



Putting our money where our mouth is - prevention and optimal outcomes

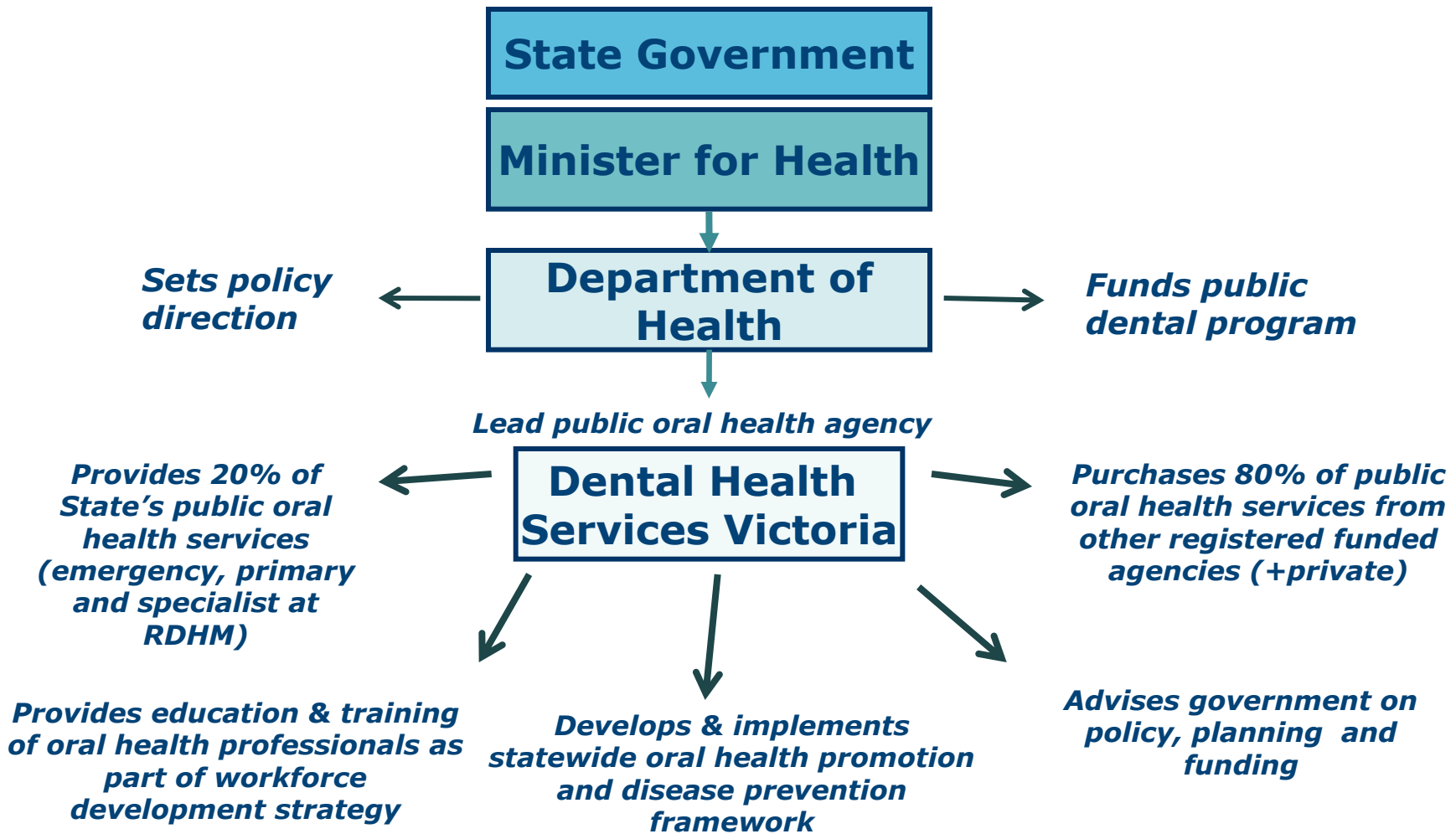
***Are we doing the right thing in the right place
at the right time to deliver the right outcomes
and how could we do better?***

Felix Pintado
Chief Executive
Dental Health Services Victoria

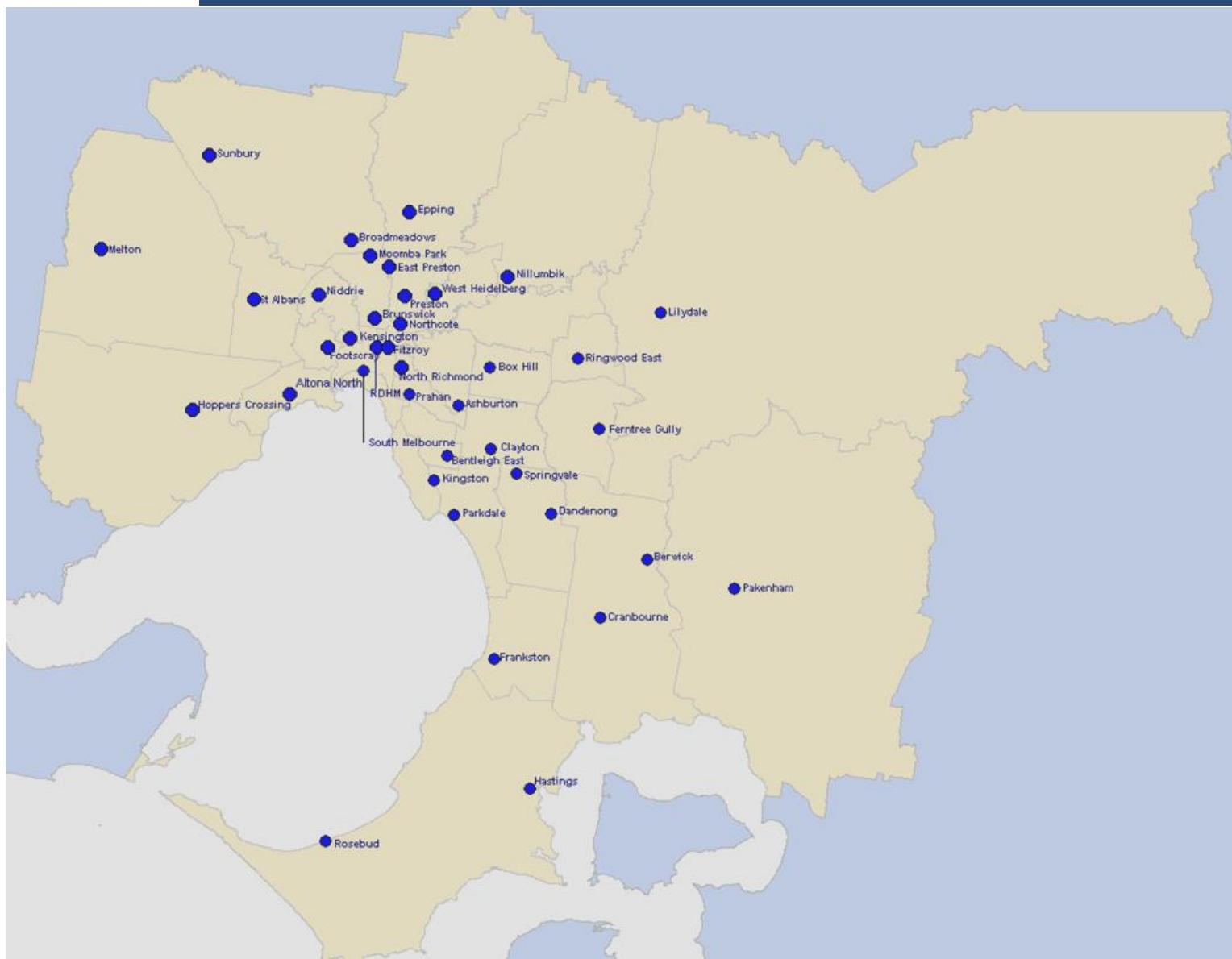
- 2020 Summit
- Grocery Watch
- Petrol Watch
- Replace WorkChoices legislation
- Climate change & carbon emission trading scheme
- 222 child care centres on school grounds
- \$2.45b home insulation scheme
- Building the education revolution
- Superannuation reform
- Asylum seekers policy
- National Health & Hospitals Reform commission
- National apology to the stolen generations
- GFC and stimulus packages
- Ratified Kyoto protocol
- More action in Iraq and Afghanistan
- National Health & Hospitals Network Agreements – Networks, Medicare Locals, etc, but no *Denticare*
- Turnbull, Grech and that email
- Wayne Swan and that ute
- Gillard and leadership challenges
- Abbott
- Approx \$60 billion deficit
- Mining super tax

- The Victorian model
- The DHSV approach – population health hot spots
- Are we providing services where they are needed most?
- Are we doing the right things to improve outcomes?
- Could we be doing things differently for the better?
- Some key actions

The Victorian model



DHSV – purchased services (metro regions)



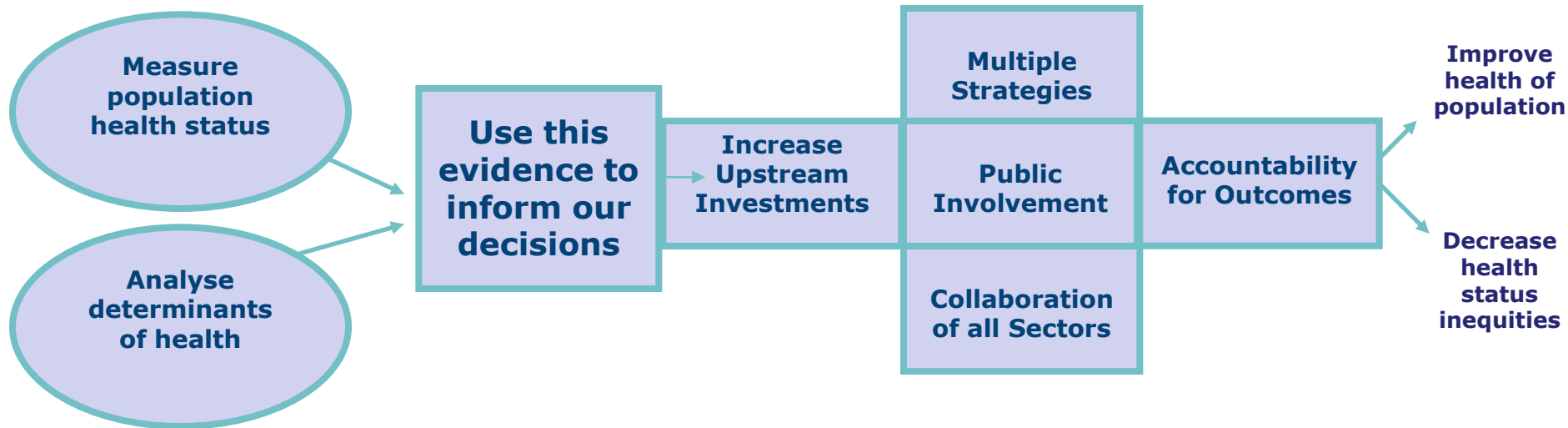
DHSV – purchased services (rural & regional)



Are we providing services
where they are needed most?

Our population health approach

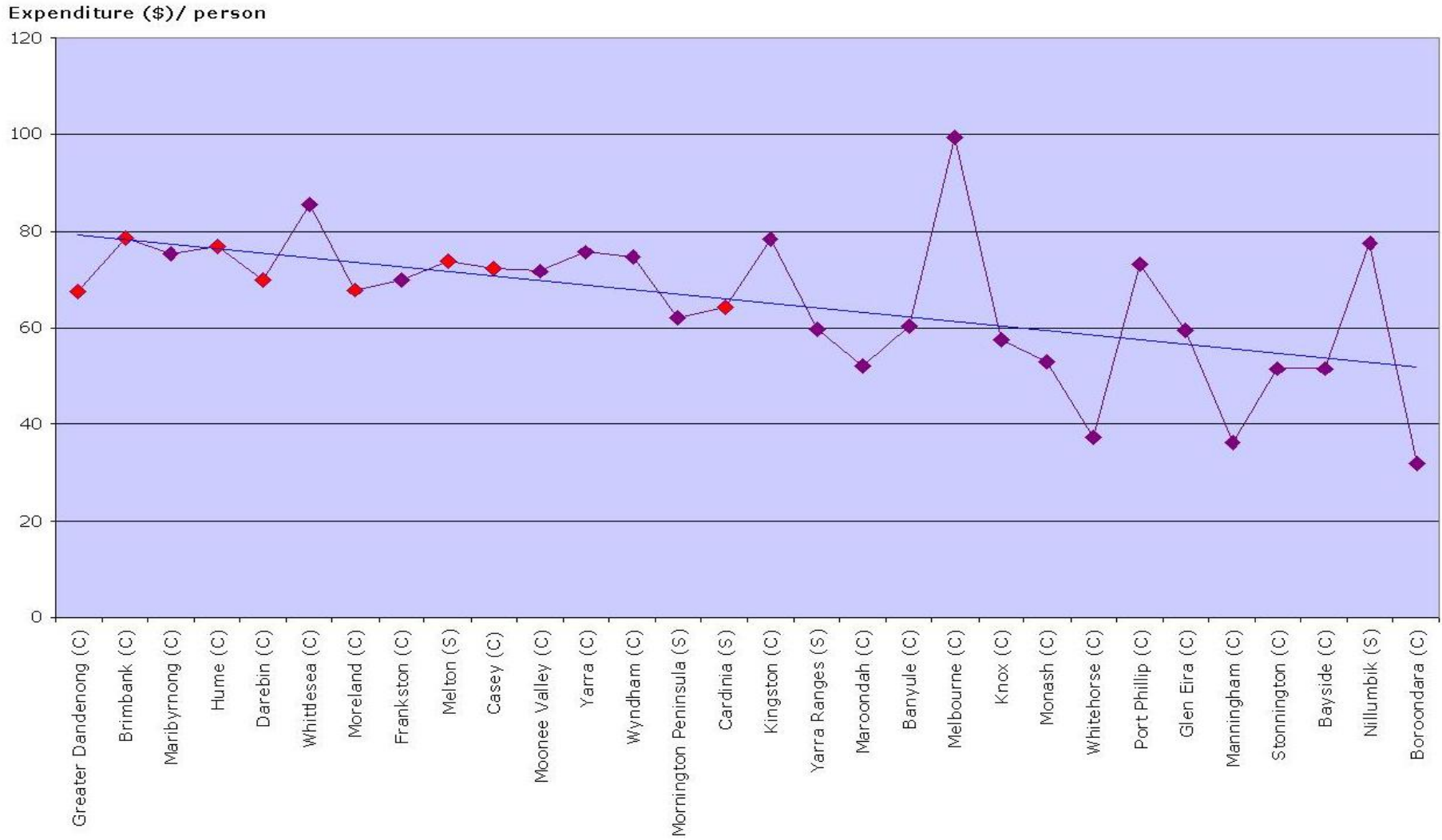
We adopted a population health approach to help us decide the most fair and equitable means of distributing services



**to improve the oral health status of Victorians,
particularly those who are disadvantaged,
vulnerable and most in need.**

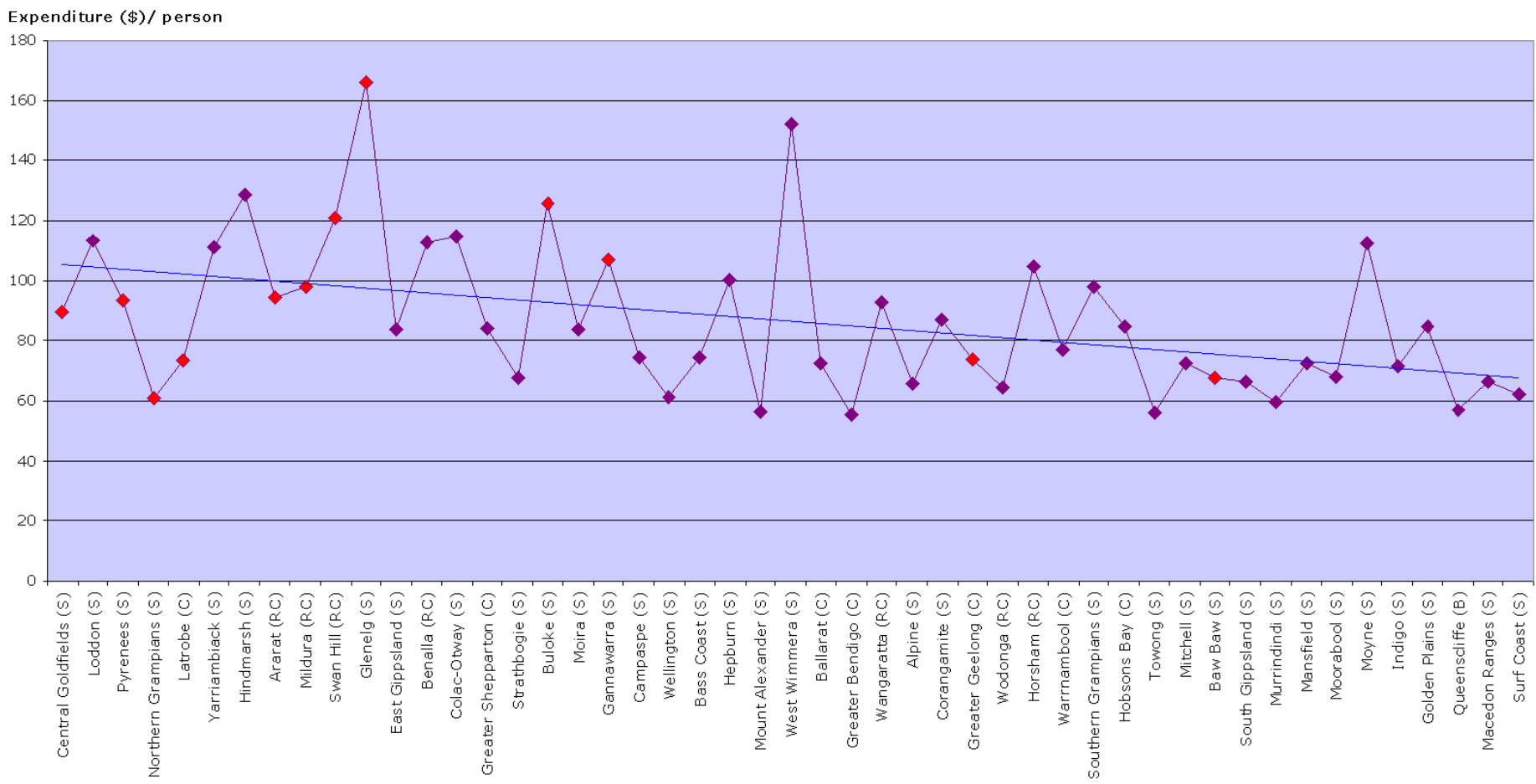
Adult oral health (metropolitan)

**Expenditure per Capita by Metropolitan LGA 2008-09
(in order of SEIFA ranking low to high)**



Adult oral health (rural & regional)

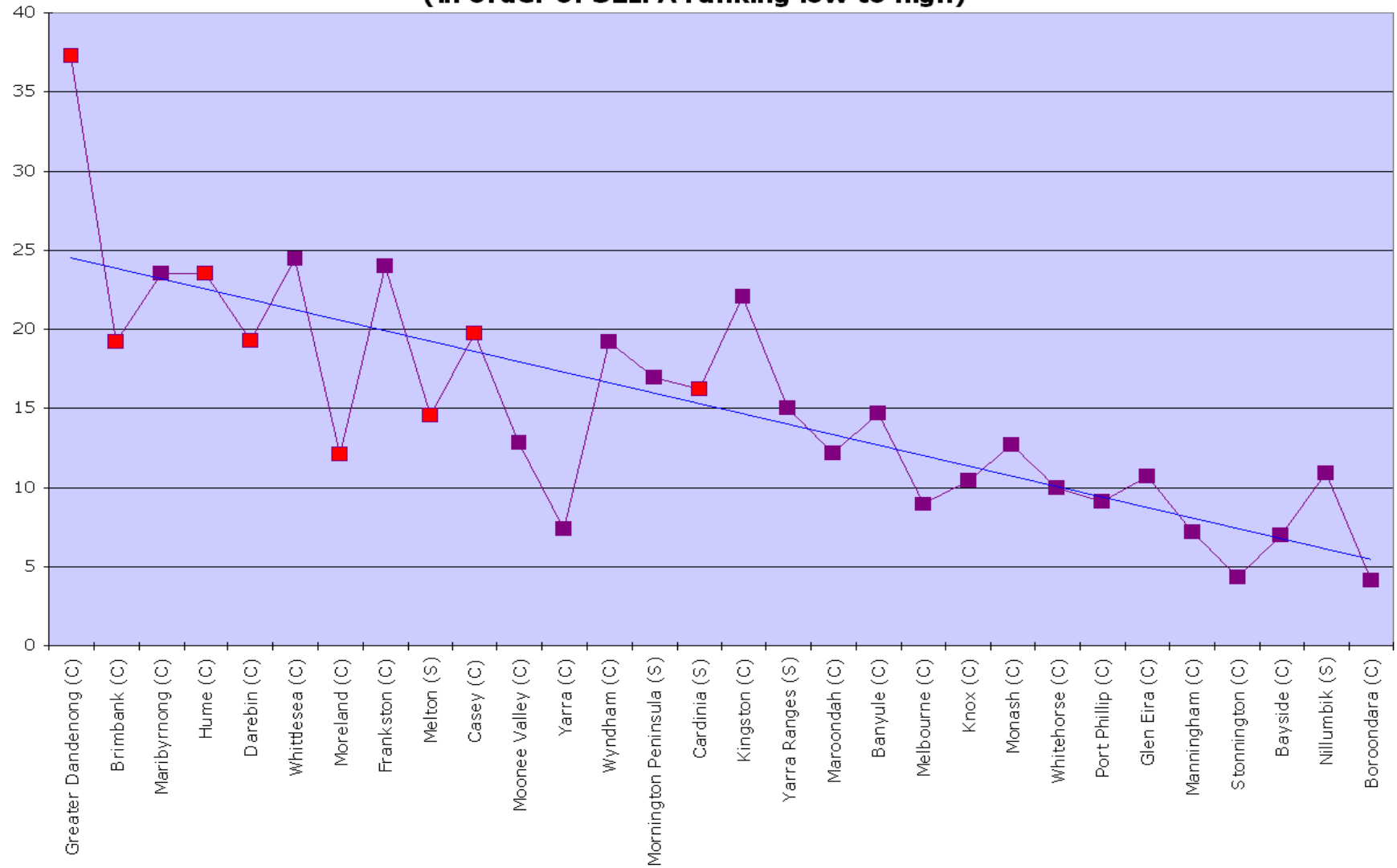
Expenditure per Capita by Rural LGA 2008-09
(in order of SEIFA ranking low to high)



Child oral health (metropolitan)

Children 0-17 years
Expenditure per Capita by Metropolitan LGA 2008-09
(in order of SEIFA ranking low to high)

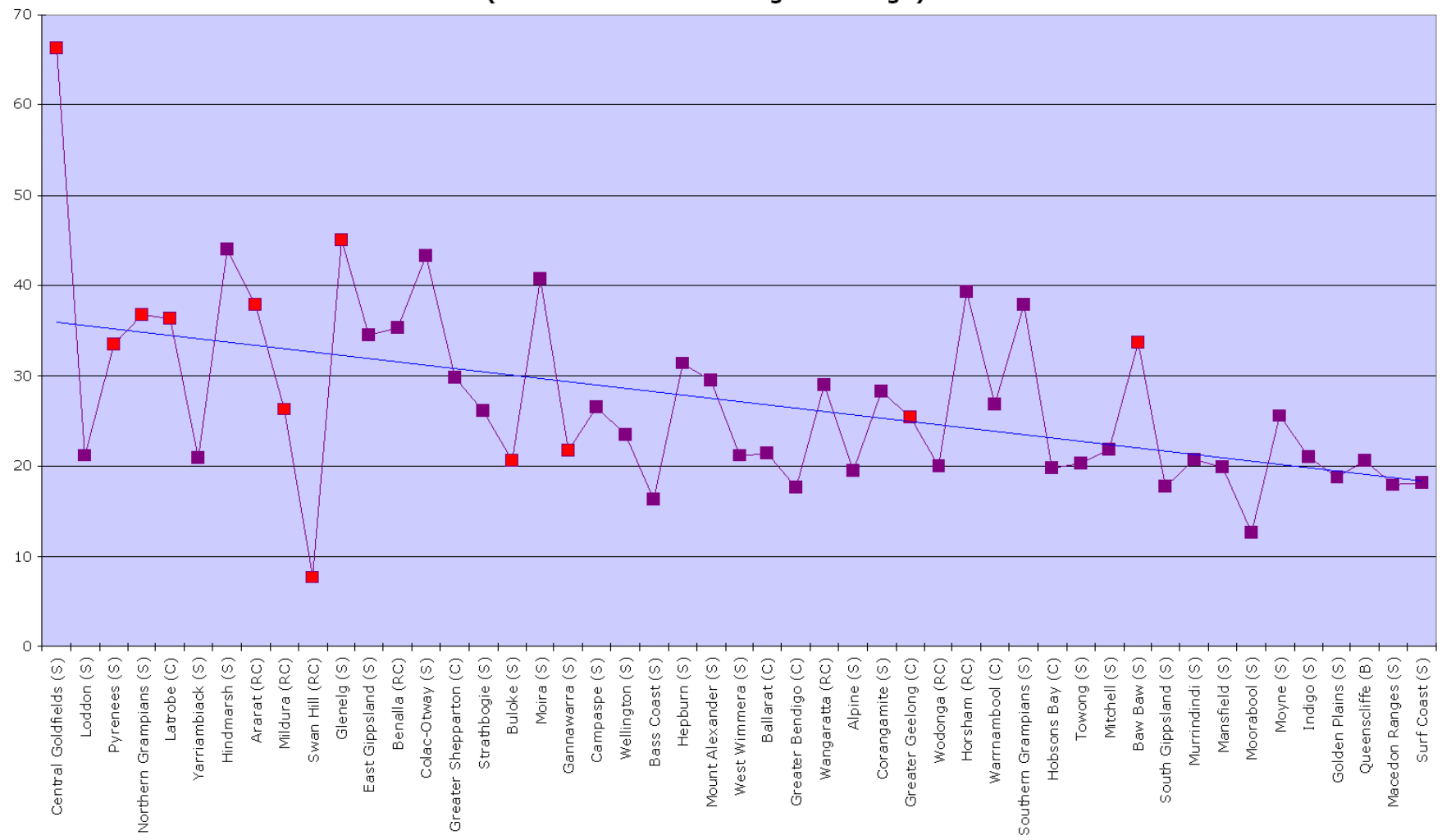
Expenditure (\$) / person



Child oral health (rural & regional)

Children 0-17 years
Expenditure per Capita by Rural LGA 2008-09
(in order of SEIFA ranking low to high)

Expenditure (\$) / person



Are we doing the right things
for optimal oral health outcomes?

What is needed for optimal oral health?

Focus areas	Elements required for optimal oral health	Level of prevention	Strategies for achieving optimal oral health					
			Public policy	Supportive environment	Knowledge (literacy)	Personal skills	Motivation	Access to services
Public health	1. Fluoride in water (as an example)	primary	Yes	No	Yes	No	No	No
Self management	2. Healthy diet	primary	No	Yes	Yes	Yes	Yes	No
	3. Oral care (including appropriate use of fluoride)	primary	No	Yes	Yes	Yes	Yes	No
Services	4. Early identification of problems	secondary	Yes	Yes	Yes	No	Yes	Yes
	5. Prevention and early intervention	secondary	Yes	Yes	Yes	No	Yes	Yes
	6. Treatment	tertiary	No	Yes	Yes	No	Yes	Yes

Could we be doing things
differently for the better?

- General health and oral health - existence of two separate health systems is a barrier to better outcomes.
- Funding systems that reward or create incentives for treatment not prevention.
- Too singular a focus on dental caries management ignores other significant causes of tooth loss such as periodontal disease.
- Little or no evaluation of the efficacy of what we're doing already to assess impact on desired outcomes.

Our big hairy audacious goals

1. Embed oral health initiatives in general health priorities.
2. Lead the emphasis away from treatment interventions and towards prevention of oral disease.
3. Develop and implement universal access models for at-risk communities.
4. Build capacity to undertake population health investigations and gather information on at-risk population groups.
5. Identify and implement new, innovative, best-practice clinical models and low-cost, high quality, readily accessible provider models.



Change public policy for clinical service delivery.

- Move towards the introduction of Minimal Intervention Dentistry (MID) in the public system.
- Shift from predominantly dental caries management to include focus on prevention and management of periodontal disease.
- Screen for oral cancer - *early identification & prevention*

Ongoing investment in evaluation of interventions.

Three focus areas for real action to improve clinical service delivery in the public oral health sector:

Tooth decay

Gum disease

Oral cancer

Tooth decay

- **MID** is a relatively new approach to oral health care that moves away from traditional surgical intervention (*‘drilling and filling’ and extraction*) to:
 - prevention
 - early diagnosis
 - personalised non-surgical interventions
 - minimally invasive treatment.
- **MID** approach could help reduce growing rate of dental disease among public dental patients:
 - saving public money
 - directing interventions to those most at risk of oral disease.

Gum disease

National Oral Health Survey 2004-06

- 20.5% of Australian adults had moderate periodontitis
- 2.4% had severe periodontitis

Prevention of periodontal diseases is mostly related to:

- early assessment and identification
- improved oral hygiene practices

Management of existing periodontal disease requires:

- early assessment and identification
- on-going maintenance by a dentist or dental hygienist
- improved oral hygiene practices



What needs to be done?

- Include **periodontal examination** as part of a comprehensive dental examination in public dental clinics.
- Develop strategies to encourage the **employment of dental hygienists** throughout public dental clinics.

- Account for up to 6.5 percent of all cancers diagnosed in Australia¹.
- More Australians die from oral cancer than cervical cancer each year².
- While occurring less frequently than dental caries and periodontal disease, it has a considerable impact on the quality of life of affected individuals.

(1) Cancer Council, Victoria

(2) Source Oral health of Australians, Australian Health Ministers' Advisory Council, Steering Committee for National Planning of Oral Health, August 2001



What needs to be done?

- Encourage primary prevention through health promotion activities aimed at reducing patients' exposure to tobacco and alcohol – social marketing to change behaviour.
- A comprehensive dental examination in public dental clinics to include screening for oral precancerous lesions and early oral cancers –early detection & prevention.
- Provide a supportive environment for clinicians – enable sufficient time to complete a comprehensive oral health examination.

- **The Australian Population Health Improvement Research Strategy for Oral Health**
 - *APHIRST-Oral Health*
- A flagship initiative of Dental Health Services Victoria in collaboration with The Jack Brockhoff Child Health and Wellbeing Program, The McCaughey Centre, School of Population Health, The University of Melbourne. Discussions also underway with Melbourne Dental School of the University of Melbourne on the various facets of research to be undertaken and the support required.
- The purpose of *PHIRST-Oral Health* is to increase the quantity and quality of public oral health improvement research relevant to oral

To increase the quantity and quality of public health improvement research that is focused on upstream interventions, to address the underlying determinants of oral health, particularly those related to the implementation of oral health policies and practices.

Why?

- Policymakers and public health researchers alike have demanded better evidence of the effects of interventions on health inequalities.
- Interventions with significant and sustained impacts are those which have multiple components acting synergistically at a number of levels and that support individuals' health promoting behaviour.
- Need to draw together expertise and facilitate communication and collaboration between researchers, policy makers and practitioners.

How?

- Identify and explore research priorities
- Develop well designed, high quality applications for research funding
- Undertake systematic reviews of existing evidence
- Promote and progress priority research projects
- Build capacity of oral health professionals across agencies to prepare funding applications and engage in research activities
- Identify innovations in policy and practice at an early stage and develop strategic research in partnership
- Maximize opportunities for ‘natural experiments’ and evaluation of emerging initiatives
- Explore the constraints and challenges in the measurement of population oral health and data linkage
- Develop and disseminate high quality research protocols and methodologies
- Execute funded research projects
- Exchange new evidence, policy developments and practitioner innovation

Structure

- Chair (DHSV Chief Executive)
- Advisory Group
- Director (Dr Andrea de Silva-Sanigorski)
- Coordinating Team
- Research Development Groups

Putting our money where our mouth is means:

- Acknowledging that we have a solid foundation but there are multiple opportunities to improve.
- Using a population health approach to engineer change.
- At a population level, to better coordinate policy and target interventions.
- At an individual level, to re-orientate services to focus more on early assessment, prevention and a minimal intervention approach to treatment.

Dream universally

Imagine globally

Think nationally

Plan regionally

Act locally