

Reform of Human Services Inquiry  
Productivity Commission  
Locked Bag 2, Collins Street East  
Melbourne Vic 8003

Dear Commissioners,

**Re: Human Services Inquiry – Draft Report**

cohealth welcomes the opportunity to comment on the Productivity Commission *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, Draft Report (the 'Draft Report').

cohealth is Australia's largest not-for-profit community health service, operating across 14 local government areas in Victoria. Our mission is to improve health and wellbeing for all, and to tackle inequality and inequity in partnership with people and their communities. cohealth provides integrated medical, dental, allied health, mental health and community support services, and delivers programs to promote community health and wellbeing. Our service delivery model prioritises people who experience social disadvantage and are consequently marginalised from many mainstream health and other services.

Please do not hesitate to contact us should you require further information or assistance in your inquiry.

Yours sincerely,

Lyn Morgain  
Chief Executive



## Introductory comments

Caring about the whole person and placing people at the centre of everything we do underpins cohealth's work. As such, the stated aims of this inquiry, emphasising consumer choice and keeping people at centre of service provision, aligns with our values and approach. As the Draft Report states "human services are essential for the wellbeing of individuals and their families, and underpin economic and social participation". Accessible and appropriate human services are particularly important for the many people cohealth works with who experience disadvantage and marginalisation. cohealth agrees with the importance of improving outcomes for these people, while maintaining or improving the quality of service (as per Inquiry terms of reference).

The cohealth submission to the Productivity Commission's earlier Issues Paper on this matter described the serious concerns we hold about conflating competition, contestability and user choice, and about the lack of evidence that increasing competition and contestability will improve outcomes for recipients of human services. We concur with the concerns raised by ACOSS in their submission to the Issues Paper, that the Productivity Commission work on human service reform "asks the wrong questions in the wrong order"<sup>1</sup>. That is, rather than starting with an open question as to how best to improve service quality and accessibility, the Inquiry "presuppose[s] that competition policy is both a goal of reform as well as the optimal way to improve the effectiveness of human service delivery."<sup>2</sup> We are reassured to note that the Draft Report recognises "that greater informed user choice, competition or contestability will not always be beneficial" and that "The costs and benefits of a reform option depend on the characteristics of the people accessing the service, the characteristics of the service itself and the market conditions where service providers and users interact" (p 54).

Despite this acknowledgement, the Draft Report identifies six sectors for reform – sectors that provide essential supports predominantly to people who experience disadvantage and vulnerability. We remain unconvinced by the arguments presented that many of the proposed changes will improve the wellbeing of these people, particularly in the absence of long overdue funding increases.

Our fundamental concerns about the approach, and proposals in the Draft Report, include:

- We are not convinced there is a direct link between greater competition or contestability and more meaningful, or effective, service user choice. Many clients using the categories of services identified in the Draft Report experience significant vulnerabilities. In these circumstances there is such a potential disparity of power and influence between often vulnerable people and resourced and skilled organisations.
- To date, increased competition has generally meant an accompanying opening up of a sector to private profit providers. In sectors as diverse as child care, age care, disability care, vocational training and utility provision this has too often led to a focus by the provider on profit over quality service provision. Almost every day there are

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<sup>1</sup> ACOSS 2016 ACOSS Response to Productivity Commission Preliminary Findings Report accessed 10 July 2017 at <http://www.acoss.org.au/wp-content/uploads/2016/11/ACOSS-Submission-to-Productivity-Commission-Competition-in-Human-Services-Preliminary-Findings-Report-Final.pdf>

<sup>2</sup> Ibid p4



reports of the exploitation of vulnerable people, a testimony to the failure of such an approach.

- While regulatory and stewardship arrangements have an important place in ensuring the quality of services provided, cohealth sees risks to consumers through exposing human service provision to private profit, and questions the wisdom of taking this path.
- Our most significant concern – one that we raised in response to the Issues Paper, and persists as a fundamental flaw in the Draft Report - remains that there is no mention of the level of funding provided to the services identified for reform. As government funded services, the extent to which they can meet community needs is, to a large extent, determined by the level of funding governments chose to allocate to them. While we acknowledge that the efficiency and effectiveness of services can be improved in a range of ways, there currently exists a significant level of unmet need for services.

The first priority should be to increase the resources available to these essential human services, and remedy this shortfall. While demand exceeds supply there will always be significant constraints to consumer choice. The inadequate level of funding of these services – and the critical need to improve funding levels as the key determinant of providing services and improving consumer choice - needs to be incorporated in the Draft Report. Governments make choices as to the revenue raised, and the way it is spent. Essential human services deserve, and require, more adequate funding. There is no shortage of proposals on how to more equitably raise revenue to pay for much needed human services. In particular, we draw the Commission's attention to the work the Australian Council of Social Service (ACOSS) has undertaken on this matter.<sup>3</sup>

In relation to **Social Housing**, cohealth holds serious concerns that the Draft Report includes no reference to increasing the overall stock of social and affordable housing. With a significant lack of affordable housing, particularly in the capital cities where jobs and human services are, there is a danger that any increase in rent assistance, as proposed in the Draft Report, will simply be passed on in higher rents. Nonetheless, cohealth supports the recommendation that Commonwealth Rent Assistance be increased, and argues this should be done as a matter of urgency, to restore the real value of this payment.

We strongly argue that Federal, State and Territory governments commit to an urgent increase in the stock of social housing.

Security is an important feature of housing, but private rental in Australia is characterised by short term leases, and limited security. The negative health impacts of precarious or inadequate housing have been well established<sup>4</sup>, with people living in precarious housing having worse health than those in adequate housing. Those living in private rental have the most insecure housing tenure, and are most vulnerable to health consequences. While the

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<sup>3</sup> See for example: <http://www.acoss.org.au/budget-2017/revenue/> ; [http://www.acoss.org.au/wp-content/uploads/2017/02/ACOSS\\_Budget-Priorities-Statement\\_2017-18-FINAL.pdf](http://www.acoss.org.au/wp-content/uploads/2017/02/ACOSS_Budget-Priorities-Statement_2017-18-FINAL.pdf)

<sup>4</sup> VicHealth, 2011, *Housing and Health Research Summary* Accessed 13 July 2017 from <https://www.vichealth.vic.gov.au/search/housing-and-health-research-summary>



Draft Report acknowledges the work being done in various jurisdictions to improve private rental security, it would be inappropriate to consider any action to encourage movement into the private rental market until positive changes have come to fruition.

In the area of **Family and Community Services**, again cohealth is concerned that one of the key limitations to meeting the needs of people experiencing hardship is the lack of funding to the sector, and the failure of funding to increase over time according to population growth and need. In line with our comments above we hold serious concerns regarding Recommendation 7.2, that in selecting providers the Governments should “not discriminate on the basis of organisational type (for-profit, not-for-profit and mutual for example”. The private profit motive of for-profit providers is inconsistent with ensuring that the maximum resources are directed to providing effective services to people experiencing disadvantage. Nonetheless, we are pleased that the focus of the Draft Report is on improving planning, contract management and the like. In particular we support the Draft Report recommendation to increase contract terms to seven years. Funding uncertainty and the limitations this places on the ability to plan for the future, develop programs and workforce and respond creatively to the needs of clients, has long plagued the sector.

The remainder of this submission will respond to the reform proposals related to **Public Dental Services**.

cohealth operates 24 public dental chairs across three sites in Melbourne, and has provided oral health services for almost 30 years. As a fully accredited oral health provider we offer high quality, low cost or free emergency and general dental care. We prioritise Aboriginal and Torres Strait Islander peoples, children and young people (under 18years), people who are homeless or at risk of being homeless, refugees and asylum seekers, people with mental health issues, people registered with disability services, pregnant women and people over 80 years of age. Our clients gain access to a professional team of registered dentists, dental and oral health therapists, dental prosthetists, oral health educators and dental assistants working together to improve the oral health of our clients. Working as part of an integrated community health service, clients are also able to be easily referred between a range of other health, allied health and community programs and supports.

In 2016-2017 cohealth provided oral health services to over 17,400 individuals, 68% of who were priority clients. These clients received over 50,000 services, nearly half of which were preventative services. Services included: nearly 24,000 preventative treatments, 12,000 restorations (fillings), 5,600 periodontic, nearly 5,800 oral surgeries, close to 900 endodontic (root canal) procedures, and the provision of 1,900 dentures. On nearly 6,500 occasions interpreters were used, and 3,300 of all services were provided in an outreach setting.

Contrary to the assertions in the Draft Report, as a public dental provider cohealth already provides extensive preventative services. We – and other public dental services - provide high quality care to people experiencing disadvantage at the most efficient price. The fundamental impediment to undertaking more preventative work, and realising the outcomes described in the Draft Report, is the chronic underfunding of public dental care.



## General comments

As the Draft Report acknowledges, public dental services have not been a major focus for government, despite the significant benefits associated with early identification and treatment of oral health problems (p313). The costs of untreated oral disease are high – to the individual, government and the community at large. However, many of these costs can be treated, and public dental providers have been critical of the fact that seriously limited funding has resulted in them having to prioritise acute treatment, leaving limited or no resources available for preventative care.

As such, cohealth welcomes the emphasis placed on preventative care and improving outcomes for users. We also welcome the focus on client directed service models, tested efficient pricing and a level playing field between public and private providers.

However, as there is currently a significant “backlog of people with oral disease who require treatment” (Draft Report, p323), shifting the focus to prevention will require an increase in funding to public dental services to ensure that treatment needs are still met. However, there is no recommendation in the Draft Report to increase funding to public dental services. Indeed, in late 2016 the already low level of public dental funding was compounded by the Commonwealth cutting funding by \$300 million. Disappointingly this was not restored in the recent federal budget. This funding cut will only further increase waiting times for public dental services.

cohealth argues that the preferred approach is for public dental programs to be adequately funded to provide care and treatment to those unable to access private dental services. Public dental services are best placed to provide quality care, at a more efficient price than private providers, and have a comprehensive understanding of the complex health needs of people experiencing disadvantage. Notwithstanding this perspective, we provide the following feedback on the specific recommendations in the Draft Report.

Other concerns we hold about the specific proposals include:

- the increased complexity of the system for clients trying to access services under the proposed changes
- the lack of discussion about the complex needs of clients
- consumer co-design is not incorporated in the proposed model
- a lack of detail regarding how risk stratification will be undertaken. We particularly note the absence of broader health and social factors despite their role in oral health
- the cost of moving to the new model particularly in a chronically underfunded system
- the reliance on the digital health record as the cornerstone of the new system when the My Health Record has had a poor take up
- evidence of reduced treatment in capitation trials in the UK, despite an increase in preventative care <sup>5</sup>

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<sup>5</sup> Draft Report 2017 “The trial found no evidence of systematic neglect under the capitation model, but concluded that dentists did not restore established carious lesions as readily as their fee-for-service counterparts.” p 343 Box 12.1



- the simplified versions of accreditation and quality requirements for private providers to participate in the system compared to the rigorous accreditation and compliance requirements for public dental services.

cohealth recommends that:

1. The Federal government immediately restore the National Partnership Agreement funding that was cut in late 2016.
2. The backlog of people on the public dental waiting list, needing assessment and treatment, be addressed as a matter of urgency through increased public dental funding.
3. Any changes are implemented in close consultation with a full range of stakeholders – clients, public and private providers of public dental health services and state dental health bodies.
4. All measures – of outcomes, priorities, payment levels (capitation or other) - include consideration of the social determinants of health, and provide adequate remuneration to meet the additional needs of priority groups and those with complex needs, including interpreters, outreach and longer consultation times.
5. Any trial to evaluate new models, such as blended payment models and allocation systems, include an assessment of whether the evidence demonstrates that these models meet the goals of improved client outcomes, and only if they do should further roll out occur.

**Draft recommendation 11.1** State and Territory Governments should report publicly against a consistent benchmark of clinically-accepted waiting times, split by risk-based priority levels.

cohealth supports this recommendation in principle, in line with our commitment to informed consumer choice, and accountability for public funds.

However, there are a range of complexities in developing benchmarks for 'clinically-accepted' waiting times, and the public reporting against them, that must be considered:

- From the discussion on 'benchmarking waiting times' it is unclear if priority level will be determined on clinical grounds alone, or whether a broader risk assessment including a range of socio economic factors would be used. In Victoria, for example, Dental Health Services Victoria recognise the influence of the social determinants of health on particular groups, and so prioritise particular population groups, including children, people experiencing homelessness and Aboriginal and Torres Strait Islander people. cohealth recommends that socio economic factors are incorporated in determining priority.
- Priorities and waiting times will need to be agreed on, and consistent, across the states and territories to allow meaningful comparison. Waiting list conditions, too, will need to be nationally consistent. For example, in Victoria a client must wait 12 months after finishing general dental care treatment before they can be placed on a general care waitlist again.
- Definitions of clinically-accepted waiting times need to take into account the fact that oral disease, such as dental caries, can fluctuate within short time frames. For



example, a woman who becomes pregnant can develop gestational diabetes and corresponding periodontal infections within a six to nine month period.

- It is unclear if a 'provider' will be defined as a single dentist or a clinic. Public reporting of waiting times and other measures is welcome if it is measured at a clinic level, as this can include the work of both dentists and other oral health team members. cohealth would not support public reporting at individual dentist level, as this would not account for the work of other professionals such as oral health therapists. This would also require a level of scrutiny of dentists that other individual health practitioners, such as GPs, are not subject to.

Finally, the cost of developing and implementing new data reporting systems is a concern, particularly if the resources for this are expected to come from the existing public dental health budget. If so, it will result in less funding for services in an already chronically underfunded system. This would be particularly concerning if public dental providers need to spend resources on system change in an environment where funding is low and service demand is high.

**Draft recommendation 11.2** State and Territory Governments should establish outcomes frameworks for public dental services that focus on patient outcomes and include both clinical outcomes and patient reported measures.

In principle cohealth welcomes the use of outcome measures to ensure that treatment is achieving results and client goals are being met. Outcome measures would need to be client driven and focussed, robust and sufficiently nuanced to reflect the complex issues of many public dental clients. The Recovery Star and Outcomes Star<sup>6</sup> models of improvement are used in other areas of care, such as mental health and homelessness, and consideration could be given to incorporating these tools into oral health care.

Good treatment outcomes are easier to achieve when a client is living in a stable environment. Clients with complex needs, such as those who are homeless, have a mental illness, or who use alcohol or other drugs may find it difficult to secure a service from dental providers who are motivated by profit, due the resources required to work with them.

The following case study illustrates the complexity of working with disadvantaged and vulnerable people:

Gemma was a 42 year old woman living in a Supported Residential Service (SRS). Although she had been diagnosed with an acquired brain injury, she was able to provide consent. Gemma reported a history of smoking, and was under the care of a local teaching hospital for a non-healing limb wound. The cohealth Oral Health Team (OHT) regularly visits the SRS to provide dental screening and oral health education to residents and staff but Gemma had been reluctant to participate. On one visit SRS staff reported that she was unwell and not eating much so the OHT visited her room and

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<sup>6</sup> See, for example, <http://www.outcomesstar.org.uk/preview-the-stars/>



encouraged her to have a screen. The examination found that Gemma had a large malodorous growth almost blocking the back of her throat and soft palate, resulting in difficulty breathing and swallowing. With Gemma's consent the OHT took images and sent them to the Royal Dental Hospital of Melbourne Oral Medicine clinic. An immediate response recommended urgent medical treatment at hospital. Gemma was transported to hospital where aggressive cancer was diagnosed. Sadly she passed away soon after.

Despite the reassurances in the Draft Report, we are concerned about the scope for 'cherry picking' of less complex clients, particularly by private providers, if the outcome measures are not well developed. Many of the clients cohealth works with experience multiple vulnerabilities, and require significant input. Private providers are generally reluctant to work with these people. Outcome measures need to incorporate the broader impact of the social determinants of health to ensure they provide an accurate reflection of work undertaken.

**Draft recommendation 11.3** State and Territory Governments should develop comprehensive digital oral health records for public dental services

cohealth has long supported a national electronic health record to provide transparency to clients and improve clinical safety, and we welcome the adoption of a similar system for oral health. However, the example of low uptake of My Health Record leads us to have concerns about the digital health record that is integral to the model proposed by the Productivity Commission. The My Health Record experience suggests that take up by consumers and providers is low and this would severely impact on the success of the new model. Extensive promotion to both providers and consumers would be needed, ensuring this was accessible to the diverse communities, eg through the extensive use of translation and accessible language, and providing reassurance to consumers regarding privacy.

Public dental service would need to be adequately resourced to meet the costs of developing and implementing the system. This would need to be in addition to existing funding, which has been inadequate for so long.

**Draft recommendation 12.1** State and Territory Governments should introduce a consumer directed care approach incorporating: risk-weighted capitation payments, performance based outcome measures and activity based payments for complex and hard to define procedures. The scheme should ensure that: patients are offered choice of provider (public and private), an enrolment period sufficient to measure outcomes, and users are able to change provider in certain circumstances.

In principle cohealth welcomes a funding system that rewards positive outcomes, encourages prevention, provides user choice and holds service providers accountable. The ambitious service model proposed by the Commission meets these requirements.





Our concern, again, is that the system is developed in a way that takes into account the needs of different groups, particularly those with complex needs. We argue that weighting should not just be for 'complex procedures', but also for factors that reflect the more involved, and costly, treatment approaches needed for particular groups. To ensure that vulnerable and disadvantaged groups, such as people who are homeless, have mental illness, from CALD communities, Aboriginal and Torres Straight Islanders are enrolled – and receive care and treatment - by a provider, the capitation payments must be weighted to reflect the additional costs (such as interpreting, outreach, longer consultation times) of providing care to these groups.

In addition to accounting for particular population group, capitation rates should account for different disease risk categories, determined by presenting conditions of the mouth. For example, a child may be in high priority population group, yet have low dental caries risk. On the other hand, a client who is on the general care waitlist as a 'non-priority' may have significant oral health risk as a result of poor saliva flow, being a smoker or poor oral health practices.

Consideration should be given to whether a 'provider' is defined as a clinic or an individual. Clinics that provide a model of care from a multi-disciplinary team are important and can provide a more cost effective method of care. With an ageing dental workforce, thought also needs to be given to responding to situations where a client's single provider retires prior to completing the defined enrolment period. Extending provider numbers to other oral health practitioners (in addition to dentists and prosthetists) such as dental hygienists, dental therapists and oral health therapists would also allow greater transparency and assist in the identification of who is providing the dental care for clients.

The Draft Report covers the concern regarding capitation and outcome based payments creating perverse incentives for undertreating and enrolling only straightforward clients in the program of providers motivated by profit. cohealth is particularly concerned by this and suggests that the oversight required to ensure that this does not occur would make a complicated system more complicated and onerous for providers.

Allowing the private sector to provide publically funded oral health care is presented in the paper as providing consumer choice. However, our experience is that in areas where public dental services are not available private providers are likewise very limited, or are already at full capacity with private clients so have little capacity to extend their care to public clients.

A greater concern is that the public dental system is, as already discussed, inadequately funded. Existing public dental chairs are therefor operating limited hours, resulting in unfilled capacity. As this infrastructure has been built using public funds cohealth argues that there should be increased funding to public providers to ensure this capacity is fully utilised, and more clients treated. Only once this occurs should consideration be given to directing public funds to private providers. As noted in the Draft Report, the cost of providing dental



care in the private sector can be approximately 30% higher than that provided through public providers<sup>7</sup>.

Although the model presents as increasing user choice, the Draft Report also suggests the people should only be able to change provider in certain circumstances, in order to reap the benefits of the enrolment period. This aspect of the model may encourage providers to only enrol clients who have stable lives and attend appointments reliably, disadvantaging people experiencing homeless or are transient. Barriers to changing providers can also work against the espoused aim of the proposal, to enhance consumer choice and control. cohealth requests that more information be provided about the about the circumstances where consumers can, and cannot, change provider, and that policies regarding this should be developed in collaboration with public dental health providers and consumers.

The following case study illustrates the need for consistent, flexible care for people with complex needs:

David is a 29 year old single parent of indigenous descent. He lives with a complex array of conditions, including mental health issues and diabetes, as well as experiences of family violence, and has issues with handling his own aggression. In the past 5 years he has had six emergency dental presentations at cohealth. In early 2016 he presented in pain, without an appointment, at a cohealth clinic. David required extraction of the painful tooth, but became aggressive when advised of the 30 minute wait for the experienced clinician to undertake the treatment. He threw dental equipment to the floor breaking it (replacement cost \$9,500) and walked out.

A year later, David recontacted our service for care and is now under general dental care. He has attended several appointments with no issues and is slowly gaining confidence in attending the clinic. At the last dental visit David disclosed more of his medical history including high blood pressure and that he had experienced an episode of endocarditis. His dental care has included removal of numerous permanent teeth, with more removals and fillings required. As David is identified as a priority client under the DHHS priority list, he has never been placed on the dental waitlist. At each of the six emergency visits he had been offered general care, which he declined up until the last presentation.

**Draft recommendation 12.2** The Independent Hospital Pricing Authority, in consultation with State and Territory Governments and the dental profession, should be funded by the Australian Government to determine the efficient prices for consumer directed payments.

cohealth is pleased to see that the Commission supports an efficient tested price, and supports a pricing model that reflects the real cost of providing dental care. Such a price needs to include consideration of the social determinants of health and their resultant effect

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<sup>7</sup> Dooland (sub. PFR300) referenced in Draft Report, p 341



on oral health care, and include a weighting for variables such as interpreters and clients with additional support needs.

We welcome a level playing field between private and public providers. Our experience has been that many private providers in our network refuse to treat clients through the voucher system because the amount paid is inadequate – despite them being paid more than public providers for the same treatment. Similarly, dentists working for corporate clinics and health insurers are reporting that remuneration structures are incentivising them to churn through clients and leading to unnecessary dental work and over servicing<sup>8</sup>.

Public dental providers are currently required to meet rigorous care and accountability standards – the NSQHS Standards for Dental Practices, regular reporting on infection control, and the use of best practice guidelines, clinical indicators and other clinical governance measures. However, we note that the Draft Report proposes private providers only need to hold a Medicare provider number and be registered with the Dental Board of Australia. To ensure consistent care for consumers, and for a level playing field to be realised, private providers would also need to meet the same standards.

**Draft recommendation 12.3** State and Territory Governments should transition to a new consumer directed care approach by first establishing initial test sites to evaluate new blended payment models and allocation systems, before a staged roll out.

cohealth acknowledges the importance of thorough piloting and evaluation before any change of such magnitude is implemented more broadly. Part of this process should be to determine whether a broader rollout is effective and justified. However, the wording of this section implies that the main role of the test sites is to review which blend of the different payment types is required and then the desired payment model will be rolled out more broadly.

cohealth cautions that it is important that the evaluation examines the evidence whether the proposed changes to the blended payment model, allocation system etc, can be supported at all rather than treat the change as a fait accompli and only evaluate the blend.

**Draft recommendation 12.4** State and Territory Governments should provide access to consumer directed care through a centrally managed allocation system that triages patients for both general and urgent care through an initial assessment.

cohealth acknowledges that there can be benefits from a centralised allocation system. However, the use of central allocations models in other health related sectors has had unforeseen consequences, particularly for clients who experience disadvantage. The separation between the assessment function and the treating provider can cause confusion

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<sup>8</sup> ABC Background Briefing “Dentists say targets and bonuses leading to unnecessary procedures on patients” Accessed 11 June 2017 at <http://www.abc.net.au/news/2017-06-30/dentists-say-targets-bonuses-leading-to-unnecessary-procedures/8665038>



for the consumer, particularly if there is a lack of communication between functions, uncertainty regarding which body to seek information from about aspects of their care, and the development of plans that do not meet the client needs.

cohealth is concerned that insufficient consideration is given in the Draft Report as to how consumers may experience a centralised assessment approach. The added complexity of centralised intake, and the need to undergo assessment before choosing a provider, may make the oral health system more complex to negotiate. We fear that the most marginalised and disadvantaged consumers are likely to drop out of the system before treatment even commences, unless additional support is provided to assist them to navigate the system.

A centralised waiting list or allocation system would need to retain a triage function that ensures those who require urgent care, or are in a priority group, receive it immediately. For example, in Victoria not all public dental clients join a waitlist. Those who are part of a group listed by Department of Health & Human Services as a priority are offered the next available appointment.

A centralised allocation system, accompanied by an initial needs assessment would require significant funding. cohealth argues that adequate resourcing of the existing public dental system would be a more efficient use of scarce funds. Nonetheless, if a system of initial needs assessments is pursued, public dental agencies are best placed to provide this, as they are well positioned to take into account a client's social history as well as the presenting oral health concerns. Funding would also need to cover language services and other personnel resources to cover a longer consultation (eg 30 – 45 min) to carefully discuss processes and options.

cohealth agrees with the suggestions in the Draft Report about the need to communicate with eligible populations, in a variety of appropriately accessible methods, about the new systems, and to improve understanding about eligibility for services and the importance of dental care. However, cohealth again has concerns about the cost of this to an already underfunded system, and emphasises that new funding must be provided for these functions, rather than reallocating existing money. We also emphasise the importance of including extensive consumer involvement, from a wide range of users, in the design and evaluation of any new system to ensure that it does indeed meet the goals of improving client choice.

