DEFENCE FORCE WELFARE ASSOCIATION
Patron-in-Chief: His Excellency General the Honourable David Hurley AC DSC (Retd)
NATIONAL OFFICE

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REVIEW OF THE DVA DENTAL PROGRAM – STAKEHOLDER SUBMISSION

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Submission

Would you like your submission to be confidential? **No**

Comments

General Comments:

The Defence Force Welfare Association (DFWA) welcomes the opportunity to make a submission to the DVA Team commissioned to not only review the effectiveness of its existing Dental Program but to examine options to markedly improve it for the benefit of veterans and their families into the future. Certainly, feedback received from our members suggests strong support for re-focussing the Dental Program away from being simply treatment orientated to a scheme with a much more 'wellness' focus.

The Discussion Paper was a valued guide to how a 'wellness' approach would benefit veterans and their families, particularly as the approach seems aimed at creating a lifetime oral health program. One major concern with the Paper is that there was no associated cost benefit analysis for the changes proposed.

Responses to Specific Questions:

1. As a DVA client or ESO, how would you describe your overall experience of the DVA dental program? Do you consider the program effective in addressing dental needs?

a. **Lack of Awareness of Current Dental Services.** Currently, most Veterans receive limited information on the dental services available from DVA under either a White or Gold card. This does not assist with overall dental health or facilitating an efficient and effective service. DVA website information is not presented in a user-friendly manner. Searching 'dental' brings up a variety of results, some aimed at providers and other various snippets of information which require further delving to check applicability to a client. Given the age demographic of the majority of DVA clients with dental entitlements, the information on the DVA web site is barely user-friendly and far from helpful to most. A complete revamp of the information is highly recommended.

b. White Card. White Card holders received advice only of any specific dental condition accepted as service-related and for which treatment is available through DVA to meet the clinical need. Veterans are mostly lay persons and have limited knowledge of technical dental terminology. Clear communication is lacking regarding what is covered. For example, one veteran stated, "*I have no idea what I am entitled to. My accepted condition is Bruxism and my dentist is no help in regard to treatments and possible complimentary treatments to alleviate this condition".*

c. Gold Card. In 2019/20 only 54% of 114,838 Gold Card holders eligible to receive dental treatment accessed that treatment. This low uptake indicates that the current program is not meeting veteran needs. Most claim that they received no useful information about the scope or administrative arrangement for dental services, except that it is free. Most information about what is covered is provided by the treating dentist rather than DVA. Some observations about this are as follows:

1) With the Manual claim system, it has been common for the Veteran to be asked to sign a DVA claim form by the dental receptionist with the lines blank, presumably filled in later by the practice. Sometimes a DVA number is inserted in the line. In any case, the Veteran has no idea what he/she is signing for or any responsibilities the veteran may have regarding checking. Consequently, as a check, it is useless. It is understood that the new on-line system requires no Veteran input. However, signing blank manual forms is not uncommon.

2) Regarding 'crowns', the Veteran can be unaware of Annual Monetary Limit (AML), but the dentist certainly is aware. Frequently, a dentist may recommend the crowning of older, heavily filled cracked teeth. It is often suggested that it be done progressively, one a year, due to the limitations placed on crowns by DVA.

3) Veteran Gold Card holders without any service-caused oral health problems and using the dental services regularly, generally do so of own volition and from practice engendered during ADF service. Regular attendance is habituated during service. Once transitioned, some dentists send reminders and schedule checks, but this proactive approach varies from dentist to dentist.

d. Reasonableness Test and AML. The extent of treatment provided under the current program is 'that which is reasonably necessary for the adequate treatment of the entitled person'. This is further constrained by the 'Annual Monetary Limit'. Interpretation of "reasonably necessary" is contentious under present arrangements and this will increase with the proposed change.

For example, currently *'DVA funds dental implants in three circumstances where they are clinically necessary (**not for cosmetic purposes)'.*** The new program redefines the *'standard of health of the oral and related tissues that enables an individual to socialise **without embarrassment and that contributes to general wellbeing'.*** Clearly, the ban on cosmetic treatments is inconsistent with the aim of socialising without embarrassment.

e. Reasonableness, AML vs Clinical Need. The interpretation of 'reasonably necessary for adequate treatment' is currently in effect, managed by blanket application of the AML. Treatment of entitled persons health needs, whether generally or dental, must as a principle, be based on the clinical need of the person as a minimum standard.

2. How would you describe the DVA dental program meeting the needs of subsets of the dental treatment population, such as:

1. ***female veterans;***
2. ***TPI veterans;***
3. ***veterans with a mental health condition;***
4. ***younger veterans;***
5. ***older clients either residing and supported in their own homes or residing in a residential aged care facility.***

a. Female Veterans. There does not seem any need to differentiate female veterans from male veterans as dental disease does not present gender specific characteristics.

b. TPI. Subset is not needed as TPI status does not seem to be related to dental health although access to treatment may be a factor.

c. Veterans with Mental Health Condition. Some mental conditions, particularly dementia and the medications that are prescribed make dental conditions difficult to diagnose and treat. Some clients may experience pain or discomfort but unable to describe it. This is a general problem but there is scope for DVA to develop some strategies in recognising dental professionals with recognised skills that could provide care to this group such as dental hygienists providing care in home visits and caring for veterans in residential care The need to spend longer time with these patients would need to be appropriately recognised in appropriate and regularly reviewed fee schedules

d. Younger Veterans. No particular differentiating issue identified – subset is not needed.

e. Older Clients – In Own Homes or a Residential Aged Care Facility. Older people in residential aged care facilities have limited access to appropriate oral health systems, preventative dental care and other dental services. Research indicates that many older people are in need of urgent oral health care when they enter aged care facilities. Aged care workers see dental health as a low priority in the face of competing demands. Dental professionals lack training and support to undertake geriatric dentistry. This is corroborated by an excellent paper titled **'Successful Ageing and Oral Health'** prepared in 2016 by the Centre of Research Excellence in Primary Oral Health Care at the School of Dentistry, University of Western Australia.

f. Older Clients - Conflicting Information from DVA. There is a belief that once entitled persons go into RACF, the Department of Health took over responsibility for their health and medical need and that, effectively, DVA lost sight of them. Dental support services are available to entitled persons in RACF. Their vulnerability and the difficulties of treating veterans with dementia and other mental health conditions, means that greater clarity of responsibilities of provision of dental services is required.

3. What do you think the program should aim to achieve?

a. The shift in focus toward veteran lifetime wellbeing instead of an illness-based focus, outlined in the discussion paper, is fully supported.

b. The program should aim to achieve a standard of health of the oral and related tissues that enables the Veteran to 'eat, speak and socialise without active disease, discomfort, or embarrassment and that contributes to general wellbeing'.

c. The new approach replaces a menu of services and treatments for prevention and specific dental conditions to a program that contributes to the broader lifetime wellbeing of the veteran. The aim should encapsulate the approach advocated in the discussion paper and view oral health as a contributor to the veteran's wellbeing – it requires the dental and oral health professionals to work cooperatively.

d. The new approach is to change 'from reactive to proactive, complex to simple, dependent to self-reliant and siloed to shared approaches' offers many challenges both to DVA and the veterans. Specifically, the old approach made budgetary measures bureaucratically easy - so much allocated to the siloed Dental budget. With a wellbeing approach, budgetary management requires greater flexibility.

4. Is information on the DVA dental program easily found on the DVA website? Are there improvements that could be made so that the program is more informative and presented in a style that is easily understood? Are there topics that are not covered that should be?

Veterans considered that the DVA website currently has a mixture of information that is applicable to various groups and the home page should be focussed on information relevant to veterans and their health. Information such as fee schedules are applicable to providers and should be published elsewhere.

a. Program Easily Found? No. It fails the basic check – search 'Dental Program' - there is no program on the website except in relation to this consultation. The design of current the Dental Program, such as it is, is DVA Centric, not Veteran Centric. The current website presents a list of services, treatments and rules fitting in with budgetary considerations and legislation that DVA administer.

b. Missing Topics. The approach is not that of a program:

- There is nothing that promotes Veteran self-reliance – where are measures to encourage preventative treatments?
- Where are the measures to encourage pro-active approach by veteran to seek a DVA dentist?
- Where is the DVA support in helping veterans find DVA approved dentists and dental specialists?

c. Wrong Question. The information on the DVA website is impossible for the Veteran to find if the Veteran is not computer literate – and even then, it is poorly designed as mentioned earlier. Consider the age of the majority cohort. Some have grasped the computing world with confidence. Most have not. Computer access in RACF is virtually non-existent.

5. How would you describe the ease of participation in the program? Are there barriers that impede access to the DVA dental program, and if so, how might these be addressed?

Limited collaboration between dentists and aged care workers exists. Dental professionals lack training in geriatric dentistry. There is lack of suitable space in the home or a residential facility to enable safe, effective and/or sophisticated oral treatment to be applied.

Treatment in a private dental surgery provides the optimum access to sophisticated treatment options but routine dental examinations and minor treatment could be managed in a home environment or residential aged care with appropriate support

Some clients have noted that it is difficult in some areas to find dentists willing to accept DVA fees. Some clients are active in social media and share information about dentists willing to accept DVA patients. Positive experiences are common from patients who have been treated by dentists who had previous ADF service and are now in the private sector and welcome veterans as a community responsibility

6. What are the challenges and opportunities DVA should be aware of in considering transitioning the DVA dental program from a treatment focused program to a wellness focused program based on the goal of creating lifetime oral health?

The difference between a treatment focussed program and a wellness program is not well understood. Dental treatment is aimed at overcoming oral disease in order to alleviate pain and discomfort, and to contribute to overall general health. This is a component of 'wellness'.

The challenge confronting DVA is to recognize that this is a major change affecting many stakeholders and an embedded culture. It is not just a matter of writing a few new procedures and expecting stakeholders to just get on with it. This is a major change.

There has to be a formal Change Management Plan, identifying all stakeholders, a few of which have not really been considered in the past, e.g., the entitled persons who do not attend routine dental health checkups, the service providers associated with Residential Care Facilities.

The previous approach was DVA Centric and very much aligned to legislation and budgetary processes with lists of treatments and aligned budget allocations. There was total disconnect with the supported Veterans. The Discussion Paper and the Questions therein refer to the DVA Dental Program – yet for Veterans and ESOs, it is not visible. The major challenge for DVA is to manage this as a 'Major Change', and to communicate with the stakeholders, particularly with Veterans, the aim being to assist them to become more self-reliant.

7. What opportunities / strategies exist to increase dental attendance especially for those clients who either don't attend dentists or only attend for treatment of a problem? How might these differ between males and females, younger and older clients and clients living in supported arrangements (home or residential aged care facilities)?

DFWA is unaware of any strategies relating to improving attendance for dental hygiene checkups and/or for treatment. As for opportunities to build on routines practiced while a veteran was serving, they could include the following:

a. **'Catch-up' Veteran Health Check**. Consider introducing a Dental Health check as part of a general 'Catch-up' Veteran Health Check every two years for all previously transitioned Veterans whether Card Holders or not. Get all Veterans who have never received a card even under Non-Liability conditions, onto the DVA 'Books'. This could be advertised through all GPs and with the publicity about the 2021 Census which includes the Veteran question for the first time.

b. **Transport**. Veterans should be eligible for transport for dental checkups and treatment according to the White or Gold Card entitlement.

c. **Heart Health Program**. This wellbeing program should include a section on dental health with a requirement to have a free dental check, if not already done.

As for clients in Supported Arrangements, they need assistance with transport and may need care/nurse assistance to attend a dental appointment. Given that many, particularly those with widow/er Gold Cards, have not been in the habit of attending and may have nil knowledge at all of any DVA Dental Program, clearly the information has to be provided before any improvement in attendance could be achieved. It is suggested that the Aged Care service provider needs to be the prime source of information to the client and would be the prime arranger of appointments.

8. What opportunities / strategies exist to assist transitioning ADF members to maintain regular dental attendance?

DFWA is unaware of any existing strategies. There is a clear need to build on the routine of regular checks habituated during ADF service, noting that this does not apply to non-veteran entitled persons with Gold Cards. Opportunities to build on this should be explored and could include the following:

a. **Pre-Transition**. Training and information sessions on dental health within the context of an overall health and wellbeing model, during service and active encouragement for ADF members families to adopt regular attendance – perhaps with private health insurers specializing in ADF families offering specific incentives.

b. **Pre-Discharge**. The current pre-discharge Separation Dental Examination is totally treatment focused. It should include a pre-discharge dental briefing covering the member's specific dental and oral health situation and likely prognosis of things about which he/she should be aware. It should address what would be covered by DVA and what would not be covered. There should be an indication of likely costs and discuss private dental insurance and how to find a private dentist – Transition Dental Preparation. Above all, the briefing should provide the veteran with a dental history and an explanation of the importance of the need for ongoing dental care particularly of sophisticated treatment such as crowns and implants.

c. **Transition Seminars**. The current ADF Member and Family Transition Guide has 13 pages in Section 5 – Medical and Dental. It has only three lines devoted to Dental.

d. **Veteran Health Check**. The annual check for the first five years should be expanded to include a dental check for all White and Gold Card holders. This should encourage 'habituation' in the new self-reliant environment.

e. **Transport**. Veterans with limited mobility due to physical and mental health condition, including those in RACF and care in the home, should be eligible for transport for dental checkups and treatment according to the White or Gold Card entitlement.

f. **Heart Health**. This wellbeing program should include a dental health section.

g. **White Card.** Veterans with a White Card and qualifying service should be advised of the dental treatment services that will be available to them on reaching the age of 70.

9. How could the current dental care model for older clients be enhanced to improve a client's oral health and wellbeing in a home-based setting or* in a *residential aged care facility?

This question has been, in greater part, addressed in several other responses. But in summary:

a. **Home based setting;** The Interim Report of the Aged Care Royal Commission recommended a marked increase in funding for Home Care packages with the aim of keeping older people in their own homes instead of moving into residential aged care. Those packages should include a dental treatment component for home care – particularly focussed on prevention. Appropriate fee schedules are required noting that longer appointments will be necessary in a home setting.

b. **Residential aged care facility:** Currently dental care in residential aged care is often conducted ad hoc. In the current system, dentists often work in isolation and without links to the primary health care team of the resident. The oral health status of older patients can decline with failing health, systemic diseases and medical treatment for comorbidities with a profound effect on nutritional status and quality of life.

10. In what ways could DVA determine the effectiveness of services provided?

Effectiveness can be measured by the proportion of clients who access the services that are available and by follow up interviews of a random group of clients.

But more broadly, the proposed way ahead should have included a cost-benefit analysis. A metrics is needed to determine the effectiveness of services currently provided vs those to be provided. Various assertions have been made regarding the effects of the proposed changes, but no hard data or comparative data from other sources has been made available. All we have is data regarding use of services currently – there is no data presented on effectiveness.

Also, greater participation by eligible persons may be one indirect measure as presumably, an increase would be an indicator of Veteran satisfaction with the Service, and as a metric, participation is the only baseline metric currently presented. Metrics are needed for:

a. **Reactive to Pro-Active.** Indicated by changed ratio of increasing preventative treatments and fewer reactive treatments to meet clinical need.

b. **Comparative Statistics.** The potential to use best business practice metrics used elsewhere in society for measurements of wellbeing.

c. **Self-reliance**: Indicated by increased numbers attending preventative treatments and Veterans continuing to attend regularly after the initiatives introduced by a clearly defined Dental Program, including:

- New Approach from the Separation Dental Examination to a Transition Dental Preparation.
- Exposure of the revised DVA Dental Program at Transition Seminars, DVA website and in the “ADF Member and Family Transition Guide”.
- The 5 Annual Health Checks after transition to include dental checks.
- A ‘Catch-up’ Veteran Health Check (two years one-off) for previously transitioned Veterans.