services between 2012–13 and 2015–16. These increases have been in the number of patients from priority access groups who bypass the waiting list system. There was a spike in access in the two-year period 2013–15, due to an injection of Commonwealth funding under the first National Partnership Agreement. The number of priority access patients accessing public dental services increased by 40 per cent from 2012–13 (140 360) to 2015–16 (196 142).

Figure 2B
Access to CDAs by eligible people over two-year periods, 2012–13 to 2015–16

Two-year period	Number of people treated	Percentage of the eligible population
2012–13 and 2013–14	563 588	23.7
2013–14 and 2014–15	624 439	26.2
2014–15 and 2015–16	611 288	24.9

Source: VAGO, based on information from DHSV.

Currently, about 31 per cent of the eligible population have either accessed or are waiting to access public dental services. Of this group:

- 24.9 per cent (611 288 people) of the eligible population were treated in CDAs over the two-year period from 2014–15 to 2015–16
- 6 per cent (147 736 people) of the eligible population were on waiting lists at 30 June 2016.

2.5.2 Timeliness of access

There are two aspects to timeliness:

- whether access to treatment is prioritised on a needs basis
- whether treatment is provided within reasonable time frames.

Assessing and prioritising need

Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024 states that 'the timing of check-ups and oral health care should be determined through individual risk assessment'.

Access to routine care in the state's public dental system is on a first-come, first-served basis. There is no oral health assessment at the point of entry to determine patients' oral health status, their needs or their risk of developing oral disease before placing them on the waiting list. However, patients on waiting lists are told to contact the clinic if their oral health condition worsens.

People who seek emergency care are assessed and managed using a triage tool. The tool is designed to help staff ask patients a series of questions so they can prioritise patients according to need. The triage process produces five triage category outcomes that require patients to be treated within either 24 hours, seven days, 14 days or 28 days or offered a general appointment. However, the triage tool can sometimes result in less urgent patients being seen before those in more urgent need of care. DHSV is piloting a new emergency management demand system at the Royal Dental Hospital of Melbourne to address this.

Eligible patients who need specialist care at the Royal Dental Hospital of Melbourne can gain access through either an emergency transfer or a referral from a CDA. Access through an emergency transfer goes through the emergency triage process. A senior oral health practitioner screens referrals in the relevant specialist area and determines the urgency of treatment.

Reasonableness of time frames

The risk of patients' oral health worsening while they wait for care should be a key consideration in allocating people to waiting lists. The higher the risk, the higher the priority should be.

A clinical working group that included experts from Victorian CDAs developed the target time frames for accessing emergency dental care. However, target time frames for accessing general, general denture and specialist care are based on available funding and resources, rather than on risk or priority of need.

Figure 2C shows the target time frames for general and general denture care would be reduced if the NPA was signed, due to extra funding being available to increase capacity to meet demand and therefore reduce waiting times.

Figure 2C
Target time frames for accessing public dental services, 2015–16

Type of service	2015–16 target waiting time (months)	2015–16 target waiting time if NPA signed (months)
Prosthodontics, endodontic, and orthodontics specialist services	15	n/a
Other dental specialist services patients	9	n/a
General care	23	14
General denture care	22	16
Priority denture care	3	3

Note: Targets for accessing specialist care only apply to the Royal Dental Hospital of Melbourne.
Source: VAGO, based on the *2015–16 Statement of Priorities*: *Agreement between Minister for Health and Dental Health Services Victoria*.

Wait times for general dental and denture care

Wait times for accessing general dental, denture and priority denture care vary across the state and within regions. Wait times for the period 2012–13 to 2015–16 are outlined in Appendices C, D and E. Factors influencing CDAs' wait times are discussed in Section 2.5.4.

The variation in average wait times in CDAs for general dental health care is greater within regions than the variation between regions across the state. Figure 2D shows the lowest and highest average wait times for general care within each region in 2015−16. Gippsland region had the greatest difference in wait times of just over two years, compared to Hume region, which had the smallest difference of just over eight months.

Figure 2D
Lowest and highest average wait times in CDAs for general dental care in each region, 2015–16

Region	Wait time (months)		
	Lowest average wait time	Highest average wait time	Difference
Barwon	9.55	21.14	11.59
Grampians	2.06	17.41	15.35
Loddon Mallee	1.04	21.44	20.40
Hume	9.54	17.71	8.17
Gippsland	4.15	28.42	24.27
Western Metro	10.80	22.87	12.07
Northern Metro	9.42	25.49	16.07
Eastern Metro	10.00	23.53	13.53
Southern Metro	7.10	20.27	13.17

Source: VAGO, based on data from DHSV.

Figure 2E shows the average wait time for general care across all regions from 2012−13 to 2015−16. In 2015−16, there was 5.7 months' difference between the shortest (Loddon Mallee region) and longest (Northern Metro region) average wait time across regions.

Figure 2E
Average wait time for general dental care in each region, 2012–13 to 2015–16

Region	Wait time (months)			
	2012–13	2013–14	2014–15	2015–16
Barwon	22.1	16.9	15.3	17.1
Grampians	12.9	7.8	8.6	12.0
Loddon Mallee	20.9	18.1	14.6	11.8
Hume	19.1	8.6	9.3	12.9
Gippsland	19.9	10.0	7.1	14.8
Western Metro	17.7	14.5	15.4	16.3
Northern Metro	16.6	12.3	13.7	17.5
Eastern Metro	17.1	13.1	12.5	15.5
Southern Metro	18.0	10.8	10.6	14.1

Note: Increased funding through the first NPA contributed to reductions in wait times in all regions in 2013–14 and in some regions in 2014–15.
Source: VAGO, based on data from DHSV.

Although the average wait times for general dental care declined from 2012–13 to 2013–14, since then they have been increasing in some regions. Five regions continued to experience a decline in average wait times in 2014–15.

Wait time data does not capture all patients who have to wait for care. Wait time data is measured from the time a patient is placed on a waiting list to the date they are sent a letter of offer for an appointment. It does not include the time following a patient being offered an appointment to the time they respond, which can take up to three months.

Patients from a priority access group are not placed on the waiting list and they are not included in this measure, even though they may have to wait two to four weeks to be treated. The measure also does not include people who choose to 'sit and wait' for dental care and are treated the same day because a pre-booked patient did not attend. Part 5 discusses performance measures in more detail.

Wait times for emergency care

In Victoria, about 40 per cent of public dental courses of care are for emergency or episodic care. Under their purchasing agreements with DHSV, CDAs are required to meet the targets for delivering emergency care based on the dental emergency triage categories. Triage category 1 clients are assessed as needing treatment within 24 hours, triage category 2 clients as needing treatment within seven days and triage category 3 clients as needing treatment within 14 days. The targets that CDAs must meet are:

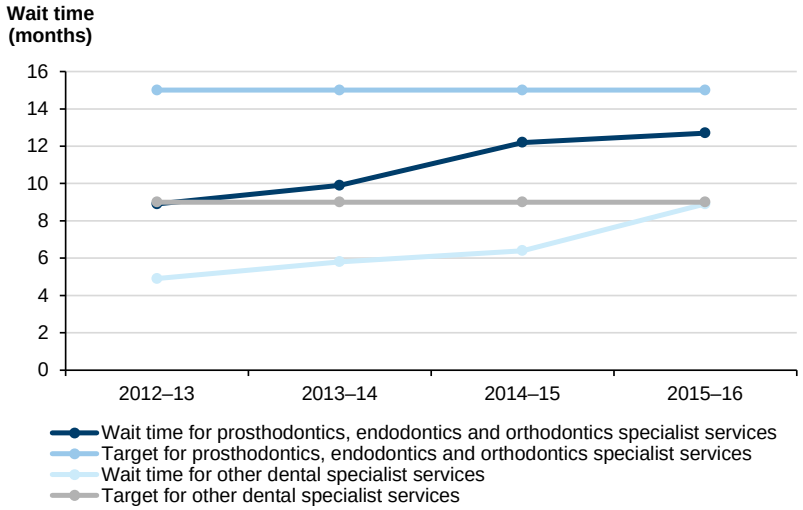
- 85 per cent of triage category 1 clients treated within 24 hours
- 80 per cent of triage category 2 clients treated within seven days
- 75 per cent of triage category 3 clients treated within 14 days.

A review of DHSV board reports shows that from 2014–15 to 2015–16 CDAs have consistently exceeded these targets at a statewide level.

Wait times for specialist care

Wait times for access to specialist services at the Royal Dental Hospital of Melbourne have increased over time, although they have been within targets. This is illustrated in Figure 2F.

Figure 2F
Wait times for specialist services at the Royal Dental Hospital of Melbourne, 2012–2016



Source: VAGO, based on data from DHSV.

2.5.3 Delivery of minimal intervention dentistry

CDAs deliver some elements of an MID approach through preventive treatments such as applying fissure sealants to teeth to prevent tooth decay. However, there is scope to expand this approach to enhance early detection and intervention by prioritising access based on assessing a patient's risk of tooth decay, and to encourage better oral hygiene. People's ability to maintain good oral health depends on their understanding of good oral health behaviours and their use of that knowledge to manage their oral health. CDAs are able to provide patients with oral hygiene instruction when delivering public dental services. However, this is only provided during treatment, and there is no regular follow-up to determine whether patients are following instructions and are better managing their oral health, unless they are a child or young person.

Under their purchasing agreements with DHSV, CDAs are required to assess all eligible children aged 0–17 years for risk of tooth decay. CDAs must make sure that 100 per cent of eligible children aged 0–17 years are recalled (offered a follow-up appointment) at 12, 18 or 24 months, depending on whether they are assessed as being at high, moderate or low risk of tooth decay.

Data from DHSV shows that regions have met these average recall interval targets between 2012–13 and 2015–16, with statewide recall interval rates reducing over this period. In 2015–16, the statewide average recall intervals for high-, moderate- or low-risk patients were 9.4, 13.6 and 12.5 months respectively. However, there was variation across CDAs—the lowest and highest average recall intervals were:

- for high-risk patients—3.7 months and 11.6 months respectively
- for intermediate-risk patients—4.4 months and 17.5 months respectively
- for low-risk patients—4.9 months and 21.9 months respectively.

Data at 30 June in 2014, 2015 and 2016 showed that there were no children overdue for recall. The percentage of children responding to recall offers between 2012–13 and 2015–16 increased slightly from 55.2 per cent to 57.5 per cent.

2.5.4 Meeting demand for public dental services

The ability of CDAs to meet time frames depends on both demand for public dental services and their capacity to address this demand. CDAs currently vary in their ability to meet increasing numbers of people on waiting lists.

Demand for public dental services

Public dental waiting lists are often used to measure demand, yet they have limitations as an indicator of real demand. This is because they:

- include only a small proportion of eligible people and those seen in public clinics
- do not include people who are eligible for and need public dental care, but who do not put themselves on waiting lists.

CDAs are required to manage their own waiting lists in line with departmental policy and guidance. Waiting list numbers vary across all regions. Figure 2G shows that waiting list numbers declined between 30 June 2013 and 30 June 2014 but that they have since increased across all regions up to 30 June 2016.

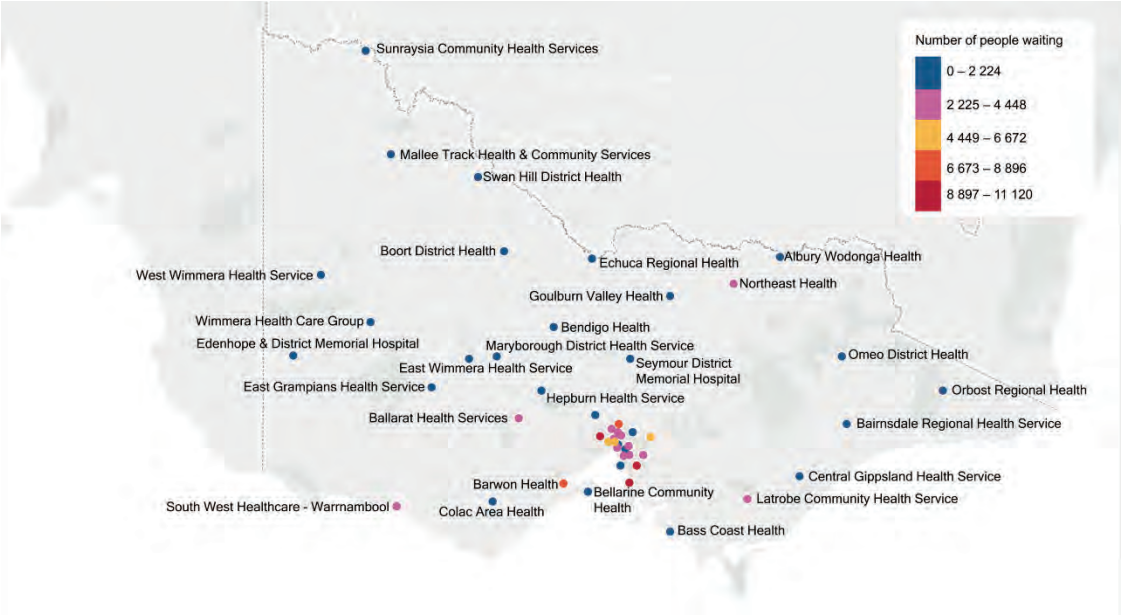
Figure 2G
Number of people on waiting lists in each region at 30 June, 2013–16

Region	June 2013	June 2014	June 2015	June 2016
Barwon	12 484	7 146	11 964	14 827
Grampians	4 568	3 189	5 108	6 624
Loddon Mallee	9 212	6 311	6 673	6 775
Hume	7 337	4 503	7 341	9 137
Gippsland	9 084	3 792	8 141	9 753
Western Metro	17 298	13 633	17 115	19 217
Northern Metro	16 121	14 139	25 037	26 484
Eastern Metro	17 389	12 666	17 535	18 669
Southern Metro	23 853	13 787	25 983	30 627

Note: Increased funding through the first NPA contributed to reductions in numbers of people on waiting lists at 30 June 2014.
Source: VAGO, based on information from DHSV.

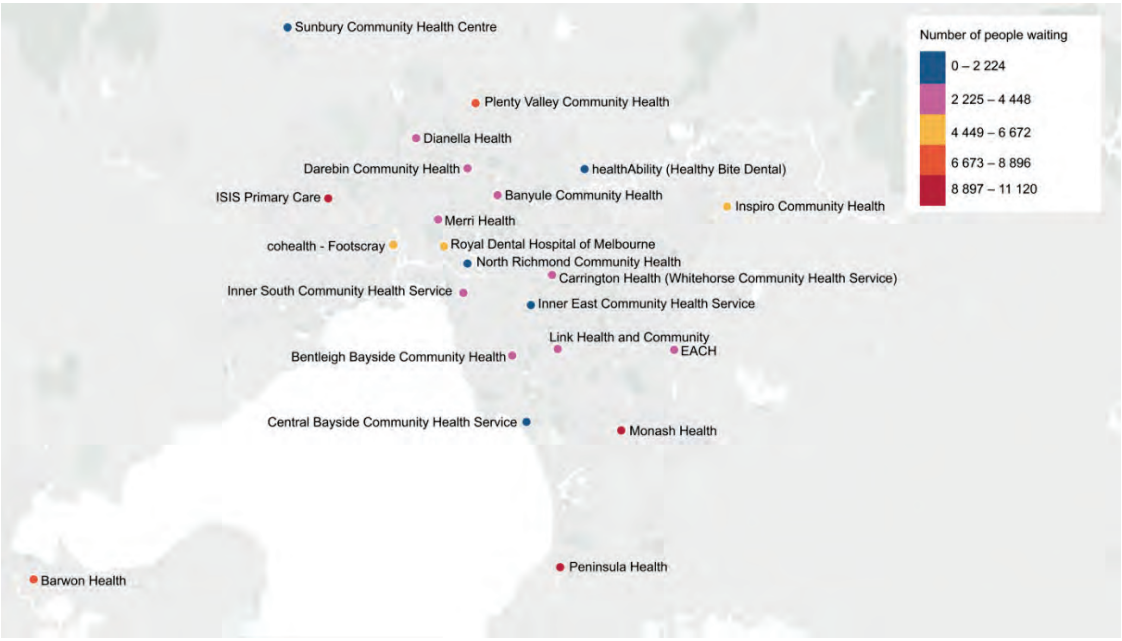
Figure 2H and 2I show the distribution of people waiting for general care across all CDAs at 30 June 2016. At 30 June 2016, the percentage of the eligible population waiting for general dental care ranged from 3.9 per cent in the Loddon Mallee region to 7.5 per cent in the Barwon region. Although the number of people waiting for care is higher in metropolitan rather than rural regions, this can partly be attributed to metropolitan regions having 2.5 times the number of eligible people in their catchments (1 747 182 people) compared to rural regions (709 796 people).

Figure 2H
People waiting for general care across all CDAs, 30 June 2016



Note: Data uses the primary location for CDAs with multiple locations.
Note: Map does not include CDAs without data. The Royal Children's Hospital and Rumbalara Aboriginal Co-operative Limited have patients with priority access so they are not placed on waiting lists.
Source: VAGO, based on data from DHSV.

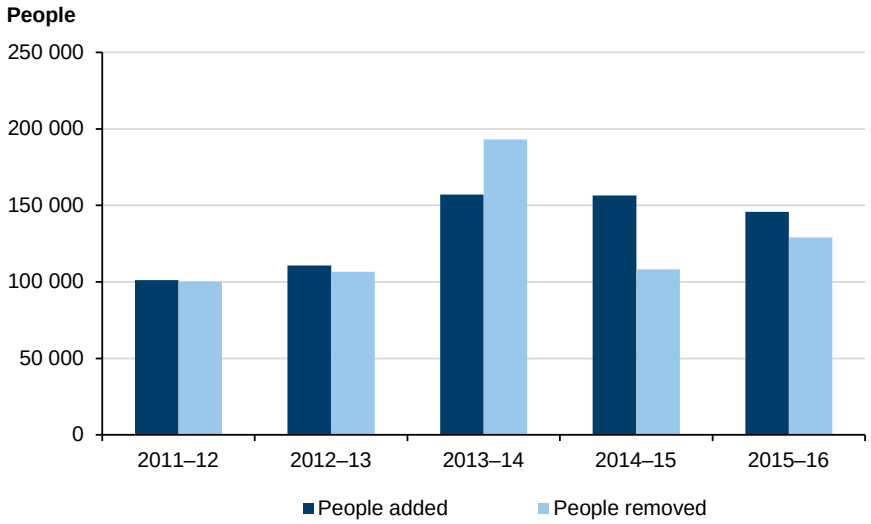
Figure 2I
People waiting for general care across metropolitan CDAs, 30 June 2016



Note: Data uses the primary location for CDAs with multiple locations.
Note: Map does not include CDAs without data. The Royal Children's Hospital and Rumbalara Aboriginal Co-operative Limited have patients with priority access so they are not placed on waiting lists.
Source: VAGO, based on data from DHSV.

Figure 2J shows that the total number of people added to all waiting lists has been greater than the total number removed from all waiting lists, except in 2013–14. With increased funding has come increased demand for public dental services. While CDAs were able to meet demand in 2013–14—with more people removed from all waiting lists than added to them—this capacity to meet demand has not been sustainable.

Figure 2J
Total number of people added to and removed from all waiting lists, 2011–12 to 2015–16



Note: Additional funding through the first NPA contributed to both an increase in the number of people added to waiting lists from 2013–14 to 2015–16 and a large number removed in 2013–14.
Source: VAGO, based on information from DHSV.

Under the current decentralised approach to managing waiting lists, people can put their name on multiple waiting lists at clinics. This, in turn, means that information about demand at the system level is not accurate.

Demand is also influenced by barriers people face in seeking access to CDAs. This is discussed in Part 4.

Capacity to meet demand

CDAs currently vary in their capacity to meet demand—in 2015–16 wait times for general care ranged from 1.04 months to 28.42 months. Figures 2K and 2L show the average wait time in months for general care across all CDAs in 2015–16.

Figure 2K
Average wait time (months) for general care across all CDAs, 2015–16

Note: Data uses the primary location for CDAs with multiple locations.
Note: Map does not include CDAs without data. The Royal Children's Hospital and Rumbalara Aboriginal Co-operative Limited have patients with priority access so they are not placed on waiting lists.
Source: VAGO, based on data from DHSV.

Figure 2L
Average wait time (months) for general care across metropolitan CDAs, 2015–16

Note: Data uses the primary location for CDAs with multiple locations.
Note: Map does not include CDAs without data. The Royal Children's Hospital and Rumbalara Aboriginal Co-operative Limited have patients with priority access so they are not placed on waiting lists.
Source: VAGO, based on data from DHSV.

The department publishes quarterly aggregated data on the Victorian Health Services Performance website on the average wait time for treatment for general, denture and priority denture care. It does not publicly report agency wait times, as the data is accurate only at a point in time—these times represent the wait time for those offered care in the past and do not necessarily represent how long patients will need to wait in the future. CDAs inform eligible people of wait times when asked. While we acknowledge that wait time data is accurate only at a point in time, making this data publicly available could assist patients in making decisions about accessing public dental services, as they could compare wait times at different CDAs in their region.

3 Barriers to a preventive approach

Most oral diseases can be prevented, and access to preventive oral health care can promote good oral health and minimise oral disease.

Part 2 identified that while community dental agencies (CDA) employ some elements of a minimal intervention dentistry (MID) or preventive approach to oral health care, there is scope to expand this focus. This Part reviews the barriers that face the Department of Health & Human Services (the department), Dental Health Services Victoria (DHSV) and CDAs when attempting to adopt a preventive approach to delivering public dental services. It also provides examples of preventive approaches.

Putting in place a more comprehensive preventive approach requires:

- a funding model that encourages delivering optimal outcomes for patients rather than outputs
- a workforce with the appropriate skills and scope to cost-effectively deliver oral health assessments, education and support for patients to manage their own oral health
- integrated delivery of oral health and general health care services to provide opportunities for early intervention and health promotion, and improved outcomes
- strategic leadership and a long-term transition plan.

DHSV's *2016–2021 Strategic Plan* has a strengthened commitment to improving patient outcomes, which includes a goal to embed preventive models of care throughout the public dental sector. This will incorporate health promotion, prevention and treatment including recall programs, MID and appointment of appropriate staff.

3.1 Conclusion

The current funding model encourages CDAs to focus on treatment to meet output-based targets. This funding model is a barrier to a more comprehensive preventive approach to public dental care. While the decision to align the state funding model with the Commonwealth model reduces the administrative burden of reporting for CDAs and the risk of inaccurate accountability reporting that could arise from the complexity of operating under two different funding models, it does not encourage an MID approach to help people keep their natural teeth and reverse the progression of oral disease. Reliance on this funding model and uncertain Commonwealth funding limits innovation in service provision and does not encourage an efficient workforce mix for delivering a preventive approach.

Helping CDAs make the transition to a preventive approach will require a long-term strategy that addresses current workforce limitations in delivering a cost-effective preventive approach and is supported by CDAs and the general health sector. Failing to implement change will prevent the public dental sector from achieving its objective of improving patient outcomes efficiently and economically for future generations of eligible people.

3.2 Funding models for public dental services

Funding models for public dental care have traditionally been focused on treating the high levels of oral disease in the eligible population. This focus on delivering treatments to meet performance targets and funding requirements has limited the ability of CDAs to identify and put in place more innovative or effective approaches to addressing demand for public dental services.

3.2.1 Funding recommendations in previous VAGO audits

In our 2002 audit *Community Dental Services*, we found a service system facing increasing demand and a mismatch between the mix of services being delivered and priorities for promoting oral health. We recommended that the former Department of Human Services (DHS) make the funding formula clearer and more transparent.

In response to our 2002 recommendation and our 2005 follow-up audit, DHS reviewed the funding model for public dental services in 2007. It concluded that the dental funding model was unnecessarily complex and lacked transparency. DHS also determined that having several prices for the same service was negatively affecting the sector. In 2011, the department introduced a new activity-based funding model and committed to reviewing it after a two-year transition period.

3.2.2 National Partnership Agreement

In 2013, the Commonwealth and state governments entered into the first National Partnership Agreement (NPA) for dental services. The Commonwealth Government contributed $85.4 million over two years to help the state treat more public dental patients. The NPA funding required CDAs to use an output-based funding model focused largely on treatment to reduce the waiting list. While states were required to report against specific output measures, nothing in this or the subsequent NPA prevented individual states from using their own reporting or performance measures within their jurisdiction.

CDAs had to reach NPA targets as well as targets for state-funded public dental services. To minimise the administrative burden on CDAs and to reduce the risk of not meeting output targets due to reporting inaccuracies caused by having two different funding models, the former Department of Health decided to align the state funding model and activity targets with the Commonwealth model. The Department of Health chose not to review the 2011 state activity-based funding model after the two-year transition period, and implemented a state funding model aligned with Commonwealth requirements.

3.2.3 Past and present funding models

The changes to funding models for delivering public dental service are outlined in Figure 3A.

Figure 3A
Past and present funding models for public dental services

Period	Funding model
Up to 30 June 2011	'Item-based' funding model, based on the number of services provided
1 July 2011 – 30 June 2013	Dental Unit of Value funding model—'activity-based' funding model, based on completing dental care for a person
1 July 2013 – present	Dental Weighted Activity Unit (DWAU) funding model—'outputs-based' funding model introduced under the Commonwealth NPA on Treating More Public Dental Patients

Source: VAGO.

3.2.4 Impact of the funding model on delivery

Funding models drive the types of services that CDAs deliver. The parameters of the current Commonwealth funding model, together with significant demand for treatment services, limit capacity to reprioritise funding from treatment to dedicated preventive approaches.

Output-based funding—the Dental Weighted Activity Unit

The Commonwealth funding model is an output-based funding model, which uses a DWAU as an activity measure.

Funding allocation is based on items set out in the *Australian Schedule of Dental Services and Glossary*, which are mainly treatment-based activities. Each item is given a weighting that takes into consideration the complexity and length of time required to complete it. For example, carrying out a tooth extraction is worth at least 0.23 DWAUs, whereas five minutes of oral hygiene instruction is worth 0.09 DWAUs.

A system that rewards more complex and time-intensive treatment activities does not encourage CDAs to carry out preventive activities. It reinforces the treatment focus of public dental service delivery.

Costly service delivery

Most oral problems can be prevented. Early detection and preventive interventions, including oral health education, can help people to avoid costly treatment interventions.

Figure 3B shows the top 10 most common procedures carried out at CDAs. Costs of these procedures are based on the Department of Veterans' Affairs dental fee schedule. This shows that preventive and early detection interventions are less costly than restorative and treatment-based interventions.

Figure 3B
Department of Veterans' Affairs fees for the most common services provided by Victorian community dental agencies

Service	Cost
Preventive, early detection	
Oral hygiene instruction	$50.30
Fissure sealing—per tooth	$46.85
Removal of calculus—first visit	$91.20
Concentrated remineralising agent application—single tooth	$27.50
Topical fluoride application	$35.15
Restorative	
Removal of a tooth or part(s) of a tooth	$133.55–$165.85
Filling, one-surface, rear tooth	$125.40
Filling, two-surface, rear tooth	$157.45
Filling, one-surface, front tooth	$117.40
Removal of an additional tooth or part(s) of a tooth	$84.15–$107.40

Source: VAGO, based on information from DHSV and the Department of Veterans' Affairs *Dental Fee Schedule*, 2014, 10th edition.

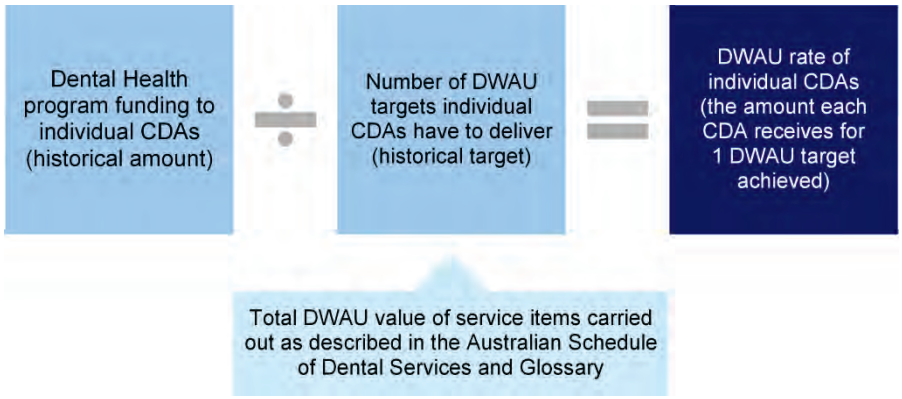
Inequitable funding of state-funded outputs

In an outputs-based funding model, CDAs should be allocated funding at the same rate for the delivery of each output, in this case a DWAU. This occurs for delivery of Commonwealth-funded outputs delivered under NPAs. However, it does not occur for delivery of state-funded outputs, resulting in some CDAs receiving more funding than others.

Under the NPAs, CDAs were funded at a standard rate for each Commonwealth DWAU delivered. Yet in 2015–16, CDAs were funded at different rates for delivery of state-funded DWAUs, ranging from $371 to $475. This is due to past funding allocations and targets being carried over to the current funding model.

When public dental services moved to the Commonwealth funding model, the department did not proceed with its planned review of the historical funding allocations and targets. As a result, instead of a predetermined uniform rate for delivery of one DWAU target, rates are determined for each CDA by dividing their historical funding allocation by their historical targets. This is illustrated in Figure 3C.

Figure 3C
Dental Weighted Activity Unit model of funding to community dental agencies



Source: VAGO.

The current state DWAU rate does not take into consideration variables specific to CDAs that affect their ability to deliver care, such as their remoteness (geographical location) or the complexity of their clients. For example, CDAs that have significant refugee and asylum seeker populations within their catchment could be expected to have higher than average interpreter costs. Although hospitals receive funding for interpreters, CDAs have found this inadequate.

DHSV has been working to address this funding inequity. The department and DHSV have not yet set time lines for implementing a statewide DWAU rate informed by sound analysis of reliable data.

Limited long-term planning

The Commonwealth Government has contributed much-needed funds to address pressure on waiting lists. However, relying on uncertain, inconsistent NPA funding to address demand in the short term does not encourage the department, DHSV or CDAs to plan effectively to meet demand in the long term. It is also strategically unwise, as it increases demand in a system that is already unable to cope with existing demand. Commonwealth funding through NPAs has defined end dates with no commitment to future funding. States are required to meet Commonwealth targets as well as state-funded targets in order to receive Commonwealth funding. This means that CDAs potentially increase demand for access without knowing whether they can meet it.

To date, Victoria has over-delivered on both NPA targets—by 161 per cent for the first NPA and by 174 per cent for the second NPA. DHSV undertook significant planning and coordination to support CDAs to deliver their targets for NPAs, including:

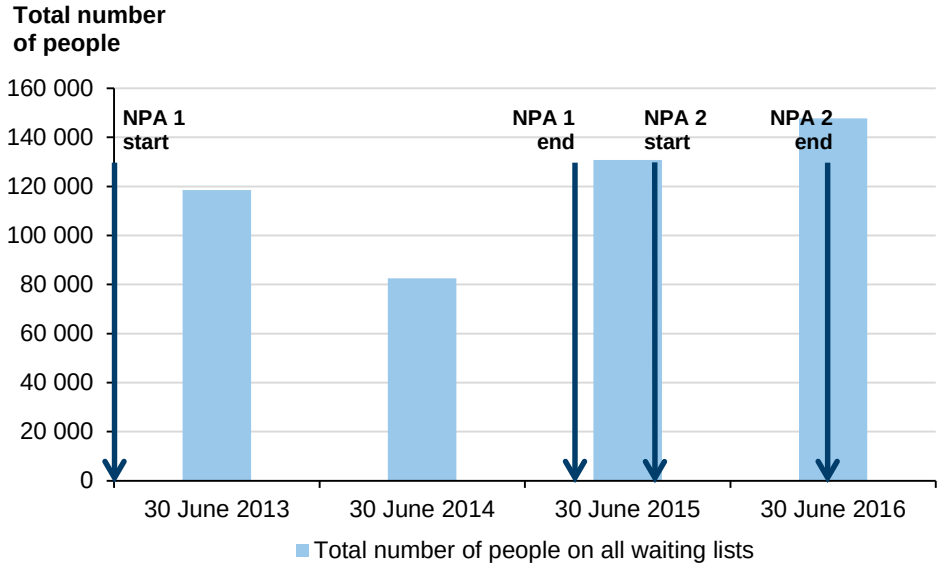
- reviewing and increasing the capacity of the public dental system to deliver the targets
- using private sector capacity through three voucher schemes:
  - Victorian Emergency Dental Scheme—designed to help CDAs to cope with peaks in demand for emergency care (valid for one month from date of issue)
  - Victorian General Dental Scheme—may be offered to patients on public general waiting lists, particularly where CDAs do not have the capacity to provide in-house care or where additional funding is available (valid for three months from date of issue)
  - Victorian Denture Scheme—designed to allow more patients to receive dentures (valid for three months from date of issue).

Between June 2013 and June 2014, the number of vouchers issued as a proportion of total public dental service activity increased from about 7 per cent (23 000 vouchers) to 23 per cent (121 000 vouchers) under the first NPA.

Between July 2015 and June 2016, 51 457 vouchers were issued under the second NPA. These accounted for about 13 per cent of total public dental service activity.

NPA funding has not been able to deliver a sustained reduction in pressure on wait times and waiting lists. The first NPA reduced waiting list numbers for 15 months. It also reduced wait times for general care from 2012–13 to 2014–15 and wait times for general denture care from 2012–13 to 2013–14. However, waiting list figures have since increased, despite a second round of NPA funding (see Figures 3D and 3E). The second round of NPA funding was a smaller amount of $38.45 million.

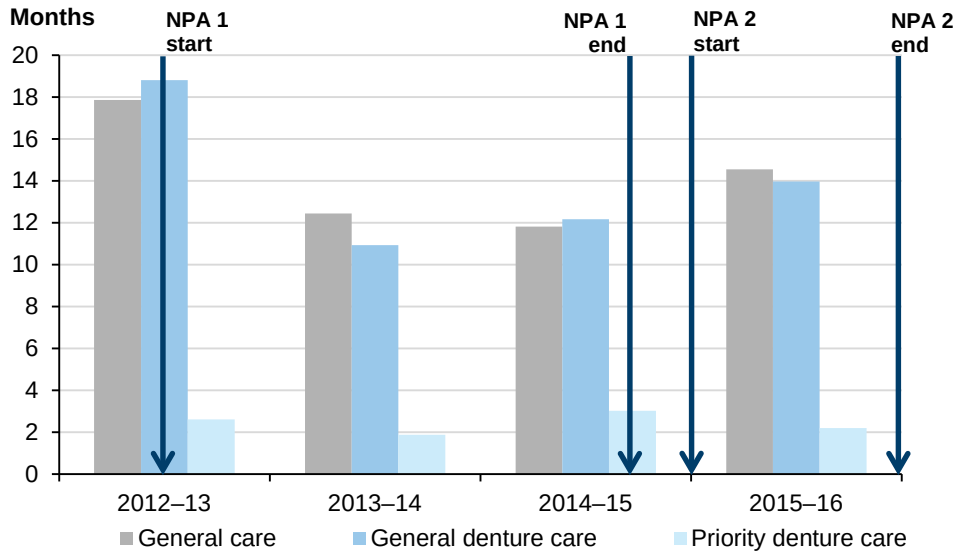
Figure 3D
Impact of NPA funding on total waiting list numbers
January 2013–June 2016



Note: Victoria received funding between January 2013 and March 2015 under the first NPA, and from July 2015 to June 2016 under the second NPA.

Source: VAGO, based on data from DHSV and information from the NPA.

Figure 3E
Impact of NPA funding on average wait times for all waiting lists
2012–13 to 2015–16



Source: VAGO, based on data from DHSV and information from the NPA.

3.3 Dental workforce

A range of dental and oral health professionals provide dental services in the private and public dental sectors. Each role requires specific minimum levels of education and has a standardised scope of practice, which outlines the procedures that members of the profession are allowed to perform.

Dental hygienists, dental therapists and oral health therapists may only work within a structured professional relationship with a dentist. Within these arrangements, these practitioners can provide preventive interventions and oral health promotion.

3.3.1 Dental workforce issues and their impact

The public dental sector has long had difficulties with recruitment, particularly in regional and rural areas. This is due to several factors, including the pay differences between the private and public sector, and between Victoria and other jurisdictions. Rural and remote community dental agencies face additional recruitment challenges due to their location. Recruiting difficulties can lead to backlogs in dental care, resulting in longer waiting lists and wait times.

The cost-effectiveness of the public dental workforce is a key consideration in a public health system with competing needs and limited resources. To achieve a cost-effective system, the most resource-intensive staff (dentists) should focus on the most complex and difficult types of services, such as treatment. The least expensive staff should carry out other services that they can be trained to deliver safely and competently, such as oral health education.

It is not cost-effective for dentists to carry out preventive activities that other members of the dental care team can do. However, according to self-reported data from CDAs, dentists make up about 61 per cent of the total effective full-time Victorian public dental workforce. This is a barrier to the cost-effective delivery of the elements of a preventive approach, such as risk assessments of patient behaviours that lead to tooth decay, oral health education, and support to help patients better manage their oral health.

Making members of the dental care team other than dentists responsible for preventive work depends on CDAs having the appropriate mix of staff. It also requires building the capacity and capability of other team members to do such work. The mix of staff in CDAs varied. One CDA we visited had dentists and dental assistants, but no dental hygienists or oral health therapists.

3.4 Integrating oral health and general health

Poor oral health shares common risk factors with other general health problems. According to the World Health Organisation, the four most prominent chronic diseases—cardiovascular diseases such as heart attacks and stroke, diabetes, cancer and chronic obstructive pulmonary diseases (progressive lung diseases)—share common risk factors with oral diseases. These risk factors are preventable lifestyle behaviours including poor diet, smoking, excessive alcohol intake and illicit drug use.

Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024 states that including oral health in all relevant models of care in the general health sector helps optimise patient outcomes, improves collaboration between health professionals, and develops understanding of the links between oral health and general health.

Most CDAs are part of community health centres or hospitals that are also responsible for delivering a wide range of other services. The department has funded primary care partnerships to improve local service coordination and use of standardised tools and processes for referrals and information sharing between a range of services. In 2012, the department introduced a single-page questionnaire to screen for patients' needs, which includes a question on oral health. According to the *Service Coordination Survey 2015*, 48 per cent of all respondents had used this screening tool for referring patients to other services.

Despite the policy drive for a more holistic approach linking general and dental health care, this tends to occur on an ad hoc basis across CDAs and is a missed opportunity to detect tooth decay and intervene at an early stage. It can also lead to poor patient outcomes.

Three CDAs we visited mentioned they had patients who had seen a doctor for a toothache and were prescribed antibiotics but were not referred to a dentist. CDAs identified a need to improve referral pathways from doctors but said they lacked the time or resources to develop partnerships with their local doctors and improve referral pathways.

The current funding model and model of care for delivery of public dental services does not encourage a holistic, patient-centred approach to service delivery.

3.4.1 Promoting linkages with the general health system

Both DHSV and individual CDAs have made efforts to address the lack of service coordination. DHSV has:

- advocated for service coordination through its 2011 report *Links Between Oral Health and General Health: The case for action*
- contributed to the inclusion of oral health questions in the maternal and child health framework for children at the eight-month, 18-month and 3.5-year consultations and in the Birthing Outcomes System for pregnant women.

DHSV's *2016–2021 Strategic Plan* includes a five-year strategy to integrate oral health into other relevant programs and has 'increased referrals between the general and oral health sectors' as a measure for monitoring progress.

Individual CDAs also demonstrated efforts to integrate oral health into other areas of health. For example, one CDA included an oral health question in the hospital's central patient admission assessment and risk screening form. It also developed an e-referral system in 2014 so that professionals and members of the public can refer anyone to dental services through the hospital's website. The system was targeted at priority access groups. An evaluation found that the e-referral system increased access to public dental services by refugees (by 200 per cent), people with an intellectual disability (by 117 per cent), homeless people (by 31 per cent), pregnant women (by 30 per cent) and clients with a mental illness (by 15 per cent).

However, a systemic approach to integrating oral health into other areas of health would require changing the current funding model and model of care for delivering public dental services.

3.5 A preventive approach to delivering public dental services

While the benefits of a preventive approach are well known, application of such an approach is still in the early stages.

3.5.1 Local case studies

We identified two examples of public dental clinics acting to deliver a preventive model of care. These are described in Figures 3F and 3G.

Figure 3F
Case study: Implementing a preventive approach in a community health centre

One community health centre in Melbourne uses a prevention-based health-promoting model of oral health care in its public dental clinic. Under this model, all new clients and clients on the waiting list attend an assessment with a dental practitioner and a pre-clinical interview with a dental assistant to obtain medical, dental, family and social history, and dietary information. The dental assistant from the most appropriate cultural group or one familiar with patients' specific health beliefs will greet them, interview them in their first language, if appropriate, and continue to support them throughout their care. This information is used to determine each patient's risk category and prepare a management plan in partnership with the patient.

All patients assessed as high risk for either tooth decay, gum disease or both are referred to an 'oral health educator', a dental assistant who has completed a Certificate IV in Dental Assisting (Oral Health Promotion). The oral health educator delivers targeted education sessions to patients including testing plaque and saliva, training on how to use preventive products, analysing and advising on diet, and review and follow-up. During these sessions, the patient and educator agree on goals for change. All high-risk patients must show good oral hygiene before moving to the next phase of their management plan. This hygiene is determined during review visits.

Under this model, patients on the waiting list are sent letters containing basic oral hygiene information. Patients are also informed that some treatments may be delayed until they demonstrate a minimum standard of oral health care. This message is delivered at least three times at various stages by all members of the dental care team, from reception staff to the dental assistant during the pre-clinical interview and the dental practitioner during the management planning discussion with the patient.

Those patients who do not want to participate in this model of care can attend a drop-in clinic or access emergency care.

In this model of care, all staff use the full scope of their skills. For example:

- receptionists are trained to also provide information and recommendations on dental care at home and relevant dental products
- dental assistants are encouraged to take further training (a 12-month part-time course) to become oral health educators and to help and support patients to manage their oral health.

Using reception staff and dental assistants—the least expensive resources in a dental team—provides a cost-effective model of delivering oral health education and supporting patients to improve their oral health care by addressing the determinants of health.

The community health centre is evaluating outcomes from this approach.

Source: VAGO.

As discussed in Section 3.2.4, CDAs are funded at different rates for each DWAU delivered, ranging from $371 to $475 for each DWAU. DHSV has told us that the community health centre discussed in Figure 3F receives a higher DWAU rate, which has allowed it to fund its preventive and restorative programs. However, while some CDAs may have greater capacity to use their funding flexibly, not all CDAs that receive the higher DWAU rate decide to trial innovative approaches to preventive care.

Figure 3G
Case study: Reorienting a community dental agency towards a preventive approach

One CDA we visited is reorienting its model of care toward a preventive approach. The new model of care will streamline pathways to accessing dental care and introduce a social and oral health risk assessment for all new clients. Upon completing their course of care, patients will be moved to a 'Sustainable Care' team which will give the patient oral health promotion education and support, such as making referrals to other appropriate services.

This transition is expected to take about five years. Progress so far has included:

- developing an oral health risk assessment template
- piloting the use of the oral health risk assessment for Aboriginal patients
- piloting integration with the mental health program in the main hospital
- developing a social risk assessment tool in collaboration with the refugee health program of the main hospital.

The time frame for this transition depends on the resources available to carry out such a project. Due to lack of funding, no staff member is specifically allocated to carrying out this project, and current staff members spend time on the project when they can.

Source: VAGO.

The CDA discussed in Figure 3G has a lower state-funded DWAU rate. The development of this model of care has been subsidised by various sources, including successful grant applications, funds from running dental conferences open to the public and private sector, and delivering the Commonwealth Child Dental Benefits Scheme, which has higher rebate rates for delivering care than this CDA's DWAU rate.

3.5.2 International case study

In the United Kingdom, a preventive approach to delivering public dental services is being implemented across the system.

Figure 3H
Case study: Systemically implementing a preventive approach

The National Health Service (NHS) provides public dental services in the United Kingdom. Private contractors deliver these services. An independent review of NHS dental services in 2009 found that:

- better aligning incentives for dentists would help to promote oral health and make dentistry more efficient
- good dentists receive little reward for improving oral health.

The reviewers recommended that:

- dental contracts have much clearer incentives for improving health, improving access and improving quality
- dental contracts be piloted for national application, including payments for continuing care responsibility, as well as rewards for both activity and quality
- the reward system of the revised contract explicitly recognises the quality of a service and the outcomes it achieves.

In response, the NHS has piloted ways to shift the focus of NHS dentistry toward prevention and oral health rather than focusing on treatment and repair. Since July 2011, this shift has been underway in 70 pilot sites. The shift involves:

- introducing a new clinical pathway based on managing risk, providing preventive care and encouraging healthy behaviours
- supporting the pathway by exploring new pay models based on capitation (paying based on the number of patients and their needs) and quality of care (clinical outcomes, patient experience and safety) rather than paying based on activity.

An Evidence and Learning Reference Group was set up to support the gathering of evidence and lessons from the pilots. This group's second report on the pilots found that:

- leadership within an organisation and support and commitment from staff and patients significantly helps in successfully adapting to the new system
- the new system reduced risks to, and improved the health of, patients who could be followed through the pathway.

The Evidence and Learning Reference Group aims to identify in detail the steps that will maintain the capacity of the service and ensure that the pathway is used appropriately.

Source: VAGO.

4 Addressing barriers to access

People from socially and economically disadvantaged backgrounds experience higher rates of poor oral health, often due to barriers that prevent them from accessing dental care. It is important to address these barriers to enable eligible people to access public dental services when they need to, and to encourage favourable visiting patterns.

According to the Australian Institute of Health and Welfare, people with favourable visiting patterns generally have good oral health, visit the same dentist once a year and visit for a check-up rather than a problem. People with unfavourable visiting patterns do not usually visit the same dentist, do not visit yearly, are often seeking treatment for a problem rather than a check-up and tend to have poorer oral health. However, as discussed in Part 2, current delivery of public dental services does not support all eligible people to improve their visiting patterns.

At the same time, increasing access to a public dental system already unable to meet demand creates additional pressures on the public dental system. This is a challenge that needs to be addressed strategically and systemically with leadership and coordination from the Department of Health & Human Services (the department) and Dental Health Services Victoria (DHSV).

This Part reviews the effectiveness of departmental and DHSV initiatives to address barriers to accessing public dental services.

4.1 Conclusion

The department and DHSV are not delivering a strategic approach to addressing barriers to access that takes into account the limitations of the current public dental system. They have not introduced effective measures to gauge whether initiatives to address barriers to access have improved oral health outcomes or encouraged better self-management of oral health. Implementing these initiatives without measuring their effectiveness will only increase pressure on a public dental system that is already unable to meet existing demand.

4.2 Effectiveness and efficiency of strategies

Current initiatives to increase access to oral health care are not being efficiently or strategically delivered and it is not certain if they have a lasting impact on improving oral health. Success is currently measured by an increase in the number of people accessing public dental services. This is a flow-on effect of a system that is focused on delivering outputs rather than optimal patient outcomes.

DHSV's *2016–2021 Strategic Plan*, which was released during our audit, has a strengthened commitment to improving health outcomes supported by goals and five-year strategies.

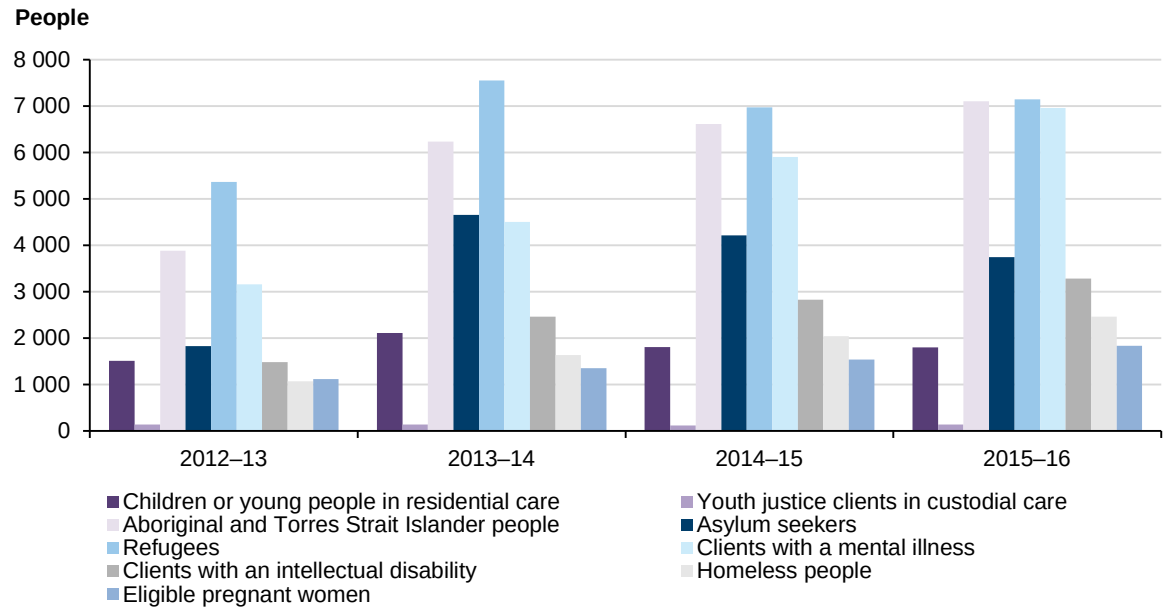
4.2.1 Improved access for target groups

In its *2013–2016 Strategic Plan*, DHSV focused on increasing access to treatment for all of the eligible population, with a specific focus on access for priority groups and people in rural and regional areas. It also aimed to increase access to specialist care.

Over two two-year periods, access increased slightly in rural and regional areas from 28.2 per cent (2012–13 and 2013–14) to 29 per cent (2014–15 and 2015–16).

From 2012–13 to 2015–16, access by all priority groups varied. DHSV's initiatives to increase access for specific priority groups generally resulted in increased access within the targeted groups. These priority groups include eligible children and young people, Aboriginal and Torres Strait Islander people, refugees and asylum seekers, clients with a mental illness, clients with an intellectual disability, homeless people and eligible pregnant women. This is illustrated in Figure 4A.

Figure 4A
Statewide access by priority access groups, 2012–13 to 2015–16



Note: This does not include access by eligible children or young people, which increased from 120 796 in 2012–13 to 161 672 in 2015–16.

Note: This data only identifies one priority access characteristic per person so there is no double counting of individuals. For example, a refugee child may have been counted as a child and not as a refugee.

Source: VAGO, based on data from DHSV.

DHSV's *2016–2021 Strategic Plan* has a strengthened commitment to improving health outcomes. DHSV states that every decision it makes will be supported by an evidence base to improve health outcomes.

4.2.2 Coordinating activities to address barriers to treatment

Most activities to address barriers to access were undertaken by individual CDAs without regional coordination or a systemic approach. To achieve a more systemic approach, the department needs to provide leadership, and DHSV needs to drive and coordinate initiatives that address need and aim to improve oral health outcomes in consultation with CDAs.

Before 2013, CDAs had opportunities to collaborate to address regional barriers to access using a more systemic approach. Under the 2007 departmental oral health plan, *Improving Victoria's Oral Health*, CDAs collaborated within regional oral health networks to develop regional oral health plans. These networks identified oral health needs and gaps within the region, and developed action plans to address regional priorities. From July 2010 to December 2013 every region received $100 000 a year to implement their plans.

In 2013, the department supported DHSV's approach to move away from regional oral health planning. Although it did not conduct a formal evaluation, DHSV identified duplication of problems and actions, and felt that it could better support CDAs to address these at a statewide level. Since then, DHSV has continued to provide regional oral health networks with administrative and secretariat support of $10 000 per year. This funding supports regions to continue holding networking meetings, with varied effectiveness.

We visited five CDAs in three regions. Only one of these regions continues to actively collaborate with oral health networks. Two CDAs in this region had successfully applied for funding from the department for a program to improve the oral health of Aboriginal and Torres Strait Islander people in their catchments. The program will provide outreach services and oral health education in community locations and aims to build the capacity of Aboriginal generalist health workers to perform dental screenings and provide referrals to public dental services.

DHSV's *2016–2021 Strategic Plan* states that it will collaborate with agencies on opportunities for improvement, particularly for priority groups.

4.3 Addressing barriers to treatment services

Only 31 per cent of the eligible population seek access to the public dental system. To date, the department and DHSV have not had a mechanism for identifying the specific barriers that result in low take-up of public dental services due to finite resources limiting their capacity to increase demand.

In its *2016–2021 Strategic Plan*, DHSV commits to identifying access barriers and to implementing strategies to overcome them. It states that some barriers might include fear and anxiety of dental services, difficulties navigating the system, and distance.

Although the department and DHSV have not identified specific barriers to access, they have worked with CDAs to address the most likely causes of barriers to access, which are:

- financial barriers—not being able to afford services
- cultural barriers—services to eligible people being disrespectful of, and inappropriate to, the community's beliefs, practices and cultural needs
- psycho-social barriers—life experiences making people resistant to dental treatment
- geographical barriers—services being physically inaccessible.

The public dental program aims to address some of these barriers by prioritising access for specific groups, namely:

- Aboriginal and Torres Strait Islander people
- homeless people and people at risk of homelessness
- refugees and asylum seekers
- children and young people
- registered clients of mental health and disability services
- pregnant women.

4.3.1 Financial barriers

For people on low incomes, cost is a key barrier to accessing dental services. Medicare does not cover dental care comprehensively, and the *National Dental Telephone Interview Survey 2010* found that 28 per cent of people avoided or delayed visiting a dentist due to cost.

Offering public dental care at a lower cost than private dental services addresses financial barriers to access. Figure 4B outlines the department's public dental fees policy.

Figure 4B
Department of Health & Human Services public dental fee schedule (patient co-payments)

Eligible cohort	General course of care	Emergency course of care	Dentures
People aged 18 years or over who hold a health care or pensioner concession card, or who are dependants of concession card holders.	$27.50 per visit. Maximum of $110 (includes an examination and all general dental treatment).	$27.50 flat fee (includes assessing and treating the tooth, gum or denture that is causing pain).	$66.50 per denture. Maximum of $133 for full upper and lower dentures.
Children aged 0–12 years who do not hold a healthcare or pensioner concession card and are not dependants of concession card holders.	$32.50 flat fee per child (includes an examination and all general dental treatment). Fees per family will not exceed $130.		

Source: VAGO, based on information from the Department of Health & Human Services.

Fees for specialist services at the Royal Dental Hospital of Melbourne depend on the treatment, and are capped at $332 for a course of care.

While some patients are charged a co-payment for treatment, most priority access groups do not have to pay fees for public dental services. In addition, the policy states that CDAs cannot refuse to provide a dental service because someone is unable to pay the fees.

CDAs assess the ability of patients to pay by considering a person's overall capacity to pay, taking into account other health service costs and whether they receive other available financial help, such as rent assistance.

Some people who are not eligible for public dental services are on low incomes and are unable to afford private health insurance or access private dental services. To help address the barriers for people in these circumstances, one CDA offers dental care at reduced rates through a private dental clinic on weekdays and a public dental clinic on Saturdays.

4.3.2 Cultural barriers

Aboriginal and Torres Strait Islander people, refugees and asylum seekers have priority access to the public dental system. The department, DHSV and CDAs have also introduced specific strategies to address barriers these groups might experience in accessing services.

Aboriginal and Torres Strait Islander people

The Australian Institute of Health and Welfare identified that Aboriginal and Torres Strait Islander people have poor oral health earlier in life and have more dental problems than other people. In addition, their dental problems are often more severe. They are less likely to seek access to treatment to prevent or address oral health problems, which can result in greater need for emergency oral health care.

DHSV has introduced strategies to improve access to public dental services for Aboriginal and Torres Strait Islander people, including:

- supporting two Indigenous students to study dentistry at La Trobe University from 2014 and 2015
- recruiting an Aboriginal community development officer at DHSV in 2014
- introducing an 18-month Indigenous Dental Assistant Traineeship program in 2012.

The number of Aboriginal and Torres Strait Islander people accessing public dental services increased by 83 per cent from 3 882 in 2012–13 to 7 106 in 2015–16.

Refugees and asylum seekers

Between January 2007 and December 2013, Victoria settled 31 375 refugees and asylum seekers—many more than at any time since the 1940s. Refugees and asylum seekers are at high risk of poor oral health for many reasons. The reasons include the closure of dental services during conflicts, disruption to dental hygiene practices, and shortage of clean water, toothbrushes and toothpaste.

From January 2012 to January 2013, the former Department of Health funded a Refugee Oral Health Sector Capacity Building Project to strengthen oral health service access and delivery. The Victorian Refugee Health Network worked on this project in partnership with DHSV. This project delivered two key outcomes—the development of a refugee and asylum seeker oral health model of care, and the Refugee Oral Health Targeted Education Program, a professional development curriculum for oral health service teams.

CDAs with many refugees and asylum seekers in their catchments have acted to improve their access to public dental services through:

- providing hospital tours and preparing information on accessing public dental care in key languages
- conducting research to identify barriers that pregnant refugees face accessing dental services.

The number of refugees and asylum seekers accessing public dental services increased by around 43 per cent from 8 425 in 2012–13 to 12 030 in 2015–16.

4.3.3 Psycho-social barriers

DHSV has acted to address barriers to access for people with a disability. This included offering small grants to day services across Victoria in 2012–14 to pilot ways to improve and promote the oral health of people with a disability. DHSV's Health Promotion team worked with participating day services to develop oral health promotion strategies.

As shown in Figure 4A, the number of people with an intellectual disability accessing public dental services increased by 121 per cent from 1 484 in 2012–13 to 3 281 in 2015–16.

CDAs participated in pilot programs to address the barriers experienced by people with mental illness. One CDA is doing research to assess the oral health risk of clients with mental illness at the governing hospital, and has identified opportunities to improve the referral pathway to dental services for these clients.

4.3.4 Geographical barriers

DHSV found that just over 82 per cent of eligible people live in areas that are within 10 kilometres of a public dental clinic. If the radius is extended to 20 kilometres, the coverage of the eligible population increases to 90 per cent. However, rural communities face greater geographical barriers to access, with only two-thirds of the eligible population in rural areas living in postcodes within 20 kilometres of a public dental clinic.

Three common ways of addressing geographical barriers to access are through:

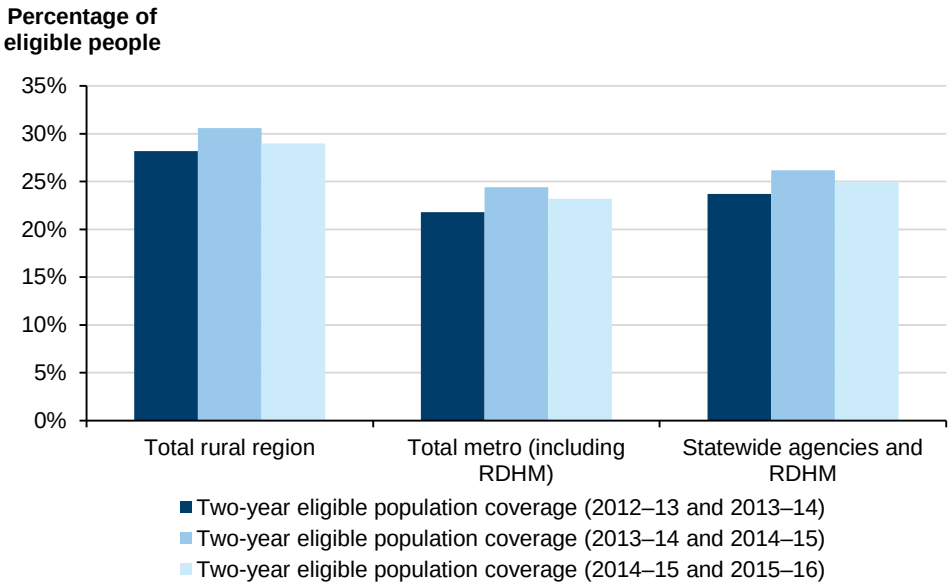
- outreach services—these provide services outside of traditional settings to a particular section of the community
- outpost services—providing services as a branch of an existing service that is at a distance from the main branch
- oral health screening and referral—screening for oral health needs carried out by oral health or allied health professionals and referring for follow-up, where appropriate.

DHSV has acted to address geographical barriers by partnering with the Australian Dental Association Victorian Branch and the Royal Flying Doctor Service Victoria in a mobile dental care pilot program to deliver outreach services to remote areas. It is improving access to specialist services through a tele-dentistry pilot—a partnership between dentists in selected CDAs and specialist staff at the Royal Dental Hospital of Melbourne. The pilot program uses telecommunications and information technology to provide specialist advice and advanced dental care to patients in rural and remote regions in Victoria.

In 2015 DHSV also started a program to train general dentists in particular speciality fields to reduce the need for patients to travel to the Royal Dental Hospital of Melbourne for treatment and care. DHSV has also been involved in integrating oral health screenings and referrals into the early childhood, midwifery and residential aged care sectors.

Figure 4C illustrates that overall there has been increased access to public dental services between 2012–13 and 2015–16, with a spike in access in the two-year period 2013–15, due to an injection of Commonwealth funding under the first National Partnership Agreement. A greater proportion of eligible people in rural areas accessed public dental services compared with metropolitan regions.

Figure 4C
Percentage of eligible people accessing public dental services over two-year periods, 2012–13 to 2015–16



Note: RDHM refers to the Royal Dental Hospital of Melbourne.
Source: VAGO, based on data provided by DHSV.

5 Monitoring and reporting on accessibility

A sound performance monitoring framework is essential for effectively managing public dental services. Such a framework should include comprehensive performance indicators that allow the Department of Health & Human Services (the department) and Dental Health Services Victoria (DHSV) to:

- show whether objectives of the public dental program have been achieved
- continually improve the delivery of public dental services
- prepare evidence-based strategies for the public dental program.

Population oral health data is not routinely collected in Australia. The Australian Institute of Health and Welfare collects data through its National Survey of Adult Oral Health and the Child Oral Health Survey, depending on the availability of ad hoc funding sources.

To be useful, performance indicators need to be relevant and appropriate, and consistently measure what they are meant to. The dental health indicators commonly used in literature and research to measure oral health are:

- tooth decay, measured by the number of decayed, missing and filled baby teeth (dmft) and permanent teeth (DMFT)—a higher value equates to more teeth affected by decay
- the number of potentially preventable hospitalisations for dental conditions—these are conditions where hospitalisation is thought to have been avoidable if timely and adequate non-hospital care had been provided earlier, such as dental conditions, pneumonia (not vaccine-preventable) and ear, nose and throat infections.

This Part reviews the adequacy of performance monitoring and reporting on outcomes achieved by Victoria's public dental health services.

5.1 Conclusion

Without clear outcomes-focused performance indicators, it is not possible to determine whether agencies are spending public money effectively. The current activities used to measure performance do not provide sufficient assurance that public dental services are improving outcomes for all members of the eligible population and, therefore, adequately meeting the needs of all eligible people. However, both the department and DHSV are working to address this gap in accountability.

5.2 Adequacy of the performance monitoring framework

The department and DHSV have a performance monitoring framework in place to monitor and report on the performance of the dental health program. However, their performance indicators to date have not been relevant or appropriate for assessing the achievement of oral health outcomes. This means that agencies are not effectively being held accountable for meeting the objectives of the dental health program.

5.2.1 Irrelevant and inappropriate performance indicators

Performance indicators should reflect how effectively and efficiently the public dental system is performing and whether desired outcomes are being met. As oral health is part of general health and wellbeing, we looked at the indicators in place to demonstrate:

- the department's performance in meeting the priorities of the *Victorian Public Health and Wellbeing Plan 2015–19*
- DHSV's performance in meeting the objectives of its *2013–2016 Strategic Plan* and as the lead agency overseeing delivery of *Healthy Together Victoria: Action plan for oral health promotion 2013–17*
- community dental agencies' (CDA) performance in meeting the objectives of their purchasing agreements.

To date, the department has not measured its performance in meeting the priorities of the *Victorian Public Health and Wellbeing Plan 2015–19*. While we conducted this audit, in October 2016 the department released the *Victorian Public Health and Wellbeing Outcomes Framework*, which identifies outcomes, indicators, measures and targets for monitoring and reporting on progress in achieving priorities.

The department's annual progress reports against the *Healthy Together Victoria: Action plan for oral health promotion 2013–17* do not show whether all expected outcomes from actions taken have been achieved, or whether the overall aim of improved oral health has been achieved. However, they do show that actions identified have been taken.

Part 1 of this report outlined the objectives stated in the state plans and DHSV's strategic plans. Under their agreements with DHSV, CDAs have an objective to maximise the eligible population that receives public dental care. Figure 5A outlines the key performance indicators for the dental health program that DHSV and CDAs are accountable for achieving. Because there are no indicators showing whether access to care has improved oral health outcomes, the targets are not appropriate for assessing whether outcomes have been achieved.

Figure 5A
Statement of Priorities key performance indicators

Category	Key performance indicator
Safety and quality	• Number of hospital-initiated postponements per 100 scheduled appointments • Health service accreditation • Ratio of emergency to general courses of dental care

Access—Emergency care	• Percentage of dental emergency triage:
	  • category 1 clients treated within 24 hours
	  • category 2 clients treated within 7 days
	  • category 3 clients treated within 14 days

Access—General and denture care	• Average recall interval for:
	  • high caries risk eligible clients aged 0–17 years (months)
	  • low caries risk eligible clients aged 0–17 years (months)
	• Waiting time for :
	  • prosthodontics, endodontic, and orthodontics specialist services patients (months)
	  • other dental specialist services patients (months)
	  • general care (months)
	  • denture care (months)
	  • priority denture care (months)

Service performance	• Total number of individuals treated • Dental Weighted Activity Units

Source: VAGO, based on information from the Department of Health & Human Services.

5.2.2 Action to address the lack of relevant indicators

Both the department and DHSV are working to address the lack of indicators to measure outcomes. However, the department's outcome measure for increased oral health is only targeted at children and will be unable to monitor progress in achieving increased oral health for adults eligible for public dental services.

Department of Health & Human Services

The department's *Victorian Public Health and Wellbeing Outcomes Framework* includes the rate of potentially preventable dental hospitalisations of children aged 0–9 years to measure an improvement in oral health. This aligns with commonly used dental health indicators. The department currently reports on this in the biennial Victorian Chief Health Officer's report, however, it is unable to break the data down according to socio-economic status due to validity issues.

The *Victorian Public Health and Wellbeing Outcomes Framework* also includes measures for other determinants of good oral health, such as low consumption of sugary drinks, cigarettes and alcohol.

Reporting against the framework will occur every third year of the four-year public health and wellbeing planning cycle. The framework will also influence and contribute to existing reporting, such as the Victorian Chief Health Officer's report.

Dental Health Services Victoria

The data that DHSV collects on tooth decay shows broad trends in improvements or deterioration. DHSV monitors dmft and DMFT rates across CDAs, regions and statewide. However, CDAs are not required to collect data about tooth decay in individuals who access their services, such as whether returning patients have less tooth decay and whether oral health has improved. The data on tooth decay is not comprehensive and its usefulness is limited.

In September 2016, DHSV released its *2016–2021 Strategic Plan*. One of DHSV's strategic goals is to develop and implement key health outcome indicators and a reporting framework. Initial efforts will be targeted at identifying indicators to monitor progress in improving health outcomes for children and pregnant women, with other age groups to follow. This includes:

- more children and pregnant women accessing services for routine care
- improved health outcomes for children by location and priority status
- fewer eligible children having untreated tooth decay.

A gap remains for monitoring outcomes for other eligible adults, including other priority groups. DHSV is working to develop oral health outcomes indicators by:

- participating in the International Consortium for Health Outcomes Measurement working group on oral health to develop a standard set of oral health outcome indicators that can be adopted worldwide
- designing a standardised reporting framework—including definitions and reporting processes—to enable reporting against agreed key performance indicators in the national oral health plan.

DHSV has improved the way it measures impacts for eligible people, such as:

- carrying out the Victorian Child Oral Health Survey in 2013–14, which will be used to create a national Child Oral Health Survey dataset
- developing and rolling out the Victorian Preschoolers Survey in 2015.

Data collected from these two surveys includes a clinical component measuring dental decay and socio-demographic and behavioural information. This data could provide a baseline for comparing the oral health of children. However, there is still a gap in showing improvements in the oral health of adults who use public dental services.

DHSV's *2016–2021 Strategic Plan* states that DHSV will design purchasing agreements with CDAs to drive improved oral health outcomes.

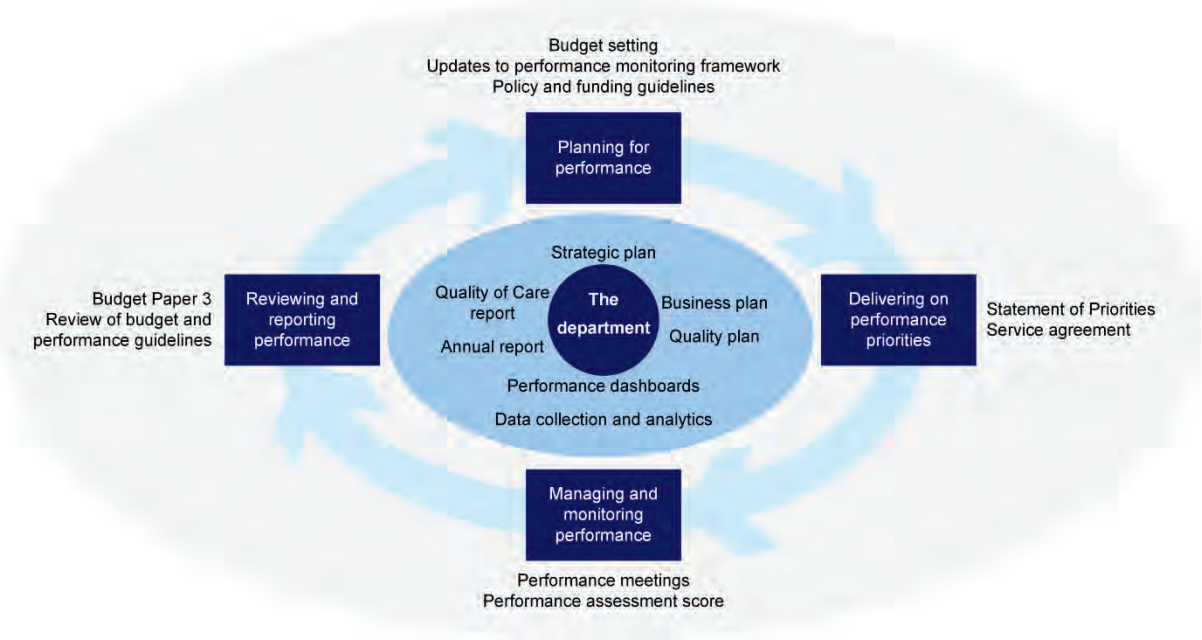
5.3 Features of the performance monitoring framework

Although the performance indicators are not relevant for assessing improved oral health outcomes, DHSV has adequate systems and processes in place for CDAs to report on their activities and for DHSV to monitor these activities and maintain the accountability of CDAs.

The department adequately oversees how DHSV performs in delivering funded outputs through existing monitoring arrangements.

Figure 5B shows how the department monitors DHSV's performance.

Figure 5B
How the Department of Health & Human Services monitors the performance of Dental Health Services Victoria



Source: VAGO, adapted from the Department of Health & Human Services, *High Performing Health Services: Victorian performance monitoring framework 2015–16*.

Key components of the performance monitoring framework are:

- Statement of Priorities (SoP)—an accountability document signed by DHSV and the Minister for Health that contains health priorities, key performance indicators for the dental health program and targets set by the government
- DHSV's strategic plans—the roadmaps that demonstrate how it intends to deliver on its goals.

The department uses the SoP indicators to monitor and assess DHSV's performance. Every three months, DHSV reports to the department on how well it has met the SoP targets. The department and DHSV meet regularly to discuss activities and progress towards meeting targets. They also discuss strategic or operational matters, such as delivering on National Partnership Agreements and finalising the SoP.

5.3.1 Monitoring the performance of community dental agencies

DHSV adequately monitors how CDAs are performing in meeting their funded output targets through existing processes.

DHSV uses four key tools and resources to monitor the performance of CDAs:

- **Purchasing agreements between DHSV and CDAs**—these outline the process for DHSV's monitoring of CDAs' performance and the performance targets the funded agency needs to meet in providing public dental services (see Figure 5B).
- **Agency Relationships team**—responsible for helping CDAs to fulfil their obligations, the team meets with each CDA every month to discuss performance in delivering dental services against baseline targets, and regional and state-level benchmarks.
- **Titanium patient management system**—this electronic system was built around the dental health program dataset, established by the department to record service provision data.
- **DHSV's extranet**—CDAs can access their agency's reports, user manuals and other important information from this secure website.

CDAs use Titanium to manage service delivery, including appointments, waiting lists, recall lists and recording clinical information for each patient. DHSV uses information from Titanium to produce individual agency reports.

DHSV provides each CDA with monthly, quarterly and annual reports listing their achievements against the key performance measures outlined in their purchasing agreement. Each performance target has a benchmark for underperformance and a risk rating. CDAs are told where they have underperformed and are required to provide an action plan and time lines to improve performance. This is monitored through the monthly reports.

The monthly reporting process allows DHSV to adequately monitor how CDAs perform and identify emerging problems. For example, in 2010, DHSV found that many CDAs were not meeting their child recall interval targets and many children were overdue for follow-up visits.

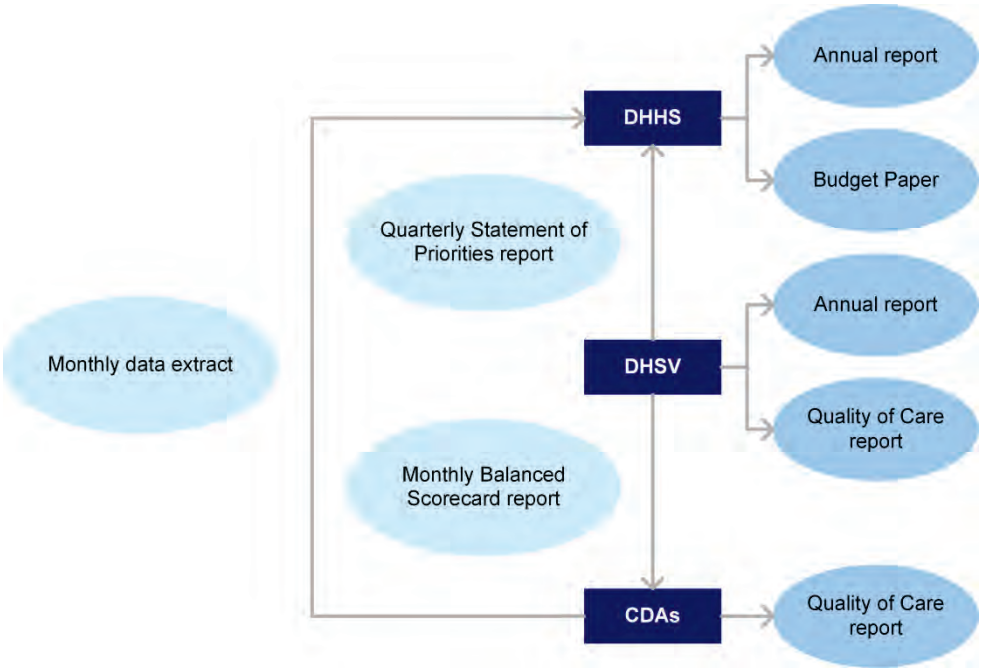
In response, DHSV began a project to help CDAs to meet their child recall interval targets, including providing additional staffing and funding, preparing a recall strategy to manage recall numbers quickly, and removing ineligible children (those who had become adults or those who did not hold a health care card and had turned 13) from recall lists. As a result, the number of children overdue for recall reduced from 25 560 in April 2010 to 1 626 at the end of October 2011. At 31 October 2016, there were no children overdue for recall.

5.3.2 Reporting on the performance of the dental health program

Dental health program performance measures are focused on outputs. As a result, reporting on the performance of the dental health program does not provide a clear indication of whether it is effectively meeting its objectives.

Figure 5C provides an overview of performance reporting on the dental health program.

Figure 5C
Performance reporting on the dental health program



Source: VAGO.

Department of Health & Human Services

The department's reporting does not provide a comprehensive picture of how it has provided access to care, because its approach to measuring performance does not assess whether it has achieved the stated objective of improved oral health.

The department reports on the performance of the dental health program through its annual report and *Budget Paper 3: Service Delivery*. Both reports show actual and targeted annual performance against five activity-based measures:

- number of people treated
- standard equivalent value units
- ratio of emergency to general courses of care
- waiting time for dentures
- waiting time for restorative (general) dental care.

The department has told us that these measures focus on outputs, in line with key frameworks such as the Department of Treasury & Finance's Performance Management Framework. As well as not providing information on the outcomes of service provision, the measures:

- do not show whether emergency care has been timely
- contain the measure of 'standard equivalent value units' which is obsolete, following departmental restructuring.

The department told us that it is reviewing the standard equivalent value units measure.

The department also briefs the Minister for Health on DHSV's performance against SoP measures and targets every year. The briefing highlights the financial performance and outputs that DHSV has delivered in the previous financial year and allows the minister to consider and approve the SoP agreement for the following year.

Dental Health Services Victoria

DHSV's annual report contains comprehensive information about its activities to deliver on its strategic plan, as well as its performance against SoP targets. It provides adequate accountability of DHSV's delivery of its commitments and outputs targets.

Community dental agencies

CDA reporting on the delivery of public dental services is focused on outputs. CDAs report on their activities through their health service's 'quality of care' report. Reporting only partly aligns with departmental guidelines because CDAs are unable to demonstrate and thus report on the outcomes of the service. However, CDAs report on the quality and safety of services, such as whether patients had to return for retreatment, as well as the total number of patients treated.

Appendix A.

Audit Act 1994 section 16—submissions and comments

We have consulted with the Department of Premier & Cabinet, the Department of Health & Human Services and Dental Health Services Victoria throughout the course of our audits, and we considered their views when reaching our audit conclusions. As required by section 16(3) of the *Audit Act 1994*, we gave a draft copy of this report, or relevant extracts, to those agencies and asked for their submissions and comments.

Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

Responses were received as follows:

RESPONSE provided by the Secretary, Department of Premier & Cabinet

Department of
Premier and Cabinet

1 Treasury Place
Melbourne, Victoria 3002 Australia
Telephone: 03 9651 5111
dpc.vic.gov.au

RECEIVED
29 NOV 2016
VICTORIAN AUDITOR-GENERAL'S OFFICE

B16/6718

Mr Andrew Greaves
Auditor-General
Victorian Auditor-General's Office
Level 24, 35 Collins Street
MELBOURNE VIC 3000

Dear Mr Andrew

Thank you for providing the proposed audit report *Access to Public Dental Services in Victoria* in accordance with section 16(3) of the *Audit Act 1994*.

I note that the audited department is responding to the proposed report.

Yours sincerely

Chris Eccles
Secretary

29 NOV 2016

RESPONSE provided by the Secretary, Department of Health & Human Services

Secretary

Department of Health and Human Services

50 Lonsdale Street
Melbourne Victoria 3000
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DX 210081

e4370009

RECEIVED
29 NOV 2016
VICTORIAN AUDITOR-GENERAL'S OFFICE

Andrew Greaves
Auditor-General
Victorian Auditor-General's Office
Level 24, 35 Collins Street
MELBOURNE VIC 3000

Dear Mr Greaves

Thank you for your letter of 17 November 2016, providing the final opportunity to comment on the proposed audit report *Access to public dental services in Victoria*.

The Department of Health and Human Services (the department) has reviewed the report and accepts the recommendations. Enclosed with this letter is the department's action plan to address the recommendations in the report.

Ensuring that vulnerable Victorians have access to affordable dental treatment services through the public dental program is a priority for the department. In addition, the department promotes good oral health through a number of initiatives and delivers important preventive activities such as water fluoridation.

The department notes that uncertainty about the Commonwealth Government's dental reform proposal is having a significant impact on the public dental program. A number of funding and policy arrangements are dependent on the timing and parameters of the proposed reforms and the department's action plan reflects this.

The department will continue to work to improve oral health outcomes for disadvantaged Victorians and has commenced implementation of a number of the identified actions.

I would like to take this opportunity to thank your staff for their work and for the professional manner in which the audit was conducted.

Yours sincerely

Kym Peake
Secretary

28 / 11 / 2016

RESPONSE provided by the Secretary, Department of Health & Human Services – continued

No	Recommendation	DHHS action	Proposed start date	Proposed end date
	That the Department of Health & Human Services and Dental Health Services Victoria work with community dental agencies to:			
1	identify and pilot models of care which redress the current imbalance between treatment and prevention services for eligible people by increasing access to the broader continuum of care, while maintaining the focus on addressing demand for treatment (see Section 2.5)	The department **partially accepts** this recommendation. In the short term, the department will work with Dental Health Services Victoria to identify where there is further scope to expand the delivery of preventive interventions and explore options to introduce further elements of Minimal Intervention Dentistry, as well as considering the results of local innovations that have been introduced by some public dental providers and their potential broader application. Longer term options for strengthening the preventive focus for priority and eligible populations will be explored. However, the pilot of a new model of care is dependent on the level of funding available and in particular, Commonwealth decisions regarding future funding for Victorian public dental services.	30 January 2017	1 July 2020
2	carry out a cost–benefit analysis of the long-term outcomes of adopting a model for public dental services (see Section 3.5)	The department **accepts** this recommendation. The department will identify short, medium and longer term model of care options and conduct cost-benefit analysis of these.	February 2018	December 2020
3	review and improve the current approach to managing waiting lists, including prioritising need and assessing the risk of people placed on the waiting list (Section 2.5.1)	The department **accepts** this recommendation. The department will work with Dental Health Services Victoria and community dental agencies to review current wait list policy and identify and consider more targeted, innovative approaches to managing waiting lists.	30 January 2017	1 July 2018
4	identify where collaboration between regional public dental services could address barriers to access and pilot related projects to test their effectiveness in	The department **accepts** this recommendation. The department will work with Dental Health Services Victoria to identify ways to strengthen existing place-based approaches and collaborations, including oral health regional networks and other initiatives that focus on	30 January 2017	31 December 2018

2

RESPONSE provided by the Secretary, Department of Health & Human Services – continued

No	Recommendation	DHHS action	Proposed start date	Proposed end date
5	improving oral health and in identifying resourcing requirements (see Section 4.2.2) identify how community dental agencies can take greater responsibility for promoting oral health, supported by adequate funding (see Section 2.3.3)	public health and wellbeing outcomes, within existing resourcing levels. The department **accepts** this recommendation. The department has commenced work with Dental Health Services Victoria and community dental agencies to enhance the skills of clinical teams to embed prevention services in their daily practice and promote the oral health of clients accessing public dental services within existing resource levels.	Commenced	30 June 2018
6	collect data on people who are eligible for public dental services as a sub-set of its broader oral health outcomes measures based on the whole population (see Section 5.2.1)	The department **accepts** this recommendation. The department will identify options to collect data on people who are eligible for public dental services as a sub-set of its broader oral health outcomes through a number of mechanisms.	30 January 2017	1 July 2018
	That the Department of Health & Human Services, in consultation with Dental Health Services Victoria:			
7	review the most appropriate and effective funding model to deliver public dental services to achieve the government's goals. This will include an assessment of the value of applying the Commonwealth funding model (see Section 3.2.2)	The department **accepts** this recommendation. The department will review funding model arrangements to identify opportunities for enhancement. Commencement of this work will be contingent on confirmation of what the future Commonwealth funding model will be, so the review can consider the value of applying this.	1 July 2017	1 July 2018
8	when developing the funding model, consider including loading for variables that affect how services are delivered, such as remoteness and client complexity (see Section 3.2.2)	The department **accepts** this recommendation. In reviewing the funding model (recommendation 7), the department given consideration to the inclusion of loadings. However, the consideration of future funding models needs to take into account future Commonwealth arrangements and broader directions in health policy funding. Any future funding arrangements should maximise benefits for the eligible population.	1 July 2017	1 July 2018

3

RESPONSE provided by the Secretary, Department of Health & Human Services – continued

No	Recommendation	DHHS action	Proposed start date	Proposed end date
9	develop an implementation plan for introducing a consistent Dental Weighted Activity Unit rate for all community dental agencies while the Dental Weighted Activity Unit funding model is in place, informed by a sound analysis of reliable data (see Section 3.2.2)	The department **accepts** this recommendation, noting that work has commenced to addressed variations in current pricing. However, the timing and approach to implementation is dependent on Commonwealth dental reforms and funding arrangements and thus a longer timeframe for completion has been proposed in case a period of sector transition is required.	Commenced	1 July 2019
10	review the relevance and appropriateness of current key performance indicators in the Statement of Priorities and identify more relevant indicators for providing a comprehensive picture of the impact of the dental health program (see Section 5.2.1)	The department **accepts** this recommendation. The department has commenced work on reviewing key performance indicators in the Statement of Priorities and will work with Dental Health Services Victoria to consider and develop indicators to measure the impact of the dental health program. The department has commenced a process to consider the role of outcome measures in measuring the impact and effectiveness of programs.	Commenced	1 July 2018
11	review the usefulness of the current key performance indicators in State Budget Paper 3: Service Delivery, and identify more relevant indicators for providing a comprehensive picture of how public dental services are delivered (see Section 5.3.3)	The department **accepts** this recommendation. The department has recently completed a review of key performance indicators in State Budget Paper 3 and will continue to work with the Department of Treasury and Finance to develop indicators to measure the delivery of public dental services.	Commenced	1 July 2017

4

RESPONSE provided by the Chief Executive Officer, Dental Health Services Victoria

30 November 2016

Mr Andrew Greaves
Auditor-General
Victorian Auditor-General's Office
Level 24
35 Collins Street
Melbourne
Victoria 3000

Dear Mr Greaves

Proposed Performance Audit Report - *Access to public dental services in Victoria*

Thank you for your letter dated 17 November 2016, regarding your proposed Performance Audit Report and your invitation to provide submissions or comments to be included within the report.

As you will be aware from our strategic plan, Dental Health Services Victoria (DHSV) is highly committed to achieving the changes which are also sought by the recommendations in the report.

DHSV will continue to work constructively with the Department of Health and Human Services and public dental agencies to implement the recommendations and to improve access to services and oral health outcomes.

However, in my opinion, funding decisions by the Australian Government and related decisions by the Victorian Government will significantly impact on implementation timing if those decisions return funding to a similar level as that which existed before the National Partnership Agreement on Treating More Public Dental Patients, introduced in 2013-14.

I would like to thank your staff for their diligence and professional manner in which they engaged with DHSV on this audit.

Yours sincerely

Dr Deborah Cole
Chief Executive Officer

dental health services victoria
oral health for better health

Dental Health Services Victoria
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Telephone 03 9341 1000
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Appendix B.

Eligibility and fee requirements

Figure B1 outlines the eligibility and fee requirements for accessing public dental services.

Figure B1
Access to public dental services

Eligible population	Priority access group	Required to pay co-payment	Exempt from paying fees
All children aged 0−12 years	✓	• People who do not hold either a health care or pensioner concession card or who are not dependants of concession card holders	• Aboriginal and Torres Strait Islander people • Homeless people and people at risk of homelessness • Refugees and asylum seekers
Young people aged 13−17 years who hold a health care or pensioner concession card or who are dependants of concession card holders	✓	×	✓
All children and young people aged up to 18 years in out-of-home care provided by the Department of Health & Human Services	✓	×	✓
All youth justice clients in custodial care, aged up to 18 years	✓	×	✓

Figure B1
Access to public dental services – *continued*

Eligible population	Priority access group	Required to pay co-payment	Exempt from paying fees
People aged 18 years and over, who hold a health care or pensioner concession card or who are dependants of concession card holders	• Aboriginal and Torres Strait Islander people • Homeless people and people at risk of homelessness • Pregnant women • Registered clients of mental health and disability services	• Pregnant women	• Aboriginal and Torres Strait Islander people • Homeless people and people at risk of homelessness • Registered clients of mental health and disability services • People experiencing financial hardship
Refugees and asylum seekers	✓	✗	✓

Note: Registered clients of mental health and disability services must have a letter of recommendation from their case manager or staff of special developmental schools.

Source: VAGO.

Appendix C.

Average wait times for general care

Figure C1 lists the average wait times, in months, for general care in all Victorian community dental agencies (CDA), from 2012–13 to 2015–16.

Figure C1
Wait times for general dental care in CDAs

Agency	2012–13	2013–14	2014–15	2015–16
Barwon region				
Barwon Health	27.80	14.70	15.35	21.14
Bellarine Community Health	29.27	14.52	10.31	9.55
Colac Area Health	26.89	32.64	24.04	18.43
South West Healthcare	15.74	13.82	16.59	19.21
Total Barwon Region	**22.14**	**16.91**	**15.26**	**17.08**
Grampians region				
Ballarat Health Services	33.06	13.39	10.78	13.82
East Grampians Health Service	15.12	11.28	9.89	17.41
East Wimmera Health Service	2.30	0.50	3.92	2.06
Edenhope and District Memorial Hospital	0.21	0.49	5.60	–
Hepburn Health Service	8.88	8.68	5.89	7.87
West Wimmera Health Service	3.46	11.10	13.14	15.28
Wimmera Health Care Group	26.94	9.33	11.05	15.30
Total Grampians region	**12.85**	**7.82**	**8.61**	**11.96**
Loddon Mallee region				
Bendigo Health Care Group	22.43	17.12	8.38	8.66
Boort District Health	10.27	9.53	10.28	9.49
Echuca Regional Health	30.34	32.34	23.60	19.41
Mallee Track Health and Community Service	15.77	7.15	9.99	10.90
Maryborough District Health Service	47.61	45.62	32.58	21.44
Sunraysia Community Health Services	19.05	14.38	16.79	11.35
Swan Hill District Health	0.57	0.35	0.40	1.04
Total Loddon Mallee region	**20.86**	**18.07**	**14.57**	**11.76**

Figure C1
Wait times for general dental care in CDAs – *continued*

Agency	2012–13	2013–14	2014–15	2015–16
Hume region				
Northeast Health Wangaratta	28.01	18.40	12.56	14.87
Goulburn Valley Health	17.95	6.86	6.14	9.54
Rumbalara Aboriginal Co-operative	–	–	4.80	–
Seymour Health	–	1.50	13.91	17.71
Albury Wodonga Health	11.35	7.55	8.93	9.61
Total Hume region	**19.10**	**8.58**	**9.27**	**12.93**
Gippsland region				
Bairnsdale Regional Health Service	24.66	11.07	3.65	14.95
Central Gippsland Health Service	13.94	13.54	17.12	28.42
Orbost Regional Health	16.97	9.86	3.29	4.15
Latrobe Community Health Service	21.13	9.11	5.04	14.08
Omeo District Health	18.98	5.88	2.86	7.95
Bass Coast Health	23.90	10.58	10.93	19.37
Total Gippsland region	**19.93**	**10.01**	**7.15**	**14.82**
Western Metro region				
Cohealth	18.09	16.42	17.70	15.30
ISIS Primary Care	21.64	16.45	18.79	22.87
Djerriwarrh Health Services	12.89	8.48	8.50	10.80
The Royal Children's Hospital	–	–	–	–
Total Western Metro region	**17.66**	**14.50**	**15.39**	**16.32**
Northern Metro region				
Banyule Community Health	10.28	9.59	11.10	14.55
Darebin Community Health Service	10.93	11.04	18.99	20.58
Dianella Community Health	16.82	14.60	17.38	18.85
healthAbility	25.99	10.66	5.49	16.36
Merri Community Health Services	17.52	15.19	19.24	25.49
North Richmond Community Health	5.63	5.97	8.89	14.45
Plenty Valley Community Health	27.36	13.86	8.79	9.42
Sunbury Community Health Centre	18.22	17.68	19.72	20.46
Total Northern Metro region	**16.59**	**12.32**	**13.70**	**17.52**

Figure C1
Wait times for general dental care in CDAs – *continued*

Agency	2012–13	2013–14	2014–15	2015–16
Eastern Metro region				
Inner East Community Health Service	8.76	6.76	8.51	11.40
Knox Social and Community Health	20.58	16.07	13.65	14.87
EACH	22.54	13.62	10.84	14.04
LINK Health and Community	8.07	6.85	5.19	10.00
Inspiro Community Health	19.91	15.99	17.25	23.53
Carrington Health	22.78	19.42	19.60	19.01
Total Eastern Metro region	**17.11**	**13.12**	**12.51**	**15.48**
Southern Metro region				
Bentleigh-Bayside Community Health	10.52	9.24	10.31	12.74
Central Bayside Community Health Services	10.73	7.92	6.72	7.10
Peninsula Health	29.19	13.71	13.60	16.68
Monash Health	33.85	17.44	10.74	20.27
Inner South Community Health Service	5.87	5.73	11.87	13.74
Total Southern Metro region	**18.03**	**10.81**	**10.65**	**14.10**
Other				
Royal Dental Hospital of Melbourne	4.79	5.53	6.94	12.07

Note: Possible reasons for no wait time data being recorded include patients having priority access so they are not placed on waiting lists, and patients being treated the same day.

Source: VAGO, based on information from Dental Health Services Victoria.

Appendix D.

Average wait times for denture care

Figure D1 lists the average wait times, in months, for denture care in all Victorian community dental agencies (CDA), from 2012–13 to 2015–16.

Figure D1
Wait times for denture care in CDAs

Agency	2012–13	2013–14	2014–15	2015–16
Barwon region				
Barwon Health	35.91	13.13	15.96	17.29
Bellarine Community Health	28.29	12.91	11.36	13.75
Colac Area Health	39.50	26.09	18.81	11.58
South West Healthcare	10.62	7.06	11.57	17.56
Total Barwon region	**22.96**	**12.30**	**12.88**	**15.04**
Grampians region				
Ballarat Health Services	11.86	1.01	3.27	6.63
East Grampians Health Service	21.85	11.69	10.26	16.03
East Wimmera Health Service	0.73	1.21	3.06	2.39
Edenhope and District Memorial Hospital	11.48	8.47	–	20.70
Hepburn Health Service	25.02	11.74	4.24	7.32
West Wimmera Health Service	6.15	7.87	2.05	2.27
Wimmera Health Care Group	15.57	8.99	10.49	8.62
Total Grampians region	**13.24**	**7.28**	**5.56**	**9.14**
Loddon Mallee region				
Bendigo Health Care Group	31.16	14.20	3.49	8.86
Boort District Health	18.19	11.24	14.44	7.94
Echuca Regional Health	30.49	28.81	35.64	39.16
Mallee Track Health and Community Service	3.89	5.54	1.40	10.32
Maryborough District Health Service	43.13	29.99	32.39	30.38
Sunraysia Community Health Services	10.61	6.38	9.07	16.45
Swan Hill District Health	8.28	4.92	6.02	7.00
Total Loddon Mallee region	**20.82**	**14.44**	**14.64**	**17.16**

Figure D1
Wait times for denture care in CDAs – *continued*

Agency	2012–13	2013–14	2014–15	2015–16
Hume region				
Northeast Health Wangaratta	24.81	11.91	18.81	19.23
Goulburn Valley Health	32.68	18.75	11.24	15.36
Rumbalara Aboriginal Co-operative	–	2.83	8.45	5.70
Seymour Health	–	1.30	6.16	11.09
Albury Wodonga Health	12.05	0.19	8.25	16.71
Total Hume region	**23.18**	**7.00**	**10.58**	**13.62**
Gippsland region				
Bairnsdale Regional Health Service	28.55	8.45	7.00	14.76
Central Gippsland Health Service	30.75	12.92	2.23	3.65
Orbost Regional Health	12.48	2.34	1.39	4.81
Latrobe Community Health Service	31.91	15.46	17.76	20.67
Omeo District Health	8.38	2.51	4.43	3.01
Bass Coast Health	21.22	7.38	10.99	17.66
Total Gippsland region	**22.21**	**8.18**	**7.30**	**10.76**
Western Metro region				
Cohealth	11.97	9.90	13.59	13.56
ISIS Primary Care	24.61	21.71	15.54	14.82
Djerriwarrh Health Services	14.97	3.91	9.81	12.23
The Royal Children's Hospital	–	–	–	–
Total Western Metro region	**16.22**	**12.10**	**14.88**	**13.54**
Northern Metro region				
Banyule Community Health	31.92	16.96	15.67	12.10
Darebin Community Health Service	13.54	8.22	14.39	13.19
Dianella Community Health	10.74	3.85	9.80	10.97
healthAbility	22.15	12.18	13.52	15.78
Merri Community Health Services	12.30	14.20	14.57	24.29
North Richmond Community Health	6.56	7.01	11.77	16.99
Plenty Valley Community Health	16.66	11.04	17.54	18.75
Sunbury Community Health Centre	30.06	32.35	26.81	15.37
Total Northern Metro region	**17.99**	**13.23**	**15.51**	**15.93**

Figure D1
Wait times for denture care in CDAs – *continued*

Agency	2012–13	2013–14	2014–15	2015–16
Eastern Metro region				
Inner East Community Health Service	15.23	8.86	9.04	17.85
Knox Social and Community Health	13.71	19.61	19.29	18.45
EACH	21.64	23.76	19.68	16.09
LINK Health and Community	17.85	9.71	6.62	6.88
Inspiro Community Health	35.97	26.94	26.67	30.00
Carrington Health	16.73	15.44	16.86	17.28
Total Eastern Metro region	**20.19**	**17.39**	**16.36**	**17.76**
Southern Metro region				
Bentleigh-Bayside Community Health	2.36	3.15	8.91	11.95
Central Bayside Community Health Services	9.48	2.65	4.34	6.53
Peninsula Health	31.65	9.87	7.71	8.66
Monash Health	28.38	10.67	27.12	23.12
Inner South Community Health Service	13.63	2.72	9.39	16.35
Total Southern Metro region	**17.10**	**5.81**	**11.49**	**13.32**
Other				
Royal Dental Hospital of Melbourne	2.61	3.54	7.49	7.61

Note: Possible reasons for no wait time data being recorded include patients having priority access so they are not placed on waiting lists, and patients being treated the same day.

Source: VAGO, based on information from Dental Health Services Victoria.

Appendix E.

Average wait times for priority denture care

Figure E1 lists the average wait times, in months, for priority denture care in all Victorian community dental agencies (CDA), from 2012–13 to 2015–16.

Figure E1
Wait times for priority denture care in CDAs

Agency	2012–13	2013–14	2014–15	2015–16
Barwon region				
Barwon Health	5.51	–	1.22	1.06
Bellarine Community Health	2.45	4.81	2.48	2.44
Colac Area Health	8.24	0.50	0.85	0.50
South West Healthcare	3.00	2.69	6.17	2.58
Total Barwon region	**4.16**	**2.22**	**3.30**	**1.64**
Grampians region				
Ballarat Health Services	1.60	1.48	2.63	5.19
East Grampians Health Service	1.25	0.89	1.25	2.76
East Wimmera Health Service	3.40	1.28	0.77	1.29
Edenhope and District Memorial Hospital	–	–	–	–
Hepburn Health Service	3.58	1.43	1.70	2.28
West Wimmera Health Service	–	–	20.00	–
Wimmera Health Care Group	1.65	2.11	2.01	1.99
Total Grampians region	**2.30**	**1.43**	**4.73**	**2.70**
Loddon Mallee region				
Bendigo Health Care Group	3.62	2.90	1.73	1.21
Boort District Health	2.92	2.37	2.80	3.57
Echuca Regional Health	2.65	3.53	3.81	3.38
Mallee Track Health and Community Service	–	–	1.77	3.30
Maryborough District Health Service	1.92	2.39	1.28	2.36
Sunraysia Community Health Services	2.91	3.03	2.88	2.89
Swan Hill District Health	2.59	1.63	1.46	2.43
Total Loddon Mallee region	**2.77**	**2.64**	**2.25**	**2.74**

Figure E1
Wait times for priority denture care in CDAs – *continued*

Agency	2012–13	2013–14	2014–15	2015–16
Hume region				
Northeast Health Wangaratta	4.49	3.16	2.79	2.16
Goulburn Valley Health	3.12	2.18	3.20	2.08
Rumbalara Aboriginal Co-operative	–	–	13.40	–
Seymour Health	–	–	–	1.32
Albury Wodonga Health	1.50	1.03	4.82	2.09
Total Hume region	**3.04**	**2.12**	**6.05**	**1.92**
Gippsland region				
Bairnsdale Regional Health Service	1.83	1.31	1.04	1.88
Central Gippsland Health Service	2.99	3.11	3.31	3.25
Orbost Regional Health	1.34	1.45	0.59	1.41
Latrobe Community Health Service	3.31	1.17	4.44	1.23
Omeo District Health	1.57	2.40	0.38	2.30
Bass Coast Health	3.01	2.76	2.80	2.35
Total Gippsland region	**2.34**	**2.03**	**2.09**	**2.07**
Western Metro region				
Cohealth	2.58	2.21	4.50	2.19
ISIS Primary Care	2.41	2.48	2.97	2.97
Djerriwarrh Health Services	3.33	1.47	2.20	1.94
The Royal Children's Hospital				
Total Western Metro region	**2.74**	**2.11**	**3.61**	**2.37**
Northern Metro region				
Banyule Community Health	2.76	0.64	0.82	1.07
Darebin Community Health Service	1.71	1.93	2.37	1.38
Dianella Community Health	1.67	1.49	2.44	2.30
healthAbility	1.81	1.83	1.86	2.37
Merri Community Health Services	2.05	1.84	2.98	2.83
North Richmond Community Health	2.73	2.10	2.65	2.63
Plenty Valley Community Health	0.76	0.79	2.16	1.33
Sunbury Community Health Centre	2.04	1.86	2.48	1.94
Total Northern Metro region	**1.94**	**1.56**	**2.22**	**1.98**
Eastern Metro region				
Inner East Community Health Service	1.89	0.94	2.26	2.46
Knox Social and Community Health	1.61	2.04	2.64	2.47
EACH	3.06	1.05	2.20	2.61
LINK Health and Community	1.60	1.17	1.28	1.87
Inspiro Community Health	2.73	1.62	2.39	3.45
Carrington Health	2.27	2.53	3.00	2.41
Total Eastern Metro region	**2.19**	**1.56**	**2.29**	**2.55**

Figure E1
Wait times for priority denture care in CDAs – *continued*

Agency	2012–13	2013–14	2014–15	2015–16
Southern Metro region				
Bentleigh-Bayside Community Health	3.64	0.41	1.97	2.17
Central Bayside Community Health Services	0.70	0.40	1.27	0.50
Peninsula Health	3.17	2.27	2.40	2.25
Monash Health	2.72	1.94	2.46	1.88
Inner South Community Health Service	1.65	1.96	1.56	1.68
Total Southern Metro region	**2.38**	**1.39**	**1.93**	**1.70**
Other				
Royal Dental Hospital of Melbourne	2.52	2.70	3.63	1.64

Note: Possible reasons for no wait time data being recorded include patients having priority access so they are not placed on waiting lists, and patients being treated the same day.
Source: VAGO, based on information from Dental Health Services Victoria.

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Enhancing Food and Fibre Productivity (2016–17:1)	August 2016
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Meeting Obligations to Protect Ramsar Wetlands (2016–17:3)	September 2016
Efficiency and Effectiveness of Hospital Services: Emergency Care (2016–17:4)	October 2016
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Water Entities: 2015–16 Audit Snapshot (2016–17:9)	November 2016
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