

Report
of the
National Advisory Council
on Dental Health

23 February 2012

The Hon Tanya Plibersek MP
Minister for Health

Dear Minister

It is my pleasure, on behalf of the Council, to provide to you the Report.

Since the establishment of the Council on 5 September 2011, my fellow Council members and I have undertaken extensive work, in line with our Terms of Reference, to develop our advice to the Australian Government.

The Council's work included consultation with dental peak bodies, consumer groups and Indigenous organisations. I would like to acknowledge all those who contributed their time and effort to our work.

The Council has given careful consideration to the issues facing Australians in accessing appropriate and timely dental care and has developed options to improve dental health. Since providing the Interim Report, the Council has further developed the options and indicative costings.

As a good oral health foundation in childhood is the key determinant of oral health throughout life, the Council commends the importance of a universal option for children. However, given the existing fiscal environment, the Council has included scaled down options for children, and adult options that are focused mainly on the most economically disadvantaged.

The Council agrees that the long-term goal for dental health in Australia should be a system that allows universal access to dental care. However, any of the four options in the report will entail preparatory work involving legislation and, most likely, COAG consideration. Therefore, the Council has provided, as a first step, forerunner measures that could be implemented while preparatory work is being advanced.

Foundational activities, such as investments in oral health promotion, infrastructure, and workforce, are integral to all options, and without advancement on all of these activities the policy objectives of the service delivery options cannot be met.

The Council trusts that the Report will assist the Australian Government's consideration of dental health of Australians.

Yours sincerely



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Chair, National Advisory Council on Dental Health
23 February 2012

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Executive Summary

On 5 September 2011, the then Minister for Health and Ageing, the Hon Nicola Roxon MP, and Senator Richard Di Natale announced the establishment of the National Advisory Council on Dental Health (the Council). See Appendix A for the Council's Terms of Reference.

The Council's deliberations have been informed by discussions with key dental health bodies, consumer group representatives, Indigenous organisations and other key stakeholders (see Appendix H). The Council provided an interim report to the Minister for Health and Ageing on 30 November 2011. This report contains options and priorities for consideration in the 2012-13 Budget.

Structure of the Report

Chapter One discusses oral health in Australia, including the significant improvements to oral health over the past few decades. Despite these improvements, too many Australians have difficulty accessing services. Many of these people have poor oral health, suffer from pain and social exclusion and have poorer general health. This extends beyond the individual to the wider economy through lost productivity and costs to the health system.

Chapter Two provides an overview of the dental system in Australia, including the roles of the State and Territory and Commonwealth Governments. It also discusses the dental workforce.

Chapters Three and Four describe the indicators of and reasons for poor oral health across the population. The burden of poor oral health is greatest in lower income groups and for rural and remote residents. The reasons for poor oral health are complex, but structural factors play a major role. In a dental system which is largely private, affordability remains a key barrier. Other factors which influence access are the inadequate capacity and funding of the public sector as well as workforce maldistribution, which limits the supply of dental practitioners in rural and remote locations. Social and behavioural factors also influence access.

Chapter Five presents eight aspirations for oral health (based on the Principles at Appendix B), which the Council believes are necessary for achieving long-term improvements in oral health. The aspirations form the pathway to achieving optimal oral health for Australians. They require collaboration and a commitment from all stakeholders to long-term reform and investment. These aspirations are also part of the framework that underpins shorter-term options, ensuring they form a solid foundation for future reform.

Chapter Six provides the Council's advice on options that take into account existing Commonwealth and state and territory programs, as well as how responses to oral health could be phased, or scaled, over time and still remain integrated with the longer-term goal. However, in the medium and longer term, financing options may be required.

The Findings of the Council

All members of the Council believe that the long-term goal should be universal and equitable access to dental care for all Australians. One member believes that equitable access to care should occur through the provision of targeted schemes aimed at delivery of comprehensive care to disadvantaged adults on public waiting lists and a universal scheme for children.

The Council understands that a comprehensive response for those facing access barriers is potentially very costly. Achieving better access across the population would require a level of funding many times above current government expenditure on oral health.

As a first step in addressing the nation's oral health needs, the Council has focused on improving access for children and lower income adults. Children are a priority because improvements to child oral health and prevention will reduce the overall burden of disease and improve long-term oral health across the population. Low income adults are a priority because they are more vulnerable to dental disease – treating their existing and complex oral health problems will lay a foundation for more effective long-term preventive measures. These priority groups could be separately targeted. However, the Council recommends that the Government considers action to address the needs of both.

The Council believes that in cases where funding is limited, it is crucial that measures to increase access to services, where possible, use existing service mechanisms so that funds are used efficiently. Engagement across governments to clearly define responsibilities would help policy planning and ensure funding can be appropriately applied within respective funding frameworks and service delivery models. In regard to priority groups, state and territory expertise should be used as much as possible to maximise desired outcomes. To recognise this, all options interact with the state and territory public dental system.

To further ensure that services are delivered efficiently, the foundational activities are proposed to encourage co-ordination of existing assets as well as support for synergies between local, state and national organisations.

The Council has structured options so that they could be articulated within a future universal access system. Furthermore, options can be scaled over time.

The Council agrees that oral health should be seen in the context of general health and that oral health reform should also be linked to current health reforms, such as the establishment of Medicare Locals and Local Hospital Networks. Incorporating oral health within these reforms will help to identify service gaps, improve access to services and integrate oral health services with other primary health care services.

It is the Council's view that the essential dental services should include diagnostic, preventive and routine services. This approach allows for a focus on prevention and early intervention. However, some patients may require more complex high-end oral care that is

not categorised as diagnostic, preventive or routine. In these cases, the Council recommends that there should be a mechanism whereby patients could access complex care items in exceptional circumstances. This could be the subject of further analysis in the context of implementing options.

The Council recognises the role private health insurance plays in the assisting 11.9 million Australians with financing of health care, including dentistry. The Council was not able to consider private health insurance in any depth. Further consideration needs to be given to the interactions between the options pursued and private health insurance. This includes consideration of the potential for overlap in public subsidies for dental services and private health insurance. The Council agreed that such consideration could extend to future reforms and incentives for private health insurance as well as other methods of financing dental services.

A summary of the Council's proposed service delivery options are presented below, with further details provided in Chapter Six and at Appendix C. Estimates of costs have been developed by the Secretariat in consultation with Dr Martin Dooland.

Professor Spencer expressed support for the implementation of options to be advanced into the 2012-13 year. This would allow the integration of the first steps for children and short-term activities for adults into the respective selected option. It would also have consequences for the costs for 2012-13 and the forward estimates.

Summary of the options for dental services for children

The Council has put forward two broad models for a universal children's scheme based on current dental service delivery systems. The first would utilise an individual capped benefit entitlement and provide a basic suite of preventive and treatment services. The second would expand services and improve consistency across state and territory public dental services.

The Council believes that the options for children have both short- and long-term benefits. In the short term, they will strengthen the existing system and maintain visiting patterns for the majority of children. At the same time, additional arrangements will focus on reaching children who are receiving inadequate services. Efforts in this area will help reduce more serious decay and infection, thereby reducing admissions to hospital for removal of teeth under anaesthetic. Over the long term, the improvements in the oral health of all children will build an excellent foundation for improvements across the population.

The child options could be scaled. This could start by targeting children of concession card holders and then moving to other groups such as low income non-concession card holders and those receiving other government payments.

Option 1 – An individual capped benefit entitlement

This option is aimed at increasing access to basic dental services for all children up to the age of 18. This could be done by expanding existing service arrangements and eligibility through the Medicare Teen Dental Program (MTDP). The annual benefit entitlement cap would be increased to reflect the cost of accessing basic preventive care and treatment.

The benefit could be used in the public or private sector (estimated cost over the forward estimates from 2012-13 – \$3.0 billion).

Option 2 – Enhanced access to public dental services

This option is aimed at increasing access for all children up to the age of 18 to basic dental services by enhancing existing public sector services. Services for children would be improved through consistent eligibility criteria and service levels across the states and territories. Program requirements and the funding model would need to be developed through formal discussions at the intergovernmental level (estimated cost over the forward estimates from 2012-13 – \$2.5 billion).

Summary of the options for dental services for adults

As a first step towards universal access, the majority of the Council believes that this should start with servicing those in greatest need, namely low income adults. Dr Shane Fryer supported an option aimed at disadvantaged adults on public dental waiting lists and believed this would be the most effective in delivering equitable and comprehensive dental care.

The Council considers that there are two broad models available for targeting services to lower income adults. The first would utilise an individual capped benefit entitlement, which could build on existing legislative frameworks, such as the Medicare Chronic Disease Dental Scheme (CDDS). The second adult option would expand capacity and improve consistency across existing state and territory services. These options are designed as a stepping stone on a path to a universal access program.

These options could include a short-term measure to fast-track services for people on public dental waiting lists. This may require additional funding to the states and territories while any other adult options are being implemented. This would be an interim measure and should not impede the implementation of other adult options.

Adult options could be scaled up over time to include other eligible groups, for example chronic disease sufferers and low income non-concession card holder adults.

Option 3 – A means-tested individual capped benefit entitlement

This option is aimed at increasing access to basic dental services for all concession card holder adults with funding provided through a capped benefit entitlement scheme through a schedule of services. The CDDS could provide the service delivery platform. A mechanism for access to high-end services or caps could also be made available in 'exceptional circumstances' (estimated cost over the forward estimates from 2012-13 – \$7.1 billion).

Option 4 – Enhanced access to public dental services

This option is aimed at increasing access for concession card holder adults to basic dental services by enhancing the public sector. Services for adults across the public dental system would be improved through capacity building and consistent service levels. Program requirements and the funding model would need to be developed through formal discussions at the intergovernmental level (estimated cost over the forward estimates from 2012-13 – \$3.0 billion).

An integrated model for card holder adults and all children

The Council also considers that implementing the adult and child options at the same time would improve services across all age cohorts. The possible combination of options for children and adults could also differentiate Commonwealth and state responsibilities for dental health. Additionally, they would help ensure that each level of government continues to maintain its effort in providing or funding dental services.

The Council examined each possible combination of child and adult options.

One example of an integrated approach demonstrates a possible division of responsibilities between the Commonwealth and the states, and uses existing systems in the short term, expanding its reach over time:

- The states and territories have a long standing involvement in school dental services and could develop the capacity to care for all children, particularly focused on those most in need. In this combination of options, states would be responsible for delivering services to children. States would also undertake additional activities to reach those children who currently do not have access to adequate care.
- The Commonwealth would take responsibility for concession card holder adults for preventive and treatment services. This could be built around an altered CDDS framework. Eligible adults would access services in the public or private sector. Phasing of this option could provide short-term assistance to the 400,000 adults on public dental waiting lists.

The total estimated cost for this option would be in the order of \$10.1 billion over the forward estimates from 2012-13. Other combinations of options and lines of responsibility are possible. Part of the dental reform process could include discussions between states and the Commonwealth (formal discussions at the intergovernmental level) on responsibility for children and adults or other options, including shared responsibility for particular groups.

Foundational activities

All service delivery options require foundational activities around workforce, capital infrastructure, oral health promotion and special access programs (for population groups that face barriers), which are specifically designed to support successful and sustainable improvements in oral health for priority groups and, eventually, universal access.

The range of activities would require an appropriate delivery framework. Appendix H highlights the work of a Medicare Local in Sydney, providing an example which could be the foundation of a future delivery framework.

Dental workforce and infrastructure

The terrain of the dental workforce has changed significantly in recent years, with the growth in the combined number of oral health therapists, dental hygienists and dental therapists (noting that there are variations within the individual professions). This has provided the context to re-examine pathways for co-ordinated analysis and planning of the future dental workforce.

The Council recognises the important work of all dental practitioners working together – dentists, oral health therapists, dental hygienists, dental therapists, dental prosthetists and dental specialists. However, workforce foundational activities would also require action on workforce utilisation, supply and infrastructure, and academic and clinical training and infrastructure.

Data and research

The Council supports improving the evidence base for workforce planning through ongoing research. The recent publication of new data on practitioner registrations highlights the need for ongoing monitoring of the dental workforce and the periodic revision of dental workforce supply projections.

Policy making, program design and evaluation needs to be supported by sufficient ongoing funding for data and research. Existing support for population-level monitoring and surveillance of oral health, use of dental services and practice activity could be maintained. The Council believes it would also be appropriate for the Government to fund periodic research and analysis.

Oral health promotion

Australia has a world class record in health promotion, including tackling road accidents and drink driving, smoking, and HIV/AIDS. However, expenditure on oral health promotion and non-clinical prevention activities is very low – estimated to be around one per cent of expenditure, compared to even the highly modest two per cent of expenditure across the whole health system. This could be significantly increased to reduce the incidence of dental caries and periodontal diseases. This would both improve the quality of life of Australians and reduce the demand for future dental care.

Groups with special oral health needs

The Council suggests a range of activities targeting Indigenous people, people residing in rural and remote areas, people in residential care, homeless people and people with disabilities. Medicare Locals could be particularly useful in coordinating services for these groups.

By undertaking these foundational activities, workforce maldistribution between rural and urban areas, as well as the public and private sectors, could be reduced. Appropriate infrastructure may help to both educate dental practitioners from under-represented groups and provide improved service levels to the population. Improved research can allow for groups with special oral health needs to receive appropriate dental care and targeted oral health promotion. These foundational activities are complementary to each other and would help to target services appropriately.

Chapter One – Scoping the Problem

Introduction

Oral health is an important part of general health, with implications not only for the individual but also for the broader health system and economy. Oral health across the population varies considerably between socio-economic groups and between adults and children. Access to services is important, with prevention and early intervention playing a key role in improving oral health status. In parts of the population where access is poor, the risk of poor oral health outcomes increases. The cost to individuals, the health system and the economy can be significant.

What is Oral Health?

In formulating our proposals, we considered the current state of oral health in the Australian population. Good oral health can be characterised by adequate dentition and the absence of untreated tooth decay or periodontal disease and a number of other less prevalent oral diseases and disorders. The impact of poor oral health is varied,¹ but as outlined in Australia's National Oral Health Plan 2004-2013, oral health "is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment".² It is for these reasons that strengthening oral health promotion and improving access to dental care in Australia is so important.

Oral Health and Visiting Patterns of Australian Adults

Information and data on the oral health of Australians is largely available through population health survey data from the Australian Research Centre for Population Oral Health (ARCPHO) and its constituent unit, the Australian Institute of Health and Welfare's Dental Statistics Research Unit (AIHW DSRU). This report discusses the oral health of Australians by looking at adults and children separately. This will help focus the development of long-term policy and shorter-term programs more appropriately, reflecting the different reasons for poor oral health in each group and the need to develop different approaches to improve outcomes.

Adult oral health indicators

There are several measures of adult oral health, including complete tooth loss (edentulism), inadequate dentition, untreated decay and periodontal disease. These measures of oral health vary across the population depending on concession card holder status (i.e. whether or not a person is a holder of a Health Care Card (HCC) or Pensioner Concession Card (PCC) issued by the Commonwealth Government), Indigenous status, education and age

¹ Sanders, A.E., Slade, G.D., Lim, S. and Reisine, S.T. (2009), 'Impact of oral disease on quality of life in the US and Australian populations', *Community Dentistry and Oral Epidemiology*, Vol. 37, pp.171-181.

² *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2004-13* (2004), Prepared by the National Advisory Committee on Oral Health.

(particularly in terms of the generation within which people were born). In 2008, only 11 per cent of adults rated their oral health as excellent.³

Tooth loss

The 2004-06 National Survey of Adult Oral Health showed that 6.4 per cent of the Australian population had lost all of their teeth. For all ages combined, the prevalence of complete tooth loss was 17.1 per cent for people eligible for public dental care compared to 2.7 per cent of those who were ineligible. However, there was little difference in complete tooth loss between Indigenous and non-Indigenous Australians. Improvements and changes in dental practice have seen declining rates of edentulism in younger generations.⁴

Inadequate dentition

Inadequate dentition is defined as having fewer than 21 teeth, because of the impact this has on function and appearance. For dentate Australians (having any number of teeth), 11.4 per cent had fewer than 21 teeth. Those without formal education beyond Year Nine had the highest proportion of inadequate dentition, at 34 per cent. The number of missing teeth increases with age. Further, people eligible for public dental care had 1.7 times more the number of missing teeth compared to those who were ineligible to access public dental care.⁵

Periodontitis

Moderate or severe periodontitis (gum disease) is present in 22.9 per cent of the Australian population. Periodontitis is strongly linked to age, with older generations having a much higher prevalence of periodontitis than younger people.⁶

Dental caries

The prevalence of untreated dental decay is also strongly linked to Indigenous status and increasing age.⁷ There is a relationship between income and dental caries prevalence, although the relationship is not strong (refer to Figure 1.1 below). For example, the mean decayed, missing and filled teeth (DMFT) of people in households with incomes of less than \$20,000 per annum was 14.97 compared to 13.34 in high income households of \$80,000 per annum. However, what is significant is that 39.8 per cent of low income households had untreated decay compared to 17.3 per cent of high income households.⁸ This suggests that differences in income make a difference to the treatment pathway, rather than the initial experience of decay (refer to Figure 1.1 below).

³ Australian Institute of Health and Welfare (AIHW)(2010), 'Self-rated oral health of adults', Research Report Series No. 51.

⁴ Roberts-Thomson, K. and Do, L., 'Chapter 5 – Oral Health Status'. In Slade, G.D., Spencer, A.J., Roberts-Thomson, K.F. (editors) (2007), *Australia's Dental Generations: The National Survey of Adult Oral Health 2004-06*, AIHW Dental Statistics and Research Series No. 34, Canberra, pp.82-84.

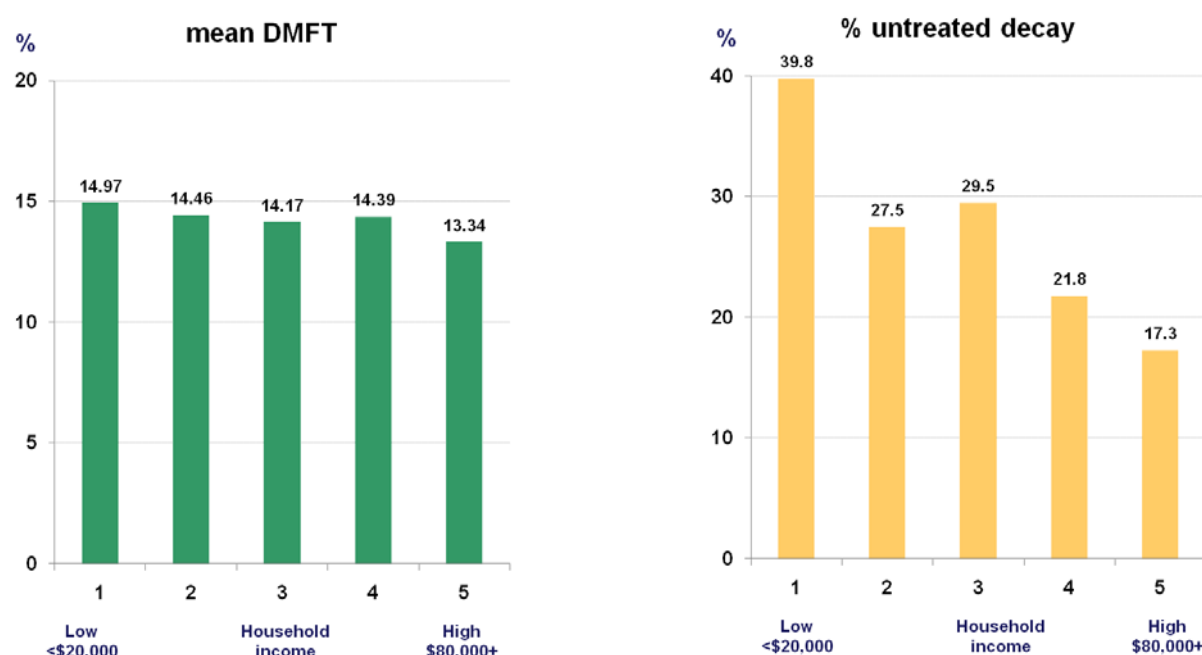
⁵ *ibid*, pp.85-93.

⁶ *ibid*, p.119.

⁷ *ibid*, p.105.

⁸ Spencer, A.J., 'Oral Health and Dental Services in Australia', Presentation to the National Advisory Council on Dental Health, 5 October 2011.

Figure 1.1: Income levels and DMFT and untreated decay among Australian adults 18+



Age and sex adjusted.

Source: Professor John Spencer, presentation to National Advisory Council on Dental Health, 5 October 2011.

It has also been found that people attending public dental clinics tended to have higher levels of decay as well as fewer filled teeth compared to those attending private dentists.⁹

Adult visiting patterns

Visiting patterns are a good indicator of oral health because the frequency and reason for dental visits indicates the likely pathway for treatment or service. Visiting patterns also provide an indication of the risk of poor oral health. 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 dentist, 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 (see Tables 1.1 to 1.3 below). In comparison to adults with favourable visiting patterns, adults with unfavourable visiting patterns are half as likely to receive preventive treatment and four times more likely to receive extractions.¹⁰ Australian adults' visiting patterns show that:

- 39 per cent of adults have favourable visiting patterns;
- 29 per cent of adults have unfavourable visiting patterns; and
- 32 per cent of adults have a mixed or intermediate visiting pattern.¹¹

⁹ Australian Research Centre for Population Oral Health (2009), 'Caries experience of private and public dental patients', *Australian Dental Journal*, Vol. 54, pp.66-69.

¹⁰ Ellershaw, A.C. and Spencer A.J. (2011), *Dental attendance patterns and oral health status*, AIHW Dental Statistics and Research Series No. 57, p.23.

¹¹ Spencer, A.J. and Harford J. (2008), *Improving Oral Health and Dental Care for Australians*. Prepared for the National Health and Hospitals Reform Commission (NHHRC), p.7.

Table 1.1: Treatment received during previous 12 months by pattern of dental attendance (per cent ^(a))

Treatment received	Dental attendance pattern		
	Favourable (%)	Intermediate (%)	Unfavourable (%)
Received an extraction	8.9	19.4	32.8
	^(b) 95% CI (7.8,10.0)	(17.3,21.4)	(29.0,36.6)
Received a filling	38.3	51.7	45.8
	95% CI (36.4,40.1)	(49.0,54.4)	(41.7,49.9)
Received a professional clean and polish and/or scaling	84.3	59.2	41.0
	95% CI (82.8,85.7)	(65.5,61.9)	(37.2,44.7)

(a) Age and sex-adjusted via logit model.

(b) Confidence Interval.

Source: Ellershaw A.C. and Spencer, A.J. (2011) *Dental attendance patterns oral health status*, Australian Institute of Health and Welfare, Canberra (Dental Statistics Research Series No.57, p.23).

While poor oral health is present across all visiting patterns, the most significant risk of poor oral health is likely to be for lower income households with poor visiting patterns. This is consistent with 2004-06 survey data which links visiting patterns to adult oral health. For example, 9.4 per cent of adults with favourable visiting patterns have fewer than 21 natural teeth compared to 23.3 per cent of adults with unfavourable visiting patterns (see Table 1.2). Both moderate to severe periodontal disease and untreated decay are also more likely in adults with unfavourable patterns compared to adults with favourable patterns.¹²

Table 1.2: Oral health of dentate adults by pattern of dental visiting

Pattern of dental visiting	DMFT	untreated decay (%)	moderate/severe periodontal disease (%)	<21 teeth dentate adults (%)
Unfavourable	13.9	38.4	31.1	23.3
Intermediate	14.4	26.9	29.7	14.5
Favourable	14.1	14.4	21.2	9.4

Age and sex adjusted estimates.

Source: Spencer, A.J. and Harford, J. (2008) *Improving Oral Health and dental Care for Australians*; Prepared for the National Health and Hospitals Reform Commission, p.26.

Around 56 per cent of high income households have a favourable visiting pattern compared to 22.1 per cent of lower income households. There is an inverse relationship with unfavourable patterns with only 16.2 per cent of high income households with unfavourable visiting patterns, compared to 43.7 per cent of low income households.¹³ However, the data show that unfavourable patterns are present across all income groups, with significant numbers of people in each of the income groups.¹⁴ This is an important caveat, because it

¹² Spencer, A.J. and Harford, J. (2008), *Improving Oral Health and Dental Care for Australians*, Prepared for the NHHRC, p.26.

¹³ Ellershaw A.C. and Spencer, A.J. (2011), *Dental attendance patterns oral health status*, AIHW Dental Statistics and Research Series No.57, p.12.

¹⁴ Spencer, A.J. (2011), *Improving access to dental services and oral health for Australians - implications from surveillance data*. Presentation to the Australia Department of Health and Ageing, 29 August 2011, Canberra.

indicates that unfavourable visiting patterns and the risk of poor oral health is present across the population although in unequal proportions (see Table 1.3).

Lower income groups are more likely to include a significant number of priority groups, including concession card holders, Indigenous Australians, lower income workers and people with more severe chronic diseases and disabilities, especially those whose illness or disability includes access to health concession cards. These priority groups and their oral health status are discussed in more detail in Chapter Three.

Table 1.3: Pattern of dental attendance, by annual household income (per cent ^(a))

Annual household income	Pattern of dental attendance		
	Favourable (%)	Intermediate (%)	Unfavourable (%)
Less than \$20,000	22.1	34.2	43.7
^(b) 95% CI	(19.1,25.5)	(30.3,38.3)	(39.7,47.8)
\$20,000–<\$40,000	28.9	34.6	36.5
95% CI	(26.8,31.2)	(32.2,37.1)	(34.1,38.9)
\$40,000–<\$60,000	38.7	33.0	28.2
95% CI	(36.1,41.4)	(30.6,35.6)	(25.5,31.1)
\$60,000–<\$80,000	43.5	31.5	25.0
95% CI	(40.3,46.7)	(28.5,34.6)	(22.2,28.0)
\$80,000–<\$100,000	51.8	27.6	20.6
95% CI	(48.5,55.1)	(24.6,30.8)	(18.0,23.5)
\$100,000 and over	56.0	27.8	16.2
95% CI	(53.0,59.0)	(25.2,30.5)	(13.9,18.9)

(a) Age and sex standardised via direct standardisation method.

(b) Confidence Interval.

Source: Ellershaw A.C. and Spencer, A.J. (2011) *Dental attendance patterns oral health status, Australian Institute of Health and Welfare, Canberra (Dental Statistics Research Series No.57 - p.12).*

People with private health insurance have more favourable visiting patterns than those without private health insurance. Across all age groups, people with private health insurance were 1.5 times more likely to have visited a dentist in the previous 12 months. Seventy per cent of people with private health insurance were likely to visit for a check-up compared to 43.2 per cent of uninsured people. Some caution needs to be applied in concluding that private health insurance is the sole reason for the increased visits because of certain demographic and socio-economic factors that influence private health insurance holders. Even so, studies have shown that insured people who are also eligible for public dental care will access dental care at similar levels to holders of private health insurance who are not eligible for public dental care.¹⁵

¹⁵ Spencer, A.J., Sendziuk, P., Slade, G. and Harford, J. Chapter 9 – Interpretation of Findings. In Slade, G.D., Spencer, A.J., Roberts-Thomson, K.F. (editors) (2007), *Australia's Dental Generations: The National Survey of Adult Oral Health 2004-06*, AIHW Dental Statistics and Research Series No. 34, p.242.

Oral Health and Visiting Patterns of Australian Children

The oral health of Australian children has improved significantly since the mid-late 1970s, with dental disease reducing substantially. This is most likely the result of improved access to fluoridated drinking water, the use of fluoridated toothpastes, the provision of preventive oral health services and the adoption of good dental hygiene practices.¹⁶

However, since the late 1990s, the prevalence of child caries and the mean number of teeth affected by dental disease in children has increased.¹⁷ The majority of child caries experience is concentrated in a minority of children who suffer a greater burden of disease. For example, approximately 20 per cent of four year olds and 20 per cent of 15 year olds have approximately 90 per cent of the total tooth decay for their age group.¹⁸ Recent studies have also revealed that there is a slight social gradient in the prevalence of child caries, with those children in the least advantaged areas experiencing approximately 1.5 times the number of caries than children in the most advantaged areas.¹⁹ However, the Council does not support an option to focus only on low income children. Caries and untreated caries are evident across all socioeconomic groups. Surprising proportions of those children affected are found in middle and upper socioeconomic groups. A universal program is the best option for reaching all children and establishing a foundation for good oral health throughout life.

Recent changes in the prevalence of dental disease in children may reflect changes in school dental programs across the states and territories as well as changes in dietary behaviours, including reduced consumption of fluoridated water and increased sugar consumption.²⁰ Children are eating less than the recommended amount of fruit and vegetables and are consuming more than their recommended energy from sugars.²¹ Poor childhood oral health is a strong predictor of poor adult oral health.²²

Child oral health indicators

Tooth loss

The Australian Child Dental Health Survey (2003-04) showed that, in children of all ages, the average number of missing teeth due to dental decay was low.²³ However, in groups where

¹⁶ Australian Institute of Health and Welfare (2009), *A Picture of Australia's Children 2009*, p.38.

¹⁷ Spencer, A.J. and Harford, J. (2008), *Improving Oral Health and Dental Care for Australians*. Prepared for the NHRC, p.36.

¹⁸ Rogers, J.G. (2011), *Evidence-based oral health promotion resource*, Prevention and Population Health Branch, Government of Victoria, Department of Health, p.42.

¹⁹ Spencer, A.J. and Harford, J. (2008), *Improving Oral Health and dental care for Australians*. Prepared for the NHRC, p.35.

²⁰ Australian Institute of Health and Welfare (2009), *A Picture of Australia's Children 2009*, p.38.

²¹ Rogers, J.G. (2011), *Evidence-based oral health promotion resource*, Prevention and Population Health Branch, Government of Victoria, Department of Health, p.42.

²² Lucas, N., Neumann, A., Kilpatrick, N. and Nicholson, J.M. (2011), 'State-level differences in the oral health of Australian preschool and early primary school-age children', *Australian Dental Journal*, Vol. 56, pp.56-62.

²³ Armfield, J.M., Spencer, A.J. and Brennan, D.S. (2009), *Dental health of Australia's teenagers and pre-teen children: The Child Dental Health Survey, Australia 2003-04*, AIHW Dental Statistics and Research Series No.52, pp.1 and 16.

dental decay is an issue, dental extractions and restorations are the most common cause for hospital separations. This outcome should be preventable.

Deciduous ('baby') tooth decay

Dental caries in children cause abscess formation, cellulitis and the systemic spread of disease.²⁴ It also causes pain, problems with eating or drinking, loss of sleep with effects on school attendance and performance.

The Australian Child Dental Health Survey (2003-04) showed that 48.7 per cent of children aged 5-6 years have experienced dental caries in their deciduous teeth and approximately 41.3 per cent had untreated decay.²⁵ The prevalence, severity and level of untreated dental decay for these children was found to be higher in areas of lower socio-economic status.

Permanent tooth decay

At approximately five years of age, children start to lose their deciduous teeth, which are then replaced by their permanent teeth.²⁶ By 12 years of age, most children have all of their successor permanent teeth. Data from the Australian Child Dental Health Survey (2003-04) revealed that 45.1 per cent of 12 year olds had decay in their permanent teeth and 24.8 per cent had untreated dental decay.²⁷ Similar to the 5-6 year old cohort, the prevalence, severity and level of untreated dental decay was higher in areas of lower socio-economic status.

Child visiting patterns

As with adults, visiting patterns for children are a good indicator of the risk of poor oral health. Children with favourable visiting patterns are more likely to receive preventive dental services and benefit from early diagnosis and prompt treatment. Children that fall into this category are also more likely to report low levels of extractions and possibly low levels of fillings,²⁸ whereas children with unfavourable visiting patterns (who do not visit a dental practitioner regularly and visit to treat a problem) are at a higher risk of experiencing oral disease.

The National Dental Telephone Interview Survey (1994-2005) shows that most children have good visiting patterns, usually visiting the dental practitioner at least once a year, with prevalence ranging from 86.8 per cent to 90.4 per cent for 5-11 year olds and around 80 per cent for 12-17 year olds.²⁹ Most children were also reported as visiting a dental practitioner for a check-up rather than to treat a problem. Children visiting a dental

²⁴ Australian Institute of Health and Welfare (2009), *A Picture of Australia's Children 2009*, p.38.

²⁵ Ha, D. (2011), *Dental decay among Australian children*, AIHW Dental Statistics and Research Report Series, No. 53, p.6.

²⁶ Armfield, J.M., Spencer, A.J. and Brennan, D.S. (2009), *Dental health of Australia's teenagers and pre-teen children: The Child Dental Health Survey, Australia 2003-04*, AIHW Dental Statistics and Research Series, No.52, p.16.

²⁷ Ha, D. (2011), *Dental decay among Australian children*, AIHW Dental Statistics and Research Report Series, No. 53, pp.7 and 10.

²⁸ Ellershaw, A.C. and Spencer, A.J. (2009), *Trends in access to dental care among Australian children*, AIHW Dental Statistics and Research Series, No.51, pp. 12 and 36.

²⁹ *Ibid*, pp.27-30.

practitioner for a check-up ranged from 84.3 per cent to 91.3 per cent for 5-11 year olds and from 76.0 per cent to 82.9 per cent for 12-17 year olds.³⁰

However, the data suggest that approximately one fifth of children are not usually visiting a dental practitioner once a year and are visiting a dental practitioner to treat a problem rather than receiving regular preventive services. A National Child Oral Health Survey, currently underway, will provide more up-to-date information on the visiting patterns and oral health of children.

Certain child priority groups are at higher risk of poor visiting patterns, which places them at a higher risk of developing oral disease. These groups include:

- children from lower income households;
- dependants of parent concession card holders;
- child concession card holders;
- Indigenous children; and
- homeless children.

These issues are discussed in more detail in Chapter Three.

Outcomes and Impact of Oral Disease

The start of this Chapter defined oral health – this section provides details on why good oral health is important. Oral disease is very common and its impact on individuals and society is significant. We believe these impacts can be underestimated for both the individual and the health system. It is important to understand that for those who find access difficult, the delay in dental treatment can often result in serious infection and pain with poor oral health outcomes. Beyond the individual, the broader cost to the health system is also a concern, with costs focused on the treatment of pain and infection, rather than access to a dental practitioner for the treatment of the underlying cause.

Impacts on Individuals

The National Oral Health Plan 2004-13 highlights the importance of oral health and the impact of oral disease:

“Oral health is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. The impact of oral disease on people’s everyday lives is subtle and pervasive, influencing eating, sleep, work and social roles. The prevalence and recurrences of these impacts constitutes a silent epidemic.”³¹

Oral diseases and disorders create short term and prolonged physical discomfort. Pain, infection and tooth loss are the most common consequences of oral disease, causing difficulties with chewing, swallowing, speaking, and can disrupt sleep and productivity. The

³⁰ *ibid*, pp.32 and 34.

³¹ *Healthy Mouths, Healthy Lives: Australia’s National Oral Health Plan 2004-13* (2004). Prepared by the National Advisory Committee on Oral Health.

National Survey of Adult Oral Health 2004-06 indicates that of the Australian population: 17.4 per cent avoid foods due to dental problems; 15.1 per cent experience toothache; and 22.6 per cent experience orofacial (jaw) pain.³² Dental disease can also lead to destruction of soft tissues in the mouth, leading to lasting disability and, in rare cases, death.

Health and wellbeing

Oral health is integral to general health. Tooth loss is directly associated with deteriorating diet and compromised nutrition,³³ which can impair general health and exacerbate existing health conditions. Further, the mouth is often an entry point for infections, which may spread to other parts of the body.³⁴ International research indicates there are associations between chronic oral infections and heart and lung diseases, stroke, low birth-weight and premature births. Associations between periodontal disease and diabetes have also been noted in international literature.³⁵

Dental disease negatively impacts general quality of life, affecting not only physical wellbeing but also psychological and social wellbeing.³⁶ The US Department of Health and Human Services notes these impacts include: “a tendency to avoid social contact as a result of concerns over facial appearance... [and]... persistent pain has similar isolating and depressing effects”. Further: “given the importance of the mouth and teeth in verbal and non-verbal communication, diseases that disrupt their functions are likely to damage self-image and alter the ability to sustain and build social relationships”.³⁷ Dental disease can affect the way a person looks and sounds, with a significant impact on wellbeing – a person whose appearance and speech are impaired by dental disease can experience anxiety, depression, poor self-esteem and social stigma which in turn may inhibit opportunities for education, employment and social relationships.

Financial

The financial impact of oral disease for individuals includes the out-of-pocket costs for private care, estimated to be \$4.698 billion per annum as at 2009-10. Acute dental

³² Harford, J. and Spencer A.J. Chapter 7 – Oral Health Perceptions, In Slade, G.D., Spencer, A.J., Roberts-Thomson, K.F. (editors) (2007), *Australia's Dental Generations: The National Survey of Adult Oral Health 2004-06*, AIHW Dental Statistics and Research Series No. 34, pp.173-184.

³³ Locker, D. (1992), 'The burden of oral health in a population of older adults', *Community Dental Health*, June; 9(2), pp.109-24.

³⁴ US Department of Health and Human Services (2000), *Oral health in America: A report of the Surgeon General*, Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, pp.104-109.

³⁵ *ibid*, pp.109-123.

³⁶ “The World Health Organization defined health as the ‘complete state of physical, mental, and social well-being and not merely the absence of infirmity’. *Physical well-being* assumes the ability to function normally in activities such as bathing, dressing, eating, and moving around. *Mental well-being* implies that cognitive faculties are intact and that there is no burden of fear, anxiety, stress, depression, or other negative emotions. *Social well-being* relates to one’s ability to participate in society, fulfilling roles as family member, friend, worker, or citizen or in other ways engaging in interactions with others.” *ibid*, p.133

³⁷ *ibid*, p.137.

conditions also can restrict the participation of adults in the workforce, including restricted duties and lost work days due to dental related illness.³⁸

Children

Children face the additional challenge of poor oral health and/or poor oral health habits having far reaching effects into their adulthood. Dental conditions in childhood can restrict children's participation in schooling and education through days lost to illness. Impaired physical appearance due to dental disease can further limit children's ability to socialise with confidence and develop social norms and relationships.

Waiting lists

For some Australians, the impacts of dental disease are magnified and prolonged because they are unable to afford private treatment and opt to go on public sector waiting lists for treatment. These people may wait significant periods for care, thereby worsening their oral health outcomes. Problems which could have been fixed relatively easily become more complex and costly to the individual. There are up to approximately 400,000 patients on public dental waiting lists; a figure which has been decreasing since 2004.³⁹ However, the waiting time has been increasing – in South Australia, preschool children are waiting an average of over two years for general anaesthetic for dental treatment in public hospitals.

Broader Impacts on the Health System

Individuals who have difficulty accessing dental care seek relief from pain and infection through other services. The end result of delays in treatment can be admission to hospital to treat serious infections. This puts pressure on the broader health system through dental treatment sought from hospitals (public and private), non-admitted clinics (outpatient treatment) and general practitioners (GPs).

Hospitalisations

Although complications from dental disease are theoretically preventable by adequate preventive care and treatment, individuals are often hospitalised because of the lack of adequate and timely dental care. In 2009-10, there were 60,251 potentially preventable hospitalisations (PPH) for dental conditions – almost 9 per cent of all PPHs and the fourth most common cause of PPH behind diabetes (24 per cent), dehydration and gastroenteritis (10 per cent) and chronic obstructive pulmonary disease (9 per cent). Table 1.4 below refers.

³⁸ US Department of Health and Human Services (2000), *Oral health in America: A report of the Surgeon General*, Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, pp.7 and 147.

³⁹ Given inconsistent definitions and measures of waiting lists numbers across the states and territories, the estimate of 400,000 currently on public dental waiting lists is based on the best available data as gathered by the state and territory public dental services through the National Dental Directors Committee.

Table 1.4: Separations for selected potentially preventable hospitalisations (public and private), by state or territory of usual residence, 2009-10

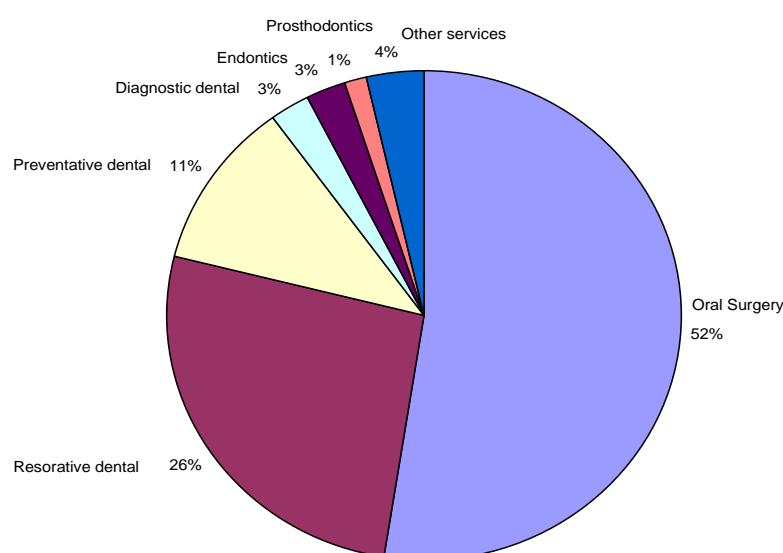
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Dental conditions	15,757	16,583	12,592	7,919	5,002	1,105	610	663	60,251
Total PPH	204,930	171,872	152,025	84,015	53,290	12,982	6,689	9,305	695,560

Source: AIHW Australian Hospital Statistics 2009-10, Table S7.10

Of the total number of hospitalisations due to dental disease, the number of admissions to public hospitals has remained fairly stable over the last decade, while the number of admissions to private hospitals has increased over the past three years.

Data from 2009-10 indicate there were 336,770 procedures performed in public and private hospitals for dental services. Of these, more than half were for oral surgery, specifically for surgical removal of teeth. Figure 1.2 below refers.

Figure 1.2: Percentage of dental procedures performed in hospitals, 2009-10

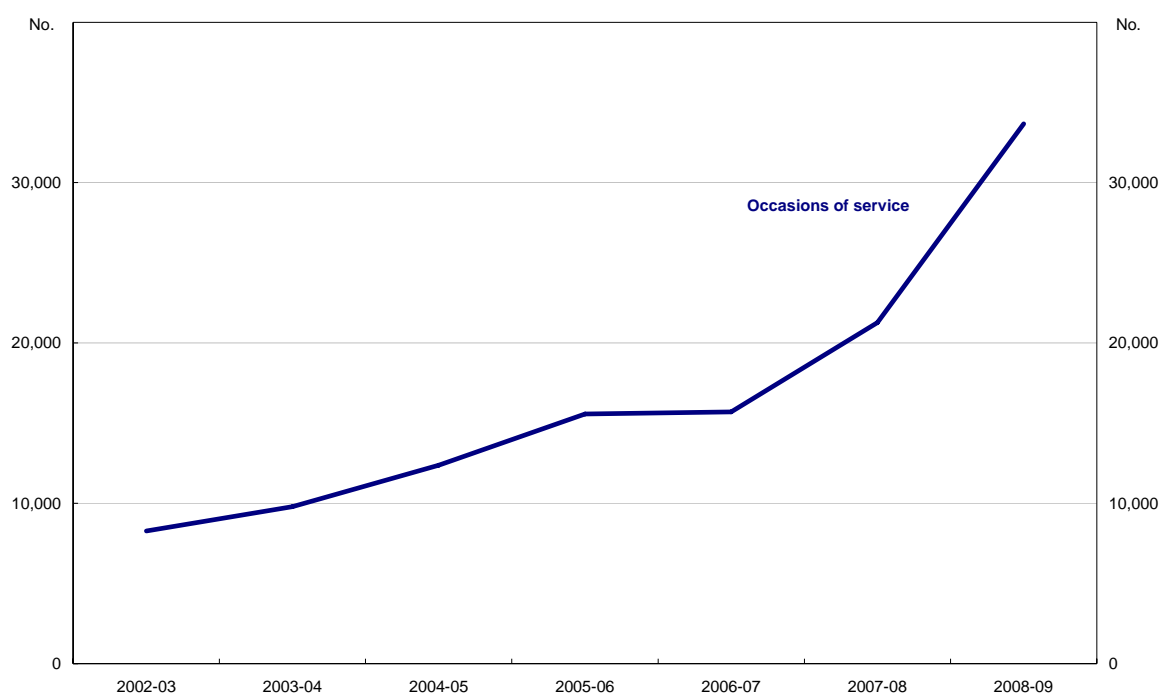


Source: AIHW National Hospital Morbidity Database (Australian Classification of Health Interventions (ACHI) data)

Outpatient clinics

Those who are not admitted to hospital for dental treatment can be treated in public outpatient clinics instead. The number of occasions of dental service for non-admitted clinics in 2008-09 was 33,672 – more than double the 2006-07 figure of 15,698 (refer to Figure 1.3 below).

Figure 1.3: Number of occasions of dental services for non-admitted (outpatient) clinics



Source: DoHA, National Hospital Cost Data Collection Cost Report, Round 13 (2008-09) to Round 7 (2002-03)

Medical services

When individuals cannot access dental care, they may seek medical assistance through a range of services, including general practitioners. Estimates suggest there were approximately over three quarters of a million encounters with general medical practitioners last year for dental problems and complaints.

The main reasons Australians visit GPs for dental problems is to alleviate pain and infection due to: dental or gum abscess; tooth or gum infection; gingivitis; and dental caries and dental impaction. The most common treatments provided by GPs include: prescriptions for pain relief medication and antibiotics; referrals to dentists; and advice on dental hygiene. Patients must also visit GPs if they wish to obtain a chronic disease management plan in order to access the Commonwealth Government's Medicare Chronic Disease Dental Scheme (CDDS).

Cost to Government and Society

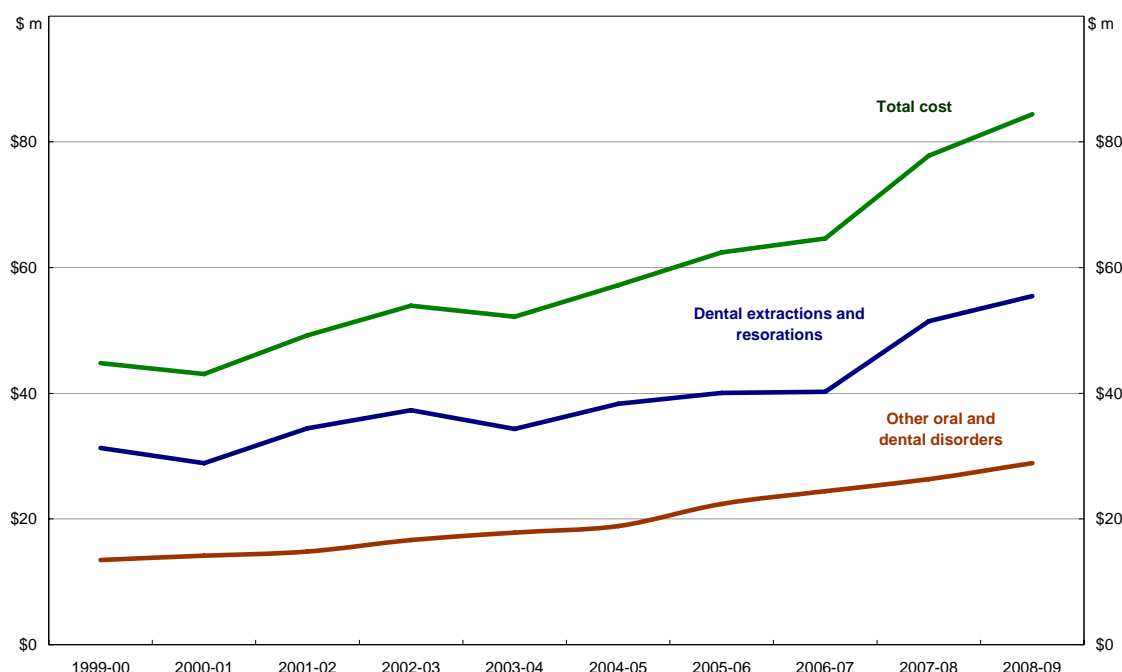
The direct costs of dental disease are the direct expenditure by individuals and governments on dental services. In 2009-10, total expenditure on dental services in Australia was \$7.690 billion. Chapter Two discusses these direct costs in more detail.

While there has been some attempt to quantify the indirect costs to government and society of dental disease on the health system, there is a lack of consistent quantitative analysis and information. Robust data and economic analysis is still required to quantify these costs and the indirect financial pressures that dental disease places on government and society.

Hospitals

The cost of public hospital admissions due to dental disease for 2008-09 was approximately \$84 million. While admission numbers remain fairly stable over time, the average cost per admission has increased, leading to an increase in total costs (refer to Figure 1.4 below).

Figure 1.4: Public sector costs of hospital admissions for dental disease (nominal \$millions)



Note: over time the cost weights are updated from AR-DRG version 4.1 to 5.2, hence the comparisons between years are indicative only and not exact.

Source: Department of Health and Ageing National Hospital Cost Data Collection Cost Report, Public Sector Estimate – Round 4 (1999-2000) to Round 13 (2008-09).

Outpatient clinics

While there has been an increase in the number of dental services for non-admitted patients, the average cost per occasion of service is quite low in outpatient clinics. The total cost for these services is estimated to be just over \$10 million in 2008-09.

Medical practitioners – Medicare and Pharmaceutical Benefits Scheme subsidies

As discussed above, patients often access the services of medical practitioners, including prescriptions for antibiotics and painkillers, for treatment for dental disease. This imposes a cost to the Commonwealth Government through payments of Medicare subsidies – for GP consultations – and Pharmaceutical Benefits Scheme (PBS) subsidies – for certain medications prescribed by GPs and dental practitioners.

While there have been some attempts to quantify the cost of Medicare subsidies to the Government – estimates range widely from \$10 million per annum⁴⁰ up to \$300 million per annum⁴¹ – there are no estimates for the cost of PBS subsidies.

⁴⁰ Australian Health Ministers' Advisory Council Steering Committee for National Planning for Oral Health (2001), *Oral health of Australians: National planning for oral health improvement: Final Report*, South Australian Department of Human Services.

Productivity

Dental decay also impacts on broader society through reducing productivity and participation in the workforce. Some claim that the cost to the economy could be up to \$2 billion per annum.⁴² However, there is no robust data or economic research to quantify the magnitude of these costs and further analysis would be required to properly assess the economic impact of dental disease on lost work days, workforce participation and productivity.

Conclusion

Over the last decades, clinical practice in oral health, home care and fluoridation has lead to significant improvements in oral health.⁴³ This is a positive outcome which reflects long-term progress in dental care and prevention. Despite these improvements, the majority of the population visit a dental practitioner less frequently than may be clinically appropriate. The major causes of this are the lack of affordable access to private services for people on below average incomes and the lack of timely care for concession card holders in the public sector due to inadequate funding. Additionally, some areas of Australia still do not have fluoridated water, thereby increasing the risk of poor oral health.

Adult visiting patterns highlight two distinct groups in the community. The first is the 39 per cent of people with favourable visiting patterns who access services focused on prevention and the early treatment of problems. This group predominately uses the private sector – an arrangement that works well. However, for the majority of the population unable to access the private sector, or with long waiting times in the public sector, current arrangements are inadequate. For this group visits are less frequent and fall outside accepted clinical recommendations, leading to greater risk of poor oral health.

This separation is evident across adults and children and can lead to very different oral health outcomes. While children's visiting patterns are high across the population, recent increases in caries in children highlights the need to refocus efforts to reduce the prevalence of dental decay, particularly in the minority of children who suffer the greatest burden of disease.

Poor oral health has an impact on individuals in terms of overall health, pain and social exclusion. Poor oral health also has broader economic impacts in terms of economic loss and the impact on Commonwealth and State and Territory government expenditure – with funds allocated to the treatment of complex problems in hospitals and visits to GPs and pharmacists for treatment of pain and infection.

⁴¹ Leeder, S. and Russell, L. (2007), 'Dental and Oral Health Policy Issue Paper: Policy Issue Paper', Menzies Centre for Health Policy, 21 September 2007.

⁴² *ibid.*

⁴³ Peterson, P.E. and Lennon, M. (2004), 'Effective use of fluorides for the prevention of dental caries in the 21st century: the WHO approach', *Community Dental Oral Epidemiology*, Vol 32, pp.319–21 and McDonagh, M.S., Whiting, P.F., Wilson, P.M., Sutton, A.J., Chestnut, I., Cooper, J. et al. (2000), 'Systematic review of water fluoridation'. *British Medical Journal*, Vol 321. pp.855–9.

Chapter Two – The Dental System

Introduction

This chapter provides an overview of the dental system in Australia, the funding components, the levels of responsibility and the workforce that delivers dental services. These issues provide important context to help understand, which parts of the system are working well, which parts are not, whether funding imbalances are contributing to problems and what arrangements are in place for the dental workforce, which is a key component in delivering existing services and meeting future demand.

The Dental System

Public services

Dental treatment is provided both in the public and the private sector. States and territories are the current providers of most public dental services. For adults, access is largely determined by eligibility for concession cards (see Appendix D). Eligible adults can generally access public dental services from age 18, with the exception of Queensland where eligibility is from 'above the age of completion of Year 10'. The type of concession card which allows access to public dental services and the amount of co-payment varies from state to state. However, the type of services available is generally similar across jurisdictions and is limited to emergency dental care and general dental treatment. Waiting times are significant, with the average exceeding two years in some states and up to five years in some locations.

For children, eligibility criteria, co-payments and level of clinical services available also vary across the states and territories (see Appendix E). There are also differences in the models of service delivery. For example, Western Australia, Queensland and South Australia have dedicated school dental programs. The Northern Territory uses a hybrid model consisting of community-based services and school dental programs. New South Wales, Victoria, Tasmania and the Australian Capital Territory rely predominantly on community-based clinics.

In the public sector, children are seen as a matter of priority for emergency and general services with no significant waiting periods for care. However, waiting times for services requiring hospital admission can be up to two years – e.g. extractions under general anaesthetic.

Private services

The private sector offers services to adults and children and is the only place that non-concession card holder adults can access dental care. A comprehensive range of services are provided in the private sector, including emergency and general dental as well as more complex and costly treatments such as orthodontic and endodontic services. Concession card holders also tend to access private dental care, with approximately two thirds of card holders visiting private dentists.

Data collected through the National Dental Telephone Interview Surveys, which are conducted every three years by ARCPOH, indicate that over half of Australian children are receiving their dental care in the private sector. The percentage of children who attended a private dental practice for their last dental service increased from approximately 33 per cent in 1994 to 53 per cent in 2005 for 5-11 year olds and fluctuated between 53 per cent and 59 per cent for 12-17 year olds.⁴⁴

Expenditure on dental services⁴⁵

Public consolidated expenditure on dental services is sourced from the Australian Institute of Health and Welfare (AIHW). The most recent publication in October 2011 relates to 2009-10 expenditure. In 2009-10, total expenditure on dental services in Australia was \$7.690 billion. Of this, \$4.698 billion was funded by individuals; \$1.257 billion by the Commonwealth Government; \$1.076 billion by private health insurance funds (which would be funded through the premiums of members); and \$628 million by State and Territory Governments. Overall, individuals directly fund a significant proportion (61 per cent) of total expenditure, reflecting the structural nature of the dental system in which the vast majority of practising dentists and services are in the private sector. In terms of public sector financing, the Commonwealth is the dominant funder, although in 2007-08 the split between the Commonwealth Government and states and territories was relatively even (see Appendix F for more detail on Commonwealth Government funded programs).

Prior to the operation of the Commonwealth Dental Health Program (CDHP) in 1994-1996, states and territories had provided approximately 80 per cent of government funding for dental services. The years between the cessation of the CDHP and the introduction of the Private Health Insurance Rebate (the Rebate) on 1 January 1999 saw the overall level of government funding for dental services maintained, despite the withdrawal of Commonwealth funds.

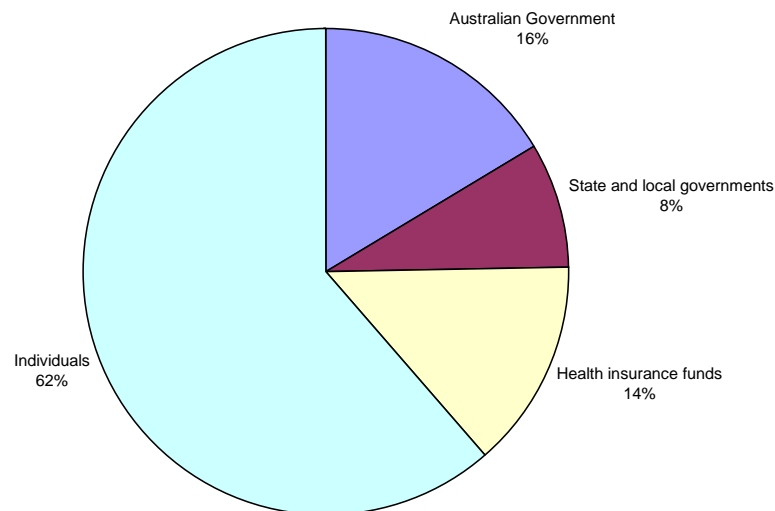
The Rebate increased the Commonwealth's share of funding for dental services from 40 to 48 per cent. This remained steady until the introduction of the CDDS in 2007-08, which has resulted in the Commonwealth's share of government funding of dental services exceeding that of the states and territories. In 2008-09, the Commonwealth contributed 61 per cent of government expenditure on dental services. This represents a reduction in state and territory funding from 80 per cent in the late 1980s to early 1990s to around 40 per cent in 2008-09. This shift is due to a significant increase in Commonwealth funding – state and territory funding has consistently increased since 2000-01.

The chart below shows the significant proportion of private expenditure directed toward dental services compared to government funding. The inclusion of private health insurance is largely an indirect extension of private expenditure as it is funded through premiums paid by individuals. With this taken into account, around three quarters of all dental expenditure is funded by individuals.

⁴⁴ Ellershaw, A.C. and Spencer, A.J. (2009), *Trends in access to dental care among Australian children*, AIHW Dental Statistics and Research Series, No. 51, p. 19.

⁴⁵ The most recent published consolidated expenditure on dental is sourced from the AIHW. The most recent publication in October 2011 relates to 2009-10 expenditure.

Figure 2.1: Percentage of Expenditure on Dental Services, by source 2009-10



Overlap of Commonwealth and State and Territory Government Responsibilities and Services

Government authority for dental health provision

The Commonwealth Government has powers to legislate for: “The provision of ... pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription)”, under Section 51 xxiiiA of the Australian Constitution. This provides the Commonwealth with the power to provide a wide range of health services and benefits, including dental health.⁴⁶

However, the State and Territory Governments have traditionally been responsible for dental health services – prior to the above amendment to the Constitution in 1946, states and territories had sole responsibility for public dental health and the Commonwealth was only responsible for health services for war service veterans (their dependants and widows).⁴⁷

This situation, whereby both levels of government have overlapping authority, invites confusion as to whether the Commonwealth or the state governments (or both) have ultimate responsibility for government provision of dental health services.

⁴⁶ Biggs, A. (2008), *Overview of Commonwealth involvement in funding dental care*, Research Paper No.1 2008–09, 13 August 2008 Parliamentary Library, Parliament of Australia.

⁴⁷ *ibid*

Who currently takes responsibility for dental service provision?

State and Territory Governments

As outlined earlier in this chapter, State and Territory Governments are responsible for public dental services. They provide emergency dental care and general dental treatment to eligible adults and school aged children.

States are also responsible for water fluoridation – a preventive measure that aims to reduce dental caries by the controlled addition of fluoride into the public water supply.⁴⁸

Commonwealth Government

Since the Whitlam Government, successive Commonwealth Governments have had differing views about the Government's role in dental health. This is reflected in their different policies—ranging from direct roles in funding targeted dental health programs, to indirect roles such as providing some limited assistance through Medicare and offering subsidies to encourage the wider use of private health insurance.⁴⁹

As at the beginning of 2012, the Commonwealth has two programs targeted to particular population groups. In 2004, the then Commonwealth Government took responsibility for providing dental services for those with chronic diseases – allowing patients with Enhanced Primary Care plans from a general practitioner to use the Allied Health and Dental Health Care Initiative to access Medicare benefits for three dental treatments a year (with a rebate of up to \$220 per year).⁵⁰ In 2007, these provisions were expanded to include benefits for enhanced diagnostic and treatment services and supply of prostheses, including dentures. The benefits cap was increased to \$4250 over two calendar years. This resulted in the current CDDS program. However, the current Government has indicated its intention to discontinue this program in order to redirect funding and take on a greater role in providing assistance to concession card holders – by contracting the states to provide additional public dental services through a new CDHP.⁵¹

In 2008, the Commonwealth expanded its responsibilities to provide up to \$150 (currently \$163.05) per eligible teenager⁵² towards an annual preventative dental check through the Medicare Teen Dental Plan (MTDP). At the time of writing this report, the legislation that administers the MTDP, the *Dental Benefits Act 2008*, was undergoing a legislative review. The Council has considered the finding of the review in this report (as noted below).

⁴⁸ Australian Research Centre for Population Oral Health (2006), 'The use of fluorides in Australia: guidelines', *Australian Dental Journal*, Vol 51, (2), pp.195-199.

⁴⁹ Biggs, A. (2008), 'Overview of Commonwealth involvement in funding dental care', Research Paper No.1 2008–09, 13 August 2008 Parliamentary Library, Parliament of Australia.

⁵⁰ *Ibid.*

⁵¹ The 1993–94 Budget provided funding for a CDHP to 1996–97. \$278 million was provided to the states and territories over four years to administer emergency care (Emergency Dental Scheme) and general dental care (General Dental Scheme) for healthcare card holders. With the cessation of the CDHP in 1997, sole government responsibility for public dental services returned to the states. *ibid.*

⁵² Eligible teenagers are 12-17 years of age in families receiving Family Tax Benefit Part A, and teenagers in the same age group receiving certain government payments.

Other Commonwealth supported measures⁵³ for dental services include:

- some support through Medicare, including the Cleft Lip and Cleft Palate Scheme;
- subsidised prescriptions by dental practitioners under the Pharmaceutical Benefits Scheme (PBS);
- providing members of the Australian Defence Force and the Army Reserve with a full range of dental services at no cost;
- a full range of dental services to eligible veterans;
- partly funding university education of dental practitioners through Commonwealth supported places and the Higher Education Loan Program (HELP);
- expanding dental training and service provision, in regional settings under the Dental Training Expanding Rural Placements (DTERP) program;
- funding up to 50 voluntary intern placements per year for graduating dentists from 2013;
- a 30 per cent tax rebate on private health insurance, which could cover dental services;
- dental services provided through Community Controlled Aboriginal Medical Services;
- dental services in the Christmas and Cocos Islands and for asylum seekers in community detention; and
- access to broader scholarship schemes and locum support.

Other Commonwealth Acts and regulation also apply to the practise of the dental practitioners, such as legislation governing the National Registration and Accreditation Scheme (discussed later in this chapter).

Individuals and private health insurance

All other individuals (i.e. non-concession card holders and those ineligible for Commonwealth programs) are responsible for funding their own dental care. This group includes low income people on lower than average incomes. The private sector is the only place that non-card holder adults can access dental care.

In 2008, 50 per cent of all Australian adults held private health insurance, including 26.8 per cent of card holders.⁵⁴ In 2011, the average benefit paid by insurers for dental treatment was 50.3 per cent.⁵⁵ A further 35 per cent of the population do not have private health insurance but use the services of private dental practitioners.⁵⁶ A significant number of children are covered by private health insurance. In 2005, 43.8 per cent of children aged 5-11 years and 49.6 per cent of 12 year olds were covered by private health insurance.⁵⁷

There are two broad levels of cover: general dental coverage, which typically covers general dental services such as cleaning, removal of plaque, x-rays and small fillings; and major

⁵³ *ibid.*

⁵⁴ Harford, J.E., Ellershaw, A.C. and Spencer, A.J. (2011), *Trends in access to dental care among Australian adults 1994-2008*, AIHW Dental Statistics and Research Series, No. 55, pp.10-11.

⁵⁵ Private Health Insurance Administration Council (2011), *Annual Report*, Data Tables, December 2011.

⁵⁶ *A Healthier Future For All Australians* – Interim Report of the NHHRC, December 2008, p.266.

⁵⁷ Ellershaw, A.C. and Spencer, A.J. (2009), *Trends in access to dental care among Australian children*, AIHW Dental Statistics and Research Series, No. 51, pp.10-11.

dental treatment, which often includes additional dental items such as orthodontics, wisdom teeth removal, crowns, bridges and dentures.⁵⁸

Overlap and duplication – Commonwealth and states

The area of most obvious overlap of responsibilities between the Commonwealth and states is services for children; states offer a range of services for most children up to the age of 18 and the Commonwealth's MTDP offers a subsidy for preventative services for eligible 12-18 year olds.

The services subsidised under the MTDP program also overlap with the basic preventive check-up and services subsidised by the majority of private health insurance providers (as noted in this chapter, a significant number of children are covered by private health insurance – 43.8 per cent of 5-11 year olds and 40.6 per cent of 12 year olds).

The Second Review of the *Dental Benefits Act 2008* noted that the uptake for the MTDP has been disappointing and declined in 2012-11 to only 30 per cent of all eligible teenagers. Further, the review noted that although the MTDP voucher system worked for a mainstream teenager audience, its appeal could not be assumed to extend to at-risk and hard-to-reach groups such as Aboriginal and Torres Strait Islander teenagers, culturally and linguistically diverse teenagers, disabled teenagers and homeless teenagers. The review also noted that evaluation of the operations of the program is warranted and recommended that further work to promote the MTDP to hard-to-reach teens should be undertaken. Given the overlap, poor uptake and deficiencies in reaching all eligible teenagers, it would be worthwhile re-evaluating the efficiency and effectiveness of the MTDP in achieving oral health outcomes for teenagers.

Data published in 2011 on the MTDP voucher use (collected as part of the National Dental Telephone Interview Survey (2010)) provided the first opportunity to examine the program's impact on visiting patterns. While the receipt of the MTDP vouchers indicated a degree of success in targeting teenagers according to income, the data indicated a generally low uptake of the vouchers and lower use among low income households. Comparison with visiting patterns for teenagers in previous years did not support a conclusion that the MTDP had a major impact on teenage visiting.⁵⁹ This supports evaluating whether to extend the MTDP entitlement to include routine dental services and further considering policies to boost use of dental services by teens.

There is also some degree of overlap for services provided to adults, with many patients eligible for treatment through the state's public system and the Commonwealth's CDDS program – approximately 80 per cent of those accessing the CDDS also have concession cards and are eligible for the dental services from the state public system. People receiving dental care through the Department of Veterans' Affairs (DVA) may also be entitled to both of the above payments. Additional overlap exists with private health insurance through the 30 per cent rebate on premiums.

⁵⁸ *ibid*, p.9.

⁵⁹ Australian Research Centre for Population Oral Health(2011), 'Teen dental plan voucher use', *Australian Dental Journal*, Vol 56, Issue 4, pp.437–440.

One potential area of overlap among jurisdictions is dental graduate activities. Some states have previously and continue to offer various new graduate opportunities in the public dental sector. As a result of decisions taken in its 2011-12 Budget, the Commonwealth will also offer dental intern placements for new graduates from 2013, largely focused on the public sector, through its Voluntary Dental Intern Program. Although the program is yet to commence, it will aim to build on and complement existing jurisdictional programs rather than duplicate or replace existing efforts.

Lack of harmonisation across the states

There is general inconsistency in state services provided for children and adults, including the treatment that is available and eligibility and co-payment requirements. There is also a significant variation between the states and territories in the level of investment in public dental services, on a per capita basis. This variation in investment will affect the speed with which options for reform can be implemented.

Children

In 1973, the states and the Commonwealth agreed to establish a common Australian School Dental scheme to provide comprehensive dental treatment for all Australian school children up to the age of 15 years. Although the states were responsible for delivery of the dental services, it was mainly funded by the Commonwealth. In the early 1980s, funding was gradually subsumed into general purpose grants to the states, which effectively ended direct Commonwealth funding and responsibility for the scheme.⁶⁰

Currently, only Western Australia, Queensland, South Australia and the Northern Territory operate some form of dedicated school dental program. New South Wales, Victoria, Tasmania and the Australian Capital Territory provide public dental services to children through community-based clinics. Eligibility for services and the level of co-payments also vary across states (for more detail refer to the table at Appendix E: Child dental services provided by the States and Territories).

It is difficult to get a clear picture of the extent to which the different state-based service arrangements affect childhood caries experience as not all states participate in the national data collection. Further information on the status of children's oral health is provided in Chapter Three.

New South Wales commissioned a Child Dental Health Survey in 2007 to establish the oral health status of primary school children aged 5-12 years. Key findings from the survey include: mean dmft for 5-6 year olds of 1.53 and mean DMFT for 11-12 year olds of 0.74; and that 61.2 per cent of 5-6 year olds and 65.4 per cent of 11-12 year olds have never experienced decay in their primary and permanent teeth, respectively. The NSW Oral Health Strategic Directions 2011 - 2020 consultation document states that these figures compare favourably to national benchmarks set in 2001.⁶¹

⁶⁰ Senate Community Affairs References Committee (1998), *Report on public dental services*, Senate Community Affairs References Committee, 1998, p.48.

⁶¹ *NSW Oral Health Strategic Directions 2011-2020* (2010). New South Wales Department of Health, December 2010.

Adults

Like child programs, there are variations between the states regarding the services they offer, the eligibility criteria for treatment and the levels of co-payments required for adults (for more detail refer to Appendix D on adult dental services provided by the states and territories).

Dental Workforce

Dental workforce characteristics⁶²

The dental workforce is comprised of dental practitioners who are categorised by registration into dentists, dental hygienists, dental therapists, oral health therapists and dental prosthetists. There is also a category of specialist registration for dentists only. Table 2.1 below outlines the role of the various dental practitioners and the number of practising workers (based on 2006 data).

Table 2.1: Dental workforce - roles and numbers of practising professionals (2006)

Dental Practitioners	Role Description	Number Practising
Dentists	Diagnose and treat diseases, injuries and abnormalities of teeth, gums and related oral structures; prescribe and administer restorative and preventive procedures; and conduct surgery or use other specialist techniques. Dentists are responsible for the supervision of hygienists, therapists and oral health therapists.	10,404
Dental therapists	Provide oral health care, including examinations, treatment and preventive care, mainly to school aged children. Must practice within a structured professional relationship with a dentist.	1,171
Dental hygienists	Use preventive, educational and therapeutic methods to help prevent and control oral disease and maintain oral health. Must practice within a structured professional relationship with a dentist.	674
Oral health therapists	May practice in both clinical capacities or may be working principally as a hygienist or as a therapist. Must practice within a structured professional relationship with a dentist.	371
Dental prosthetists ^(a)	Independent practitioners who make, fit, supply and repair dentures and other dental appliances.	921
TOTAL		13,541

(a) No data were available for prosthetists practising in the NT.

Source: Balasubramanian M, Teusner D 2011. 'Dentists, specialists and allied practitioners in Australia: Dental Labour Force Collection, 2006'. Dental statistics and research series no. 53. Cat. no. DEN 202. Canberra: AIHW.

⁶² All data cited in this section of the report is from the following source, unless noted otherwise:
Balasubramanian M, Teusner D (2011), *Dentists, specialists and allied practitioners in Australia: Dental Labour Force Collection, 2006*. AIHW Dental Statistics and Research Series, No. 53.

The total number of the practising dental workforce was 13,541 in 2006. In addition, there were 15,381 practising dental assistants, who support dental professionals by preparing patients for dental examinations and assisting dental practitioners in providing care and treatment, and 2,558 dental technicians, who construct and repair dental appliances under the direction of a dentist.

Dentists make up 77 per cent of the dental workforce (excluding dental assistants and technicians). Of these, 84 per cent are in general dental practice and 12 per cent are registered dental specialists.

More recent data have become available from the Dental Board of Australia (DBA) based on the 2010-11 registrations of dental practitioners through the Australian Health Practitioner Registration Agency (AHPRA). The total number of registrants was 18,319 comprising; 13,830 dentists; 1,206 dental therapists; 1,148 dental hygienists; 610 dual qualified dental hygienists and dental therapists; 362 oral health therapists; 1,160 dental prosthetists; and a very small number of practitioners otherwise categorised.⁶³ These numbers are higher than those presented above for the dental workforce in 2006 because it covers all registrants, not just those actively practising dentistry. Active participation rates vary across different practitioners. For instance the participation rate among dentists is approximately 94 per cent.

Time series data suggests that the numbers of practising dentists have increased over the past decade – from 8,338 in 1996 to 10,404 in 2006 (a 24.8 per cent increase). However, relative to the population, the numbers of practising dentists have only increased slightly over this same period – from 46.6 to 50.3 dentists per 100,000 population.

In addition, the dental workforce was projected to grow across the later part of the 2000 decade. For instance, the number of practising dentists was projected to grow from 10,067 in 2005 to 11,551 in 2010. However, when DBA and AHPRA data have been reconciled against the existing data across the 2000 decade they indicated that the dental workforce may have grown a little more rapidly than projected.

Gender

Males make up the majority of the dental workforce – 71.0 per cent of dentists; 82.5 per cent of dental specialists; and 90.0 per cent of dental prosthetists. However, women make up the majority of dental hygienists (96.7 per cent), dental therapists (98.8 per cent) and oral health therapists (94.8 per cent). The number of females entering dental study is increasing, with around 53 per cent of commencing students and 58 per cent of dental graduates.

Age

In 2006, the average age of the dental workforce was around the mid 40s. The dental profession with the oldest workers on average was dental prosthetists (50.1 years), followed by dentists (45.1 years – with 37 per cent of dentists over the age of 50 years), dental therapists (42.9 years) and dental hygienists (37.7 years).

⁶³ Australian Health Practitioner Registration Agency and the National Boards, *Annual Report 2010-11*, p.49.

Internationally born dentists

Forty-seven per cent of practising dentists in Australia were born overseas. Some of these dentists completed their qualification overseas whilst others obtained their initial or specialist qualification in Australia.

Hours worked

Dentists have been practising roughly the same hours per week over the last decade. Females practise fewer hours on average than men (34.1 hours per week compared to 40.2 hours). The hours worked decreased on average for dentists aged 60 years and older.

Indigenous dental workforce

The most current recognised source of data for Indigenous dental workers indicates there were 18 Indigenous dentists, 15 oral dental workers and 171 dental assistants in 2006. It should be noted that not all Indigenous health professionals choose to identify as Indigenous or practice in Indigenous regions.⁶⁴

Workforce distribution

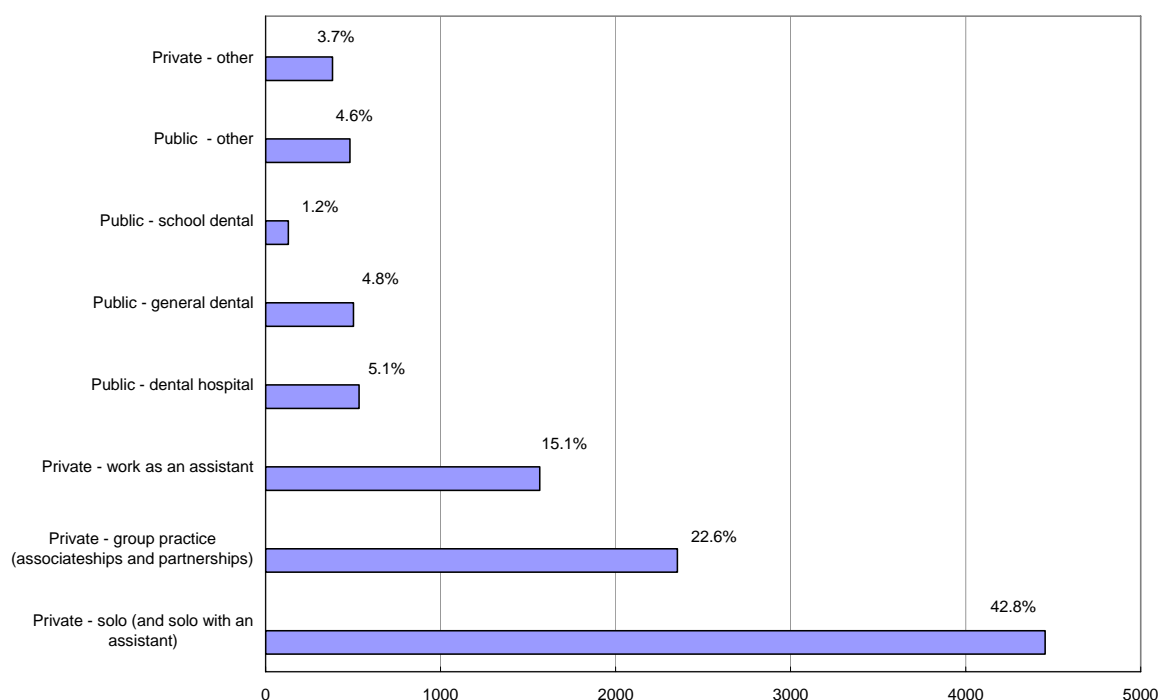
Private and public employment

Based on their main area of practice, the majority of the dental workforce is employed in the private sector: 84.2 per cent of dentists; 92.7 per cent of dental hygienists; around 62 per cent of oral health therapists; and 90.5 per cent of dental prosthetists.

Dentists employed in the private sector tend to work in 'solo' and 'solo with an assistant' practices, as shown in Figure 2.2 below.

⁶⁴ Australian Bureau of Statistics, *Census of Population and Housing*, 2006.

Figure 2.2: Practising dentists by practice type at main location



Source: Balasubramanian M. and Teusner, D. (2011), *Dentists, specialists and allied practitioners in Australia: Dental Labour Force Collection, 2006*. AIHW Dental statistics and research series, no. 53.

Dental therapists have the highest proportion of employees in the public sector, with 81.9 per cent working predominantly in public school dental services (60.4 per cent) and in public community dental clinics (16.2 per cent).

A number of dental practitioners also engage in volunteer or philanthropic work, such as providing clinical services to vulnerable and disparate people in society as well as volunteer teaching. (Refer to Appendix J on pro-bono services provided by dental practitioners).

The state governments are the main employers of public sector dentists. The Commonwealth Government only employs 94 dentists for the Australian Defence Force. Further, while the Commonwealth may fund the services of general medical practitioners through payments made under the Medicare Benefits Schedule (MBS), the Commonwealth's funding role through the MBS for dentists is quite limited (with the exception of payments for the CDDS program).

Geographic location

The geographical distribution of the dental workforce is concentrated in urban areas. The majority of the dental workforce practise in Major Cities: 81.0 per cent of dentists; 87.4 per cent of dental hygienists; 62.2 per cent of dental therapists; 74.7 per cent of oral health therapists; and 67.5 per cent of dental prosthetists.

There are three times as many dentists practising per 100,000 population in Major Cities (59.5 per 100,000) than in Remote/Very Remote areas (17.9 per 100,000). However, there are more dental therapists practising per 100,000 population in Outer Regional areas (7.5 per 100,000) areas than in Inner Regional areas (6.7 per 100,000) and in Major Cities

(5.1 per 100,000). Table 2.2 below shows the distribution of the dental workforce by remoteness area.

Table 2.2: Dental workforce per 100,000 population by Remoteness Area, 2006

Dental Professional	Major cities	Inner regional	Outer regional	Remote/Very remote	Australia
Dentists	59.5	33.1	27.5	17.9	50.3
Dental therapists	5.1	6.7	7.5	4.3	5.7
Dental hygienists	4.1	1.5	1.2	--	3.3
Oral health therapists	2.0	1.4	1.8	0.6	1.8
Dental prosthetists ^(a)	4.4	5.9	2.8	0.9	4.4

(a) No data is available for prosthetists practising in the NT.

Source: AIHW/DSRU Dental Labour Force Survey 2006.

A comparison with the distribution of medical practitioners – specifically primary care clinicians – highlights the relative maldistribution of dental practitioners in Remote/Very remote areas. Data from AIHW's 2009 Medical Labour Force Survey shows that the number of primary care clinicians per 100,000 population is 118.4 in major cities and 125.8 in remote and very remote areas.

The maldistribution of the dental workforce, between sectors and geographically, can impede timely and affordable access to services for certain groups, including rural and remote communities, Indigenous peoples, low socio-economic groups and those with special needs.

Regulation of the dental profession

Historically, the regulation of health professionals was undertaken by states and territories. In July 2006, the Council of Australian Governments (COAG) agreed to implement a National Registration and Accreditation Scheme (NRAS) for health professionals. The NRAS was established on 1 July 2010 to align the state and territory registration schemes for certain health practitioners, including dental practitioners.

The scheme operates independently of the Commonwealth Government under the *Health Practitioner Regulation National Law Act 2009*. Oversight of the NRAS is provided jointly by state, territory and Commonwealth Health Ministers through the Australian Health Workforce Ministerial Council.

Under the NRAS, the DBA is responsible for: registering dental professionals and students; developing standards, codes and guidelines for the dental profession; handling notifications, complaints, investigations and disciplinary hearings; approving accreditation standards and accredited courses of study; and assessing the skills and qualifications of overseas trained dental practitioners who wish to practice in Australia.

The DBA is supported by an independent statutory agency, AHPRA, which administers the receipt and processing of applications for registration and maintains a public register of registered health practitioners. The DBA has appointed the Australian Dental Council (ADC)

as the accreditation agency responsible for accrediting education providers and programs of study for the dental profession as well as assessing international dental practitioners.

Registration process

Students of accredited Australian dental courses are granted student registration under the NRAS. Students seeking to work as dental practitioners in Australia following graduation must gain general registration under the NRAS before practising in the workforce (with the exception of dental technicians and dental assistants). To register as a dental practitioner, individuals must complete a DBA approved program of study (list of studies are in Table 2.3) and have their application assessed and registration confirmed by AHPRA. New graduates are registered and eligible to start working as soon as their name is published on the Register of Practitioners by AHPRA.

A notable difference between dental practitioners and general medical practitioners seeking general registration is that dental practitioners are not required to complete a mandatory approved internship in addition to their approved course of study in order to practise in their own right.⁶⁵

Registration standards developed by the DBA further define the requirements that dental practitioners must meet to practise in their field and maintain registration. These include scope of practice registration standards, continuing professional development and recency of practice standards.

⁶⁵ <http://www.medicalboard.gov.au/Registration/Types/General-Registration.aspx> (as at 18 October 2011).

Table 2.3: Approved programs of study - qualifications which lead to general registration as a dental practitioner

Institution	Dentists Programs of study	Allied dental practitioners Programs of study	Dental prosthetists and technicians Programs of Study
Griffith University	Bachelor of Oral Health in Dental Science Graduate Diploma of Dentistry	Oral health therapists - Bachelor of Oral Health	Masters of Dental Technology (Dental Prosthetics) Dental technician - Bachelor of Oral Health (Dental Technology)
University of Adelaide	Bachelor of Dental Surgery	Oral health therapists - Bachelor of Oral Health	
Charles Sturt University	Bachelor of Dental Science	Oral health therapists - Bachelor of Oral Health	
James Cook University	Bachelor of Dental Surgery		
La Trobe University	Bachelor of Health Sciences in Dentistry Master of Dentistry	Oral health therapists - Bachelor of Oral Health	
University of Melbourne	Bachelor of Dental Science Doctor of Dental Surgery	Oral health therapists - Bachelor of Oral Health	
University of Queensland	Bachelor of Dental Science	Oral health therapists - Bachelor of Oral Health	
University of Sydney	Bachelor of Dentistry Doctor of Dental Medicine,	Oral health therapists - Bachelor of Oral Health	
University of Western Australia	Bachelor of Dental Science Doctor of Dental Medicine		
Curtin University		Oral health therapists – Associate Degree	
University of Newcastle		Dental therapists – Graduate Diploma Dental hygienist – Bachelor of Oral Health	
TAFE-South Australia		Dental hygienists – Advanced Diploma	Advanced Diploma of Dental Prosthetics Dental Technician - Diploma of Dental Technology
Baxter Institute (VIC)			Dental Technician - Diploma of Dental Technology
Central Institute of Technology (WA)			Advanced Diploma of Dental Prosthetics Dental Technician - Diploma of Dental Technology
Charles Institute of Technology (NSW)			Dental Technician - Diploma of Dental Technology
DNA Kingston (WA)			Dental Technician - Diploma of Dental Technology
Holmesglen (VIC)			Dental Technician - Diploma of Dental Technology
RMIT University (VIC)			Advanced Diploma of Dental Prosthetics Dental Technician - Diploma of Dental Technology
Southbank Institute of Technology (QLD)			Advanced Diploma of Dental Prosthetics Dental Technician - Diploma of Dental Technology
Sydney Institute, Randwick College, TAFE			Advanced Diploma of Dental Prosthetics Dental Technician - Diploma of Dental Technology

*this program is in process of new program accreditation by the ADC

The majority of dental professions require tertiary education qualifications, which have varying course durations. Dental and oral health therapy students typically gain their clinical experience in the public sector and university facilities

Table 2.4: Dental professions – course durations

Dental Practitioners	Study Time (full time)
Dentists	5 years of university education (or 4 years if commencing dental program with an applicable undergraduate degree). Specialisation – an additional 3-5 years at dental schools accredited by the Australian Dental Council and the Dental Board of Australia.
Dental therapists	1 year postgraduate program accredited by the Australian Dental Council and the Dental Board of Australia. Previous dental therapist education was a 2 year certificate or diploma course delivered by some state governments – these have been acknowledged by the DBA as registrable qualifications.
Dental hygienists	2 or 3 years of education accredited by the Australian Dental Council and the Dental Board of Australia.
Oral health therapists	Generally 3 years of education and accredited by the Australian Dental Council and the Dental Board of Australia.
Dental prosthetists	Generally 2 years of training prior to registration, following 2 years of dental technician training. Accredited by the Australian Dental Council and the Dental Board of Australia.
Dental assistants	Generally complete a certificate level qualification or in service training.

Source: Dental Board of Australia, <http://www.dentalboard.gov.au/Accreditation.aspx>

Demand and supply

Australia entered the 2000 decade with a projected shortfall in its dental workforce relative to the expected demand for dental visits and services. As a result, one of the action areas in the National Oral Health Plan 2004-13 was the development of the dental workforce. In the decade since, there have been substantial changes in the recruitment to and loss of dental providers from the workforce and to the expected demand for dental services from the Australian population.

Over the last decade there has been excess demand for the services of dentists in both the public and private sector.

- In the public sector, approximately 400,000 people are currently estimated to be on waiting lists. This indicates that there is more demand for services than the public sector is able to supply.
- Private sector patients also can experience difficulty accessing treatment and getting ‘on the books’ for private clinics. This is exacerbated by the variation between areas in the rate of supply of dentists, for instance the low supply rate in rural and outer metropolitan areas of capital cities. In addition, the significant price differential in the private sector sends a price signal to consumers to moderate demand – although patients may have a high willingness to pay for services, their relatively lower ability to pay may mean they have to consume fewer dental services than they would prefer.

The demand for services across Australia is likely to increase in the future in response to a range of factors including population growth, an increasing proportion of adults who are dentate (i.e. have some natural teeth), and rising consumer expectations.

Further, new policy options are likely to add stimulated demand for dental visits and services from ‘target’ groups that have formerly been low users of dental services.

Domestic supply of dentists

The number of dentist graduates in Australia has increased, from 228 in 2006 to 469 in 2009, a doubling in three years. This reflects the addition of a new dental school graduating dentists in this period as well as increases in the intake and graduate numbers from the five long-standing dental schools. The number of international students has been increasing within the intakes of dentist students in Australian universities.

In 2007 and 2008 around 85 per cent of graduates were domestic students and in 2009 this increased to 89 per cent. The number of dentist graduates between 2003-2009, including domestic and international students is shown below.

Table 2.5: Dentist graduates, 2003-2009^(a)

2003	2004	2005	2006	2007	2008	2009
227	220	230	228	193	349	469

(a) 2007 to 2009 data sourced from Department of Education, Employment and Workplace Relations administrative data, 2009; may include postgraduate course completions.

Source: 2003 to 2006, ARCPOH, based on data sourced from the then Department of Education, Science and Technology on graduates from dental schools offering Bachelor of Dental Studies or Bachelor of Health Science with Master in Dentistry.

International supply of dentists

The ADC administers assessments to allow overseas trained dentists gain registration in Australia. There are three pathways to general registration in Australia for dentists with overseas qualifications:

1. dentists who are registered to practice in New Zealand under Trans-Tasman mutual recognition;
2. dentists with eligible qualifications from the United Kingdom, Republic of Ireland, New Zealand and Canada; or
3. dentists with other qualifications (administered by the ADC).

Dentists who meet the requirements of pathway one or two are eligible for general registration in Australia and can apply directly to the DBA for registration.

Dentists with qualifications that do not meet the automatic registration requirements need to either complete an Australian qualification or undertake the examination procedure conducted by the ADC, which involves clinical practice in the public sector.⁶⁶ In 2006,

⁶⁶ Dentists may undertake the following limited practice options while they work towards General Registration under pathway 3:

- *Public Sector Dental Workforce scheme*: The scheme was introduced in 2005 to help alleviate workforce shortages in the public sector, with a particular emphasis on rural and remote areas. Graduates with certain degrees from Canada, Hong Kong, Ireland, Malaysia, Singapore, South Africa, United Kingdom and the United States are granted an exemption from the ADC Preliminary Examination and must complete the Final Examination within three years of first becoming registered. Participants must undertake supervised practice and be employed in a public sector facility.
- *Limited Registration of Dentists for postgraduate training or supervised practice – Other international graduates*: An alternative pathway for graduates not eligible for the PSDWS. These dentists must

158 overseas trained dentists successfully completed the ADC final examination. This increased to 204 in 2009. The ADC can also provide similar services for the assessment of dental therapists, dental hygienists and oral health therapists.

Projected workforce to 2020

The latest published dentist labour force projections were made in 2008 by AIHW DSRU. The 'best estimate' projections indicate that the number of practising dentists is forecast to increase between 2005 and 2020 by 49.4 per cent, to over 15,000 by 2020.⁶⁷ The study also predicts that the number of dentists per 100,000 population is expected to increase by 27.9 per cent, to 63.2 dentists per 100,000, by 2020. Capacity to supply dentist visits is projected to increase by 28.6 per cent by 2020 – from approximately 31.5 million visits in 2010 to 36.6 million visits in 2020.

The numbers of oral health practitioners is also projected to grow, but this reflects varying trends among the component occupations. Dual qualified dental therapists and dental hygienists are increasing rapidly from a very low base of some 591 in 2010 to an anticipated 2,117 in 2020. The numbers of dental hygienists are also projected to increase from 1,065 in 2010 to 1,458 in 2020. However, the numbers of dental therapists are expected to decrease from 1,023 in 2010 to 443 in 2020. Total numbers of dental hygienists, dental therapists and oral health therapists are almost doubling from 2,404 in 2010 to 4,017 in 2020. Dental prosthetist numbers are projected to be slowly decreasing. The capacity of these oral health practitioners to provide visits and services to the Australian population is increasing.

The latest published projections for effective demand between 2005 and 2020 show that visits could increase to 33.6 million visits in 2020 when only population growth and increasing proportion of adults being dentate were considered.⁶⁸ However, there has been a long-term historical trend of an increasing use of dental services by the adult population and an increasing average number of dental visits made in a year. If even a modest continuation of this trend were to occur, then the expected demand for visits at 37.9 million visits would slightly exceed the projected capacity of the dental workforce to provide visits and services.

When these projections were made in 2008 by the AIHW DSRU, the comparison of projected supply with projected demand for total aggregate dental visits indicated an approximate shortfall of 800 to 900 dental practitioners by 2020.

The recent publication of workforce related data have highlighted the need for ongoing monitoring of the dental workforce and the periodic revision of dental workforce supply (e.g. projections of the DBA and AHPRA data on dental practitioner registrations in 2010-11;

complete the ADC Preliminary Examination within one year of gaining limited registration in order to apply and then must also work under supervised practice employment in a public sector facility.

⁶⁷ AIHW Dental Statistics and Research Unit (2008), *Dentist labour force projections, 2005-2020*, DSRU Research Report, No. 43, and AIHW Dental Statistics and Research Unit (2008), *Projected demand for dental care to 2020*. DSRU Research Report, No. 42.

⁶⁸ Teusner, D.N. Chrisopoulos, S. and Spencer, A.J. (2008), *Projected demand and supply for dental visits in Australia: analysis of the impact of changes in key inputs*, AIHW Dental Statistics and Research Series, No. 38.

the data on intakes in the Australian dental schools; and the numbers of candidates sitting and successfully passing the ADC examinations process in 2011). A reconciliation of this new data on registrations in 2010-11 with the projected number of practising dentists for the year 2010 has indicated a faster rate of growth of the number of practising dentists than expected between 2005 and 2010.

Although some caution is required in interpreting the AHPRA data (i.e. it may include multiple registrations and may not accurately reflect employment rates of registered professionals), some general observations could be made, including:

- the number of domestic graduates has increased faster than expected (through increases in graduate numbers in the long-standing dental schools);
- the full extent of international students remaining in Australia to practice may not be captured in the migration assumptions in existing models; and
- the number of successful ADC candidates is larger than expected (although the proportion who take up active practice of dentistry in Australia remains little understood).

There has been some discussion that the expected number of dentist graduates across the 2010 decade will continue to exceed that assumed in 2008 and the number of dentists recruited from overseas actually taking up practise in Australia will also be higher than expected. This may result in dentist numbers exceeding the existing projections for 2020. Actual employment rates, recruitment of internationally qualified dentists, retirements and workforce participation of dental professionals in the future are not known and may impact, positively or negatively, on overall dentist supply. The impact will not be known without further research into and analysis of dentist supply projections.⁶⁹

While the number of dentists is increasing there are concerns over the number of dentists going on to procedural specialties and with the distribution of those specialists across the various speciality areas. Further, the increase in capacity to supply dental visits is somewhat tempered by changes in work hours and in the number of visits supplied in that work time.

Factors affecting workforce supply

Education and training

In 2007, three new dental schools were established and are expected to increase the supply of dental graduates – Charles Sturt University, James Cook University, University of Newcastle and La Trobe University. These schools are expected to graduate their first intakes by 2013. Griffith University also started a new dental program and graduated its first cohort of oral health therapists in 2006 and dentists in 2008. Additionally, Charles Sturt University and La Trobe University each graduated their first cohorts of oral health

⁶⁹ It needs to be recognised that uncertainty also exists around effective demand for dental services. For instance, since the 2008 study, the Australian Bureau of Statistics has revised the population projection for the year 2020, increasing the forecast total number of visits by nearly two million. In addition, policies to improve access to dental services would also stimulate demand. Overall growth in supply is expected to outpace population growth through to 2020 allowing for new demand. A crucial issue is whether that new demand will come from groups in the population marginalised from regular dental services or not.

therapists in 2011. Other Australian universities are considering establishing dentist and oral health practitioner courses.

Further, the broader move towards a demand-driven university system from 2012 may affect the supply of domestically educated dentists. The Government will be funding Commonwealth Supported Places for all undergraduate domestic students accepted into an eligible higher education course, including for dentistry (but excluding medicine). Higher education providers will decide how many places they will offer, and in which disciplines, in response to employer and student demand. While the impact of this will not be known for some years, the numbers of dental graduates may increase due to uncapped demand or decrease if potential students are lost to other professions.

The continuing growth in student uptake is having an impact on clinical training capacity and will be a challenge in the future if clinical training capacity cannot be maintained. Further, increasing Australian educated graduate numbers may also have flow on impacts to the number of international dental graduates recruited into Australia. Australia's National Oral Health Plan 2004-13 emphasised a sustainable self-sufficiency for the dental workforce and supported the recruitment of international dental graduates as a short-term measure to boost supply.

Dental academics in universities and complementary workforces

The supply of complementary workforces affects the ability of the dental workforce to provide services – i.e. the availability and quality of supervisors and dental academics influences the potential numbers of new dental students as well as the quality of their education at university and once they commence practice.

Forty-two per cent of dental academics were aged 50 years or older in 2006,⁷⁰ which could potentially lead to high retirement rates in coming years. The gap between academic salaries and remuneration for privately practising dental practitioners makes it difficult for dental schools to attract and retain teaching staff.

In addition, an adequate supply of dental assistants and dental technicians are required to support practising dental professionals to efficiently provide services.

Workforce demographics

The dental workforce is also ageing, which may lead to more dental practitioners retiring or reducing the hours they work in coming years. Younger dental practitioners may also choose to work fewer hours due to lifestyle choices. Female dentists are more likely to work part time and have career breaks than male dental practitioners, which may also impact future supply if the proportion of female graduates increases.

Registration and accreditation controls

The registration and practise of dental practitioners is controlled by the registration and accreditation standards set by the DBA. Any future changes to the standard, either relaxing or tightening, could result in an increase or decrease in the supply of dental practitioners.

⁷⁰ Council for the Humanities, Arts and Social Sciences (2008), *Occasional Paper No. 6*, November 2008.

Infrastructure and capital

There are several issues related to infrastructure for dental services that can affect the supply of dental services and the incentives and ability for dental practitioners to provide these services in various locations and practices:

- capital infrastructure – buildings and clinics, dental chairs and equipment, mobile dental facilities for remote locations etc; and
- social infrastructure (especially relevant for remote locations) – student accommodation in rural areas for clinical placements, social support structures, transport, professional networks etc.

The availability of these different types of resources varies considerably between jurisdictions. Rural areas face pronounced infrastructure constraints impacting the ability of regional centres to attract and retain dental professionals.

Public sector issues

There is a significant difference in expected salaries for the public and private workforce – average salaries for all dental professions in the private sector are almost double that of those in the public sector. This discrepancy makes working in the public dental sector less attractive and is one factor that inhibits the workforce supply in the public sector. Other factors include a perceived lack of a defined career path compared to the private sector, clinical support and continuing professional development opportunities as well as risks around deskilling. Ergo, measures to increase general workforce numbers may not necessarily correlate with an increase in public dentistry workforce numbers.

Government measures to affect workforce supply

As mentioned earlier in this chapter, the Commonwealth Government has several measures which affect the workforce supply:

- government partly funds university education of dental practitioners through Commonwealth supported places through HELP (however, the context for such support may change with the introduction of an uncapped system of university training places);
- over the next three years from 1 July 2011, the Government will continue to support six Australian dental faculties to extend or maintain the DTERP program, in order to encourage dental students to take up a career in rural practice;
- government funds the Puggy Hunter Memorial Scholarship Scheme to support the training of Indigenous people studying in health disciplines, including dentistry and oral health fields;
- most recently, Government agreed to fund up to 50 voluntary dental internship places per year, which will potentially increase the capacity of dental services, particularly in the public sector; and
- there are also various broader education and training scholarships and locum support activities.

State governments also run the Public Sector Dental Workforce Scheme which enables graduates from some overseas dental programs to practice in the public sector for a period up to three years while they work towards completing the ADC Final Examination to gain Australian dental registration.

However, dental workforce measures supported by government have generally been ad hoc. They tend to be short term and lack co-ordination with broader health workforce planning. For example, there are numerous Health Workforce Australia (HWA) projects that currently do not, but arguably should consider dentistry, including, but not limited to:

- Workforce Profile Reports and Data Recourses;
- Aboriginal Torres Strait Islander Health Worker Project;
- Rural and Remote Health Workforce innovation and reform strategy;
- Aged care reform;
- Inter-professional learning and practice program;
- Integrated regional clinical networks;
- International Health professionals; and
- Nursing and allied health recruitment for rural and regional Australia.

In 2011, HWA completed the Dental Therapy, Dental Hygiene and Oral Health Therapy Scope of Practice Review. The report of the review was approved by HWA on 21 October 2011 and is yet to be considered by the Health Ministers.

HWA is undertaking analysis of the dental workforce in 2012, as part of the National Training Plan Mark II. HWA's analysis will examine issues around nationally agreed data on the supply and demand of the dental workforce and will project the number of professionals and dental students that would be required for a range of planning scenarios. HWA aims to also facilitate a greater degree of dialogue and co-ordination between the dental schools regarding training and clinical placements. The results of this analysis are not expected before the end of 2012.

Conclusion

The structure of the dental system in Australia is largely private, with both providers and services concentrated in major cities. The funding structure in the dental system is different to the rest of the health system, in that individuals pay for the majority of their care. While government funding is significant, the subsidies available are far less than those provided in the general health system. The amount of funding available to the public system is dwarfed by consumer expenditure in the private system.

Issues surrounding the dental workforce mirror the general health workforce. The period of the 2000 decade was a time of estimated shortage of supply against effective demand. The response has been: a doubling of dentist graduates; strong recruitment of international dentist graduates; and increases in oral health practitioner graduates. As a result, supply capacity may have grown faster than projected through to the end of the 2000 decade. The latest published supply and demand projections indicate a small shortage of supply in 2020. However, supply and demand projections should be updated. The preparation of a national dental workforce plan by HWA across 2012 will bring forward such information.

The rapid expansion of the numbers of dental practitioners in training has accentuated concerns with the infrastructure available for students in university training. This includes both university facilities and staff and public sector service providers and clinical placement

facilities. The constraints imposed on appropriate training environments will be further heightened by the introduction of the Voluntary Dental Intern Program, noting that infrastructure funding is being provided under the measure and that participants will be fully qualified dentists who can provide services without the need for significant supervision, unlike dental students.

In addition to the aggregate supply and demand balance, there is significant maldistribution between urban and rural areas and across urban areas as well as between private and public dentistry. In this way, workforce maldistribution affects the ability of people to access dental care, either in the public or the private systems. The factors leading to this maldistribution are multi-faceted, including differences in income and career opportunities between the two sectors.

Chapter Three – Who Misses Out?

Introduction

There are several priority groups within the low income category who are likely to have unfavourable visiting patterns and a greater risk of oral disease. The reasons for poor visiting patterns are complex, but broad themes associated with income and affordability, social disadvantage, and inadequate public dental funding are key factors. There are many groups who find access difficult, and several of these are priority groups which have been identified in the Council's Terms of Reference. For some of these groups, data are not available. To compensate for the lack of more detailed data, the Council has focused on broader population data, which is likely to include priority groups. Identifying groups which are likely to miss out on services is important in developing a long-term strategy as well as more short-term targeted proposals.

Adults

Concession card holders

Concession card holders are primarily recipients of the age pension, disability support pension or unemployment payments. In 2011, there were between 7.4 and 7.5 million Australians eligible for PCC and HCC.⁷¹ Of these, almost two million were dependent children. These figures show that around one-third of the Australian population is eligible for concession cards. Concession card holders and their dependants are eligible to access public dental services provided by their state or territory. Given the income eligibility requirements for concession cards, most of these Australians are on low incomes, although there are some 'self-funded' retirees on part pensions that have access to PCC.⁷²

Survey data for concession card holders is consistent with visiting patterns and oral health status in low income categories. It shows that 41.7 per cent of concession card holders have unfavourable visiting patterns, compared to 23.7 per cent of non-concession card holders.⁷³ This is reflected in the greater rates of untreated decay, moderate to severe periodontal disease and fewer than 21 teeth compared to non-concession card holders.

Concession card status is a reasonable proxy for need and disadvantage and at a broader level there is considerable overlap with many of the priority groups included in the report. Concession card holders broadly include several high-risk, low-income groups, such as: elderly Australians; the unemployed; disability pensioners; and Indigenous Australians. These groups, because of age and income, are more likely to be suffering from chronic diseases and disability which may also restrict access to regular employment and participation.

⁷¹ Department of Families and Housing, Community Services and Indigenous Affairs data used for determining eligibility to concessional access to the Pharmaceutical Benefits Scheme.

⁷² A list of Centrelink supported pensions and their eligibility for concession cards is included in Appendix G.

⁷³ Spencer, A.J. and Harford, J. (2008), *Improving Oral Health and Dental Care for Australians*, Prepared for the NHHRC, p.23.

Rural and regional residents

Rural residents have a higher incidence of unfavourable visiting patterns (38 per cent) than urban residents (27 per cent).⁷⁴ These visiting patterns increase the risk of poorer oral health in rural residents compared to urban residents, which is supported by survey data. For example, 31.7 per cent of rural residents have untreated decay compared to 24.8 per cent of urban residents and 32.8 per cent of rural residents have moderate to severe periodontal disease compared to 26.1 per cent of urban residents. Of the dentate population, 18.5 per cent of rural residents have fewer than 21 teeth compared to 13.8 per cent of urban residents.⁷⁵

Indigenous Australians

Of Indigenous Australians, 40.2 per cent have unfavourable visiting patterns compared to 28.2 per cent of non-Indigenous Australians. This difference is not as great as concession card versus non-concession card holders across the Australian population, but it is significant. Given existing income disparities and disadvantage, it is likely that many Indigenous Australians would be eligible for concession cards. The tendency for Indigenous Australians to have unfavourable visiting patterns increases the risk of poorer oral health. For example, 49.3 per cent of Indigenous Australians suffer from untreated decay compared to 25.3 per cent of non-Indigenous Australians. Periodontal disease is also significantly higher at 34.2 per cent compared to 26.7 per cent of non-Indigenous people. Of dentate Indigenous Australians, 19.6 per cent have fewer than 21 teeth, compared to 14.2 per cent of non-Indigenous Australians.⁷⁶

Frail and older people in the community and in residential care

Australians aged 65 years and older have more favourable visiting patterns than the general population. This age group would appear to be at less risk of oral disease than the broader population.⁷⁷ This reflects caveats that should be applied to broader population data – visiting patterns are a risk indicator, but do not account for risk groups within a cohort. While the visiting patterns of elderly Australians is generally favourable, there would be particular groups within this cohort where visiting patterns and oral health are poor. Older Australians in low income groups and residential care facilities may be one such group.

Low income workers

Survey data shows that there is a link between income and visiting patterns. Low income workers are generally ineligible for concession cards and are not holders of private health insurance. There are various definitions of lower income workers (sometimes defined as the 'working poor'). A submission to the Council by the Australian Healthcare and Hospitals Association indicated that there were 876,000 (aged over 15 years) 'working poor' earning less than \$924 per week.⁷⁸

⁷⁴ *ibid*, p.23.

⁷⁵ *ibid*, p.23 and p.25.

⁷⁶ *ibid*, p.23 and p.25.

⁷⁷ *ibid*, p.23.

⁷⁸ Australian Healthcare and Hospitals Association (2011), *Policy Paper on Oral Health*, p.5.

Homelessness

There are many causes of homelessness affecting a range of people. Homelessness includes: those without shelter; people that are forced to stay with friends, relatives and in hotels; and those who live in boarding houses and caravan parks with no private facilities or lease. These circumstances make it very difficult for people to be employed or lead a healthy and stable life.⁷⁹ Dental survey data does not collect visiting patterns and oral health status on homeless Australians. Given the broader concession card holder arrangements and the large eligible population, homeless people are likely to be eligible for these services. However, it may be difficult for dental services to reach these people for a range of reasons, including the lack of a fixed address. The provision of services to homeless Australians may require mobilising existing, new and emerging social assets so that services are delivered where they are needed.

Children

Concession card holders

Children in the concession card holder group are those whose primary carer holds a PCC or an Commonwealth Government HCC and those children who hold a HCC themselves.⁸⁰ The child concession card holder group includes children from low income families, homeless families and those children whose parents are unemployed or disabled.

Generally, child card holders are more likely to have unfavourable oral health habits than non-card holders and are therefore at higher risk of developing oral disease. With regard to frequency of visits, non-card holder children are more likely to visit a dental practitioner annually than card holder children.

In the National Dental Telephone Interview Surveys from 1994 to 2005, non-card holders were 18.8 per cent more likely to visit a dental practitioner yearly than card holders. Non-card holder children were also more likely to visit a dental practitioner for a check-up rather than to treat a problem. Card holders were generally reported as having a higher prevalence of extractions and fillings. For the younger cohort, the prevalence of preventive treatment (scale and clean) declined over time among card holders but remained fairly consistent among non-card holders.⁸¹

Rural and regional residents

Children living in rural and remote locations also face barriers to dental services. These include availability of oral health services mainly from the maldistribution of the dental workforce. Children from rural areas have often been found to have poorer health outcomes than their urban counterparts. Data sourced from the National Dental Telephone Interview Surveys showed that children in rural and remote areas were just as likely as children in urban areas to visit a dental practitioner at least once a year and visit the dental practitioner for a check-up. However, slight differences were found in the course of treatment received by children and when such treatment was provided. In general, children

⁷⁹ The Australian Government (2008), *The Road Home: A National Approach to Reducing Homelessness*, p.3

⁸⁰ See Appendix G for a list of Centrelink concession cards.

⁸¹ Ellershaw, A.C. and Spencer, A.J. (2009), *Trends in access to dental care among Australian children*, AIHW Dental Statistics and Research Series, No.51, pp.30-45.

in rural and remote areas were more likely to receive their course of treatment in the public sector. Additionally, adolescents in rural and remote areas were more likely to receive extractions⁸² and fillings than children in urban areas.⁸³

Indigenous children

Indigenous Australians have consistently been found to have poorer oral health than other Australians. Indigenous Australians are more likely to experience tooth loss, gum disease and receive less treatment for caries.⁸⁴ In general, Indigenous Australians also have poorer oral health visiting patterns, accessing dental care less frequently than their non-Indigenous counterparts.⁸⁵

The poor oral health of Indigenous children was confirmed through the Child Health Check Initiative (CHCI) under the Northern Territory Emergency Response, which found that 43 per cent of children had an oral health problem. The most prevalent problem reported was untreated caries (40 per cent of all children), followed by gum disease (5 per cent of all children).⁸⁶

Children of low income earners

Children of low income families (in households earning less than \$924 per week⁸⁷) may be ineligible for public dental services, depending on jurisdiction and age, and are likely to be non-holders of private health insurance. Financial barriers, particularly the costs associated with purchasing private health insurance and receiving dental services without insurance benefits, place this group at risk for unfavourable visiting patterns and poor oral health.

In general, children that have private health insurance or are covered by their parents' private health insurance package are more likely to have favourable visiting patterns and are hence at lower risk of experiencing oral disease. In general, children with insurance are more likely than uninsured children to visit a dental practitioner at least once a year,⁸⁸ and are more likely to visit the dental practitioner for the purpose of receiving a check-up rather than treating a problem.⁸⁹ Uninsured children are generally more likely than insured children to receive extractions and fillings.⁹⁰

⁸² "In all survey years except 2005 the percentage of adolescents receiving an extraction was higher in rural and remote regions, but differences were not statistically significant": Ellershaw, A.C. and Spencer, A.J. (2009), *Trends in access to dental care among Australian children*, AIHW Dental Statistics and Research Series, No.51, p.39.

⁸³ *ibid*, pp.39 and 41.

⁸⁴ Australian Health Ministers' Advisory Council (2010), *Aboriginal and Torres Strait Islander Health Performance Framework*, AHMAC, p.32.

⁸⁵ Jamieson, L.M., Roberts-Thomson, K., and Sayers, S.M. (2010), 'Risk Indicators for Severe Impaired Oral Health Among Indigenous Australian Young Adults', *BioMed Central Oral Health*, Vol 10, No. 1, p.10.

⁸⁶ AIHW (2011), *Dental Health of Indigenous Children in the Northern Territory – Findings from the Closing the Gap Program*, p.1.

⁸⁷ Australian Healthcare and Hospitals Association (2011), *Policy Paper on Oral Health*, p.5.

⁸⁸ Ellershaw, A.C. and Spencer, A.J. (2009), 'Trends in access to dental care among Australian children', AIHW Dental Statistics and Research Series, No.51, pp.28 and 30.

⁸⁹ *ibid*, pp.32-34.

⁹⁰ *ibid*, pp.37-44.

Conclusion

No single risk factor or indicator completely explains who is more likely to miss out on dental services. Unfavourable visiting patterns are present across the population. While the question of who misses out is complex, there are certain groups and areas where access is lower and risk of poor oral health is greater than the general population. These include rural and regional residents, Indigenous Australians, frail older people in the community, people in residential aged care, and homeless people and others with special oral health needs.

In broad terms, low income groups have a high incidence of unfavourable visiting patterns and, therefore, follow a different treatment path which increases the chance of poor oral health outcomes. Income plays a significant role in assessing which people are more likely to miss out on treatment, especially regular preventive services. Social disadvantage is an important determinant of oral health access and status with links to income and educational attainment. This pattern is evident in both the adult and child population. For children the socio-economic status of their parents has an impact on whether they access services.

Income is only a rough proxy for who misses out on dental services. A number of issues related to workforce distribution both within urban areas and between regional areas and urban settings also play a role. Residents of rural and regional Australia are at greater risk of poor oral health outcomes with income playing a role, but with the added complexity of workforce maldistribution making access more difficult. Indigenous Australians are also at greater risk, with added complexity of service access in remote locations.

Chapter Four – Causes of Poor Oral Health

Introduction

What the earlier chapters have shown is that visiting patterns are a risk indicator of poor oral health and that favourable visiting patterns, which include a yearly preventive check-up, can help reduce the risk of poor oral health. In this sense reducing unfavourable visiting patterns and increasing favourable patterns can make a contribution to improving oral health across the population. Identifying the reasons for poor visiting patterns can help determine some of the key reasons for poor oral health and assist in the development of short- and long-term options for improving oral health. Factors other than visiting patterns can also play a role. The reasons for poor access are complex, often based on structural issues of affordability, geographic location and the organisation, delivery and financing of dental services.

Access

Affordability of private care - adults

Access to dental services is determined by several factors, including cost, locality and behaviour. With the majority of dental services provided in the private system, cost of services can be a significant barrier for lower income earners. The National Dental Telephone Interview Survey has been monitoring the number of adults who report that they had avoided or delayed dental care due to cost. In 1994, 27.1 per cent of adults reported an avoidance or delay in accessing care due to cost – a percentage which remained relatively constant through the 1990s. In recent years this has increased significantly, with the most recent results indicating 34.3 per cent of adults avoided or delayed care due to cost. Another measure of affordability, in which adults report whether cost had prevented them from a recommended course of treatment, remained constant from 1994-2005 at 20.2 per cent of adults.⁹¹

In terms of at risk groups, 46.7 per cent of concession card holders reported delaying dental treatment compared to 30.2 per cent of non-card holders, indicating the increased effect of cost for lower income earners. This has increased significantly for both card holders and non-card holders since 1994. However, the impact of cost on avoiding or delaying dental care was not significantly different across the population, with very little difference between regional and urban areas.⁹²

Australia's dental service provision, whereby the vast majority of services are privately provided and funded, provides a structural impediment to lower income earners' access. This is not unique to Australia, but is a common problem in health systems focused on

⁹¹ Harford, J.E., Ellershaw, A.C. and Spencer, A.J. (2011), *Trends in access to dental care among Australian adults 1994-2008*, AIHW Dental Statistics and Research Series, No.55, pp.45 and 49.

⁹² *ibid*, p.47.

private service provision for dental services.⁹³ For the vast majority of Australians, the private system provides high quality dental care, which is partly reimbursed and subsidised for around 50 per cent of the population with private health insurance. This in part contributes to the good oral health of a significant number of Australians. The problem is for those whose access is limited because of costs and other barriers.

Access in the public sector – lack of funding and waiting times for adults

Under existing dental system arrangements where cost remains an issue, public dental services provide a safety net for concession card holders. However, limited funding for the public sector has constrained access through the low number of services available relative to the number of individuals needing care. This has led to significant waiting times for a range of services, effectively limiting access to people in need. Around 400,000 Australians are on public dental waiting lists with average waiting times of up to 27 months and some people waiting up to five years. Many public patients start on public dental waiting lists seeking preventive or restorative treatment but become emergency cases by the time they receive treatment.⁹⁴ The significant wait for dental services can lead to a piecemeal approach to care, with people seeking treatment through emergency dental visits. There are also a large number of eligible people seeking private treatment.

Limited funding within the public sector is the primary reason for these difficulties. The public sector dental practitioners work in an environment with limited resources, while servicing some of the most disadvantaged people in the community who often experience complex health problems. The lack of funding exacerbates workforce pressure, with difficulty recruiting and retaining dental practitioners given the incentives to work within the private sector instead.⁹⁵

The oral health status of public patients compared to the general population is considerably worse across a range of indicators, including periodontal disease and having fewer than 21 teeth.⁹⁶ Funding constraints and waiting times may be contributing factors to poorer oral health of public patients.

Low income earners

Access and affordability for services are also felt across the wider community, extending to those not eligible for public dental care. Many of these are low income households whose financial circumstances make them ineligible for public dental services because they do not qualify for concession cards, yet their income is insufficient for them to access comprehensive dental services in the private system. The Australian Council of Social

⁹³ Leak, J.L. and Birch, S. (2008), 'Public policy and the market for dental services', *Community Dentistry and Oral Epidemiology*, p.287-295.

⁹⁴ Australian Healthcare and Hospitals Association (2008), *Policy Monograph 2008: Oral and Dental Health*, p.37.

⁹⁵ Leak, J.L. and Birch, S. (2008), 'Public policy and the market for dental services', *Community Dentistry and Oral Epidemiology*, pp.287-295.

⁹⁶ Brennan, D.S. (2008), *Oral health of adults in the public dental sector*, AIHW Dental Statistics and Research Series, No.47, p.vi.

Service (ACOSS) estimates that 23 per cent of Australian adults (2.3 million adults) not eligible for public dental care delayed or avoided treatment because of cost.⁹⁷

Access (Availability of Services)

The geographic size of Australia and the distribution of its population places people in regional and remote areas at a disadvantage in accessing a range of services, including dental care. This is not unique to dental services but a broader structural problem that regional and remote residents face when accessing a range of health services.

As with some medical professionals, the dental workforce is unevenly distributed across Australia. The supply of dental practitioners in regional and remote Australia is substantially lower than in urban areas. Even in locations where dentists are available, access can be affected by the availability of transport and distance to services, as well as socio-economic issues.⁹⁸

Structural imbalances in workforce distribution are highlighted in ARCPDH workforce data. The Dental Labour Force Collection 2006, showed an increase in the number of practising dentists per 100,000 people across all states and territories between 2003 and 2006. Practising dentists in Major Cities increased by 11 per cent, but declined in regional and remote areas. With regard to allied dental practitioners, which include dental hygienists, dental therapists, oral health therapists and dental prosthetists, workforce distributions varied slightly between 2003 and 2006:

- dental hygienists' practising rate showed a decline in outer regional areas;
- dental therapists' practising rate across all remoteness areas decreased; and
- dental prosthetists in this same time period demonstrated a decreasing practising rate in all areas except inner regional.

For oral health therapists, where 2006 is the first year where they are reported on separately, there are no comparisons with earlier points in time.

While addressing geographic distribution among practising dentists is paramount, the imbalances in other dental practitioners also needs to be targeted in any remedial activities.

Behaviour

Behaviour can have a significant influence on oral health. There are a range of complex social and behavioural changes which could lead to long-term improvements in oral health or long-term declines across a population. Improvements in oral health may be reversed by significant social changes in behaviour or new food products which result in changes in diet. For example, increased bottled water consumption may have an influence on the oral health benefits otherwise gained from water fluoridation.⁹⁹ These influences are complex

⁹⁷ Australian Council of Social Service (2008), *Fair dental care for low income earners: national report on the state of dental care*, p.2.

⁹⁸ National Rural Health Alliance (2005), *Public dental service in Australia: whose responsibility?*, p.25.

⁹⁹ Mills, K., Falconer, S. and Cook, C. (2010), 'Fluoride in still bottled water in Australia', *Australian Dental Journal*, Vol 55, Issue 4, pp.411–416.

because they are linked to other behaviours which may also influence the outcome. For example, bottled water consumption may not be as influential in people who visit a dental practitioner regularly and have a healthy balanced diet. For children in particular, behavioural influences can establish long-term patterns which can affect their oral health into adulthood.

Diet and behaviour

Diet and behaviour can have an impact on oral health. High acid and sugary foods and poor oral health habits can lead to an increased incidence of caries and tooth erosion. The Australian Dental Association (ADA) discusses the established link between high sugar and acid diets and caries and tooth erosion and recommends the reduction in consumption of these foods.¹⁰⁰ Other behaviours such as smoking and high alcohol consumption increase the risk of periodontal disease, tooth loss and oral cancer.¹⁰¹

Fear of the dentist

Dental fear and anxiety can contribute to an individual visiting a dentist infrequently, with those who are most anxious least likely to visit a dentist.¹⁰² Less frequent visiting, visiting only when there is a problem and cancelling appointments or treatment leads to greater treatment needs in the long term.¹⁰³ Additionally, lower income is an indicator for dental anxiety, particularly in terms of affording the cost of treatment, and this can lead to decreased access to dental care.¹⁰⁴

Children

Access

Across the population access for children appears less of a problem than access for adults. Around 80 per cent of children aged 5-17 visit the dentist every year, indicating a much more favourable rate than the adult population.¹⁰⁵ Even measures of affordability are a relatively low, with around 10 per cent of parents indicating that the last dental visit had been a financial burden.¹⁰⁶ This figure was slightly lower for 5-12 years olds and higher for 12-17 year olds, perhaps reflecting more potential for complex treatment in older children. For adults waiting times for public treatment are significant, while the same waits are not experienced by children. Children are given priority in accessing public dental services, although there are waiting times of around two years for extractions under a general anaesthetic in public hospitals.

¹⁰⁰ Australian Dental Association (2010), *Policy Statement, Community Oral Health Promotion: Diet and Nutrition*, section 2.2.2.

¹⁰¹ Australian Dental Association (2010), *Policy Statement, Community Oral Health Promotion: Tobacco*, section 2.2.4.

¹⁰² Roberts-Thomson, K.F. and Slade, G.D., (2008), 'Factors associated with infrequent dental attendance in the Australian population', *Australian Dental Journal*, Vol. 53, pp.358-362.

¹⁰³ Armfield, J.M., Slade, G.D. and Spencer, A.J. (2007), 'Dental fear and adult oral health in Australia', *Community Dentistry and Oral Epidemiology*, Vol. 7, pp.200-230.

¹⁰⁴ Armfield, J.M. (2010), 'The extent and nature of dental fear and phobia in Australia', *Australian Dental Journal*, Vol. 55, pp.368-377.

¹⁰⁵ Ellershaw, A.C. and Spencer, A.J. (2009), *Trends in access to dental care among Australian children*, AIHW Dental Statistics and Research Series, No.51, pp.29-31.

¹⁰⁶ *ibid*, pp.57-61.

On the surface the access issue appears to indicate lower risk of oral disease for children. However, the Council views this area as more complex. Earlier chapters showed that the burden of disease in terms of caries is borne by a minority of children. Within this group there may be significant areas of social disadvantage which should be addressed.

Parental education and awareness – fear of dentist and lack of oral health education

The ability of parents to provide appropriate oral care, such as tooth brushing, can have an impact on the oral health of their children. Lack of parental confidence providing and modelling such behaviours is often linked to their lack of knowledge of the risk factors for early childhood caries (tooth decay).¹⁰⁷ Parental roles and responsibilities in ensuring regular visits to dentists or clinics also play a role. Increased sugar intake and changes in diet may also contribute to increased decay. A study of children with caries (aged 4-7) found that they had a higher median intake of soft drinks than children without caries.¹⁰⁸ Oral health promotion and education can help mitigate some of this risk. As oral health status in childhood is often a predictor of future dental problems, poor guidance by parents with regards to oral health can set children up to experience poor oral health for life.

Conclusion

Even though particular groups are at greater risk of poor oral health than the general population, risk factors and poor oral health are present in all groups across the population. This shows that a complex interaction of factors can lead to poor oral health. Income distribution helps illustrate this point: lower income groups are more likely to have unfavourable visiting patterns than higher incomes groups, yet there are a significant proportion of people with higher incomes that have unfavourable visiting patterns. Unlike lower income earners' visiting patterns, this cannot be singularly explained by income alone and so other reasons must be present. This is not to exclude income and cost as an issue, but more to explain that the causes of poor oral health are more complex than an initial assessment might reveal. This indicates that there are structural and social as well as individual factors affecting access. Diet and behaviour shaped and maintained by social circumstances across the whole population also play a role in determining poor oral health.

Survey data shows that caries occur across the whole population and that their occurrence is not closely linked to income. However, whether and how caries are treated is closely linked to income. This is evident in patterns of untreated decay which are far greater in low income groups. What generally appears to happen is that those with favourable patterns access a preventive regime and restorative treatment earlier, while those with unfavourable patterns access care later – once the caries have progressed and more comprehensive and costly treatment to save a tooth is required. The increased cost of saving a tooth shapes the decision to negotiate the alternative treatment of a tooth being extracted. Level of income and other barriers to access have a significant influence on outcomes.

¹⁰⁷ Gussy, M.G., Waters, E.B., Riggs, E.M., Lo, S.K. and Kilpatrick, N.M. (2008), 'Parental knowledge, beliefs and behaviours of oral health of toddlers residing in rural Victoria', *Australian Dental Journal*, Vol. 53, pp.52-60.

¹⁰⁸ NSW Centre for Public Health and Nutrition (2009), *Soft Drinks, Weight Status and Health: A Review*, p.22.

There are differences in access between adults and children, with some of the key access problems experienced by adults not as extensive for children. Children have far better visiting patterns, which provide some indication of why children's oral health has improved over the last several decades. However, with the burden of disease borne by a small number of children, and recent increases in caries following years of improvement, resources need to be focused on those children suffering from oral disease. As well as this, investments need to ensure that high visiting patterns are maintained to support the good foundation of oral health for the 80 per cent of children with regular access. Any decline in these areas risks problems and increased costs in the future.

Chapter Five – Long Term Aspirations

Goal

In order to properly frame the proposals, we have developed a long-term goal. This will help ensure that the development and implementation of dental proposals are part of an overall framework. While Government priorities regarding the constraints of the current fiscal environment have determined the short-term goals of the Council and its proposals for the 2012-13 Budget, the broader goal will help to guide thinking around the future of dental health in Australia.

The Council agreed that the following statement reflected the long-term goal for dental services:

An integrated national oral health system, as part of the broader health system, that provides equitable access for people in Australia to prevention, promotion and clinically appropriate, timely and affordable oral health care.

The goal embodies the principle of universal access (equitable access to services across the population) which was one of the overarching long-term issues considered by the Council.

Council Discussions on Universal Dental Care

The Council's discussion of a particular model for a universal scheme in the short- to medium-term did not receive unanimous support from all members. This was partly due to concerns about whether a universal scheme would meet the dental needs of all Australians, what it would provide by way of services, what rules it may impose on practitioners, funding concerns and any impact on some current service arrangements that are working well.

Many members support the development of a universal scheme because it is seen as an appropriate way to deal with the structural inequity within current arrangements – where significant numbers of people are excluded from accessing services because of cost. This particular universal model would allow a progressive tax arrangement to increase and redistribute dental expenditure more equitably through the system,¹⁰⁹ with the aim of improving affordability and access in general.

The differences of opinion on the design of a universal model were based more on practical issues relating to implementation. However, there is not only very high support in the community for creating universal access, but also an acceptance that increased revenue is required.¹¹⁰ It was acknowledged that an ageing population and decreased edentulism would place pressures on funding from the outset. In addition, a universal scheme would be

¹⁰⁹ Mr Longshaw noted that there was no information presented or debated by the Council associated with a progressive tax arrangement, and that such an approach has not been fully considered or agreed by the Council.

¹¹⁰ Dental Health Services Victoria (2011), *Australian community attitudes to dental services: research findings*, DHSV, Melbourne.

difficult to implement over a shorter time frame, given supply constraints within the existing system. There are many areas where capacity would need to be improved before a universal scheme could operate. Maldistribution of service providers would still be an issue, as it is for Medicare-funded health services, in regional and remote Australia and across the system.

Given the above, and the short time-frame for this report, the Council did not venture into a detailed conversation about a particular universal model. However, rather than supporting a particular style or model of universality, the Council was in agreement on the principle of universal access. This reflects a view that the long-term goal should be for all Australians to access affordable dental care within acceptable timeframes when they need it. This principle of universality could be applied in many ways, including a design which includes a mix of the best aspects of existing arrangements, an expansion of these arrangements, along with other mechanisms for those who find access a problem.

The Council believes such an approach is appropriate because it provides flexibility, accounts for divergent views and considers the long-term nature of this goal. In the Council's view, the long-term nature of this goal makes the endorsement of particular models redundant at this time because it cannot account for long-term changes in the dental system. It would be more practical for the Government to consider its preferred model of universality across the population when it considers it appropriate. This would mean that its design could more appropriately and effectively take account of changes to the system.

A number of actions would support the achievement of this goal and are discussed below. These aspirations are based on the principles in the Report. Not all principles have been listed separately because in some cases an aspiration will cover several principles. In addition some principles can only be met by achieving several aspirations.

Aspiration One

Ensuring oral health is considered part of general health by including oral health as part of the health reform processes and the health care system

The National Oral Health Plan 2004-13 highlights the need to recognise that oral health is an integral part of general health.¹¹¹ Dentistry emerged alongside, but independent of, the medical profession. Dental schools and hospitals provided professional support and clinical experience, like the broader medical profession, but operated independently. This may have contributed to the separation of oral health from broader health in both on-the-ground services and in policy and funding terms.¹¹²

¹¹¹ *Healthy mouths; health lives: Australia's National Oral Health Plan 2004-2013 (2004)*, Prepared by the National Advisory Committee on Oral Health, p.vi.

¹¹² Spencer A.J. (2001/02), 'What options do we have for organising, providing and funding better public dental care', *Australian Health Policy Institute Commissioned Paper Series 2001/02*, p.5.

In practical terms, the community's view of oral disease and its consequences, including infection and pain, are not viewed differently to other broader medical conditions. A person is unlikely to see much of a difference in terms of treatment and relief between a toothache and severe earache. Yet health policy treats these conditions very differently.¹¹³

The Council believes that the ongoing policy and health system separation between oral health and general health is contributing to a lack of direction and focus. Seeing oral health and general health together is a sensible principle with practical long-term benefits, including benefits to the patient. For example, oral disease is associated with many diseases and similar causal factors can operate in dental as in general disease, such as tobacco and alcohol consumption and diabetes. These links should be recognised within the system by ensuring oral health is integrated into the work of existing health policy agencies such as the Australian National Preventive Health Agency.

Including oral health reform as part of the wider health reform processes could help to alleviate pressures around access and cost. It is for these reasons that oral health should be integrated into general health. Practical integration could involve service mapping via Medicare Locals and practical support for service providers to implement IT and information management systems.

Aspiration Two

Improving equity and access to dental services

It is clear to the Council that equity and access are key issues for improving oral health in Australia. Access to services is influenced by a range of complex factors, with affordability for private care and waiting times for public care significant players. Maldistribution of the services and workforce is also a key influence. Adopting a long-term aspiration to improve access to dental services provides a guiding principle for policy and program development and will help design responses which are focused on the key determinants of access.

The Council considers that a starting point for this aspiration is an acknowledgement of what access means and what expectations need to be met in terms of patterns of visiting and treatment. Currently, there are no minimum standards across Australia for the provision of dental care, including how often people should access a check-up. Because of this, some people may not visit a dentist regularly and only attend for emergency treatment. We acknowledge that standards alone will not improve access. However, defining this provides a goal for the development of policy. These goals could focus on standards of access (minimum visiting patterns) and standards for mechanisms (affordability and workforce numbers) which would help improve access to minimum acceptable visiting patterns. This could include setting a goal that Australians seeking care should have access to a dental check-up and preventive services every two years at least.

¹¹³ *ibid*, p.5.

These targets could be modified, but the key issue is that without a general understanding of what constitutes an acceptable visiting pattern and what areas need to be targeted to achieve this, outcomes on improving access could be less than desired.

Over the long term, improving equity and access will require a concerted effort in a number of areas – some with different causes and differing solutions. At this stage, lower income affordability for private sector services, long waiting times for public general treatment and workforce constraints in rural Australia are having an impact.

Aspiration Three

Investing in the future of oral health through dental programs for children

Existing survey data shows that around 80 per cent of children have visited a dental practitioner in the previous 12 months. This may create the impression that children are at far less risk than adults of oral disease and that a focus on children may not be necessary, given limited resources. The Council has strong views on the dental health of children, with a strong bias for expanding and continuing services to children. The improvement in the oral health of children over many decades must continue because of the strong foundation it provides for future oral health in Australia. Oral health needs to be initiated in childhood where oral health is shaped. Dental disease in childhood is a predicator of dental disease in adulthood.

The Council is concerned that recent increases in dental caries in children may signal a change in direction for the worse. If a decline in oral health of children becomes established, children will require increased services in the future – this will have impacts on long-term costs into adulthood. The Council also believes that the good oral health of all children should be an underlying principle of any dental system, with children entitled to live free from pain and discomfort for conditions which are largely preventable with oral health promotion, good oral and general health habits and access to services.

Public dental programs for children in Australia are currently provided by the states and territories. Eligibility for these programs differs between jurisdictions and current infrastructure can limit the number of children seen each year. Furthermore, differing definitions of what age bracket defines children can mean that some young people below the age of 18 are unable to access public dental services.

Easily accessible dental programs for children, with appropriate infrastructure, would allow the entire child population to access treatment. By treating all children below the age of 18, good oral health is likely to be attained, leading to improved oral health outcomes for their future as adults. Clearly, health promotion will play an important role in this approach and, given the common risk factors and drivers of obesity, health promotion should be integrated across these two issues (see below).

Long-term investment in children and young people is an important part of long-term oral health.

Aspiration Four

Supporting oral health promotion across the population

The Council views oral health promotion as an integral part of improving oral health across the population. The Council's view of oral health promotion is broad, focusing on integrating oral health promotion across a range of activities and levels and using a similar multi-dimensional approach applied so successfully to tackling road accidents, smoking and HIV in Australia. Oral health promotion underpins the long-term improvements in oral health. The other aspirations and oral health promotion are integrally linked and together form part of a broader strategy for improvements across the population. The reason for a broader perspective of oral health promotion is to improve effectiveness and long-term outcomes. For example, promotion without improved access to services would be less effective, because individuals cannot access preventive or treatment services.

The National Oral Health Plan 2004-13 highlighted that oral health promotion and prevention "needs to address oral health at both the individual and population levels, based on the identified needs of the community". This includes: extending fluoridation of water supplies; timely access to primary care; promoting oral health; a common risk factor approach (common oral and general disease risk factors); advocacy by oral health providers; and up-to-date data to help with planning and evaluation.¹¹⁴ Promoting oral health should start at a young age, be aimed at parents and children and be integrated into education systems and service delivery mechanisms. It should extend beyond oral health messages and be linked into broader general health promotion with links to oral health, such as diet, exercise and smoking. Both population oral health activities and service providers should play a role.

A national oral health campaign, co-ordinated with the states and territories, that uses successful oral health messaging and is underpinned by social research is recommended. This national campaign would also link to the general health promotion activities of the Australian National Preventive Health Agency.

Aspiration Five

Clarifying roles and responsibilities of the states and territories and the Commonwealth

The separation of government responsibilities for dental services in Australia has largely seen states and territories provide public dental services to eligible lower income populations, while the majority of the population is served through the private system. The Commonwealth role has been sporadic, with varying forms of intervention largely through funding and subsidies to support affordability of services. One example was the previous

¹¹⁴ *Healthy Mouths, Healthy Lives; Australia's National Oral Health Plan 2004-13*, (2004), Prepared by the National Advisory Committee on Oral Health, p.16.

CDHP, which started in 1994 and was closed at the end of 1996. Funding for this program improved access for public patients, but when funds were withdrawn in 1996 waiting times increased again and public patients' access to services declined.¹¹⁵ This sporadic approach has inhibited the ability to improve the long-term oral health of public patients. In combination with funding constraints within state and territory budgets, public patient access has remained a problem, with subsequent effects on overall oral health. Waiting list numbers and waiting times have decreased in recent years following some increases in state and territory expenditure. However, access is still far poorer than when the CDHP was operating in 1994-96.

The Commonwealth has in recent years become a dominant funder of dental services. Some of this is the result of legacy programs. This is to be expected, with changes in government leading to varying areas of focus and funding. Even changes to legacy programs, consistent with the Government's priorities, would leave funding allocated across a range of overlapping priorities. Improved integration of these programs, linked to clear objectives and lines of responsibility, should be considered as well as integration with state and territory programs and responsibilities.

The Council believes that with limited resources, efforts need to reduce duplication and make effective use of limited dollars. This would begin with a change in approach with more clearly defined responsibilities at all levels of government. The Council sees the state and territory system as the foundation of public dental service provision. The states and territories have particular skills and efficiencies in the organisation, delivery and funding of public dental services. This responsibility should continue albeit with increased funding.

The Commonwealth's role has been as a funder of dental services rather than a service provider. With a clear delineation of responsibilities in terms of service provision, the question lies more in focusing funding responsibility. For example, states and territories are funding public dental services for both children and adults, while current Commonwealth programs, the CDDS and the MTDP, fund respectively adults and teenage children. As at the time of writing, the current Government's policy is to abolish the CDDS and introduce a CDHP.

The Council agrees that for public dental services, one level of government should be responsible for delivery. In addition, funding should be directed through a single funding pool for adults and a single funding pool for children which should improve co-ordination and integration.

Clarifying the roles of the states and territories and the Commonwealth is essential in effectively directing funding to those population groups identified earlier and tailoring programs to meet demand and ensure access, not just entitlement, through outreach programs and collaboration with other community-based services. This is a long-term goal that is crucial in making every dollar work by focusing funds on the most efficient service delivery mechanism(s). In an environment where fiscal limitations are paramount, sparse resources could be directed to the needy and focused on improvements in access to dental

¹¹⁵ Dooland, M., (1998), 'The Cessation of the Commonwealth Dental Health Program', *New Doctor (Winter)*, pp.4-8.

services. A long-term increase in resources and commitment to public dental services would make a significant contribution to improving child and adult oral health and build an excellent foundation for further oral health initiatives.

Aspiration Six

Enhancing public dental services and academic and oral health centres

Public dental services are crucial in helping improve the oral health of Australians. Without a well functioning public dental sector: oral health for Australians on low incomes will continue to worsen; training oral health practitioners will become more difficult; and overall cost to the system, through increased private out-of-pocket expenditure, will continue.

Around one-third of Australians are eligible for public dental services. Only a minority of concession card holders rely on public dental services. However, there is a significant number whose only point of access is a public dental clinic. The Council would like to highlight its support for the public sector and the important foundation it provides to the whole dental system through population oral health promotion services to public patients and training and education of the dental workforce. The public dental sector provides services to high needs patients and, for the limited funding available, works hard at service delivery.

The Council recognises that waiting times for services, especially for adults, are unacceptably long, with a public system highly skewed to emergency and urgent care, which undermines access to timely preventive care and to early intervention. But attention needs to be focused on the key cause, which is a lack of funding, notwithstanding Commonwealth and states increasing funding over recent years. This has been a blind spot for all governments across Australia over decades. The Council believes that the public sector is underfunded and that long-term investment will improve access. This will also shift focus from crisis management and mitigation of complex oral disease to one of prevention and more comprehensive dental care, leading to an improvement in the oral health of public patients.

Because of the problems in the public sector, the private sector models of delivery can be seen by some as superior and more efficient, while the public sector perceived as low quality and inefficient. The Council does not support this proposition. Private and public sector models should not be viewed as either inferior or superior, but rather as complementary, with each playing a role in the oral health of Australians. The Council wants to maintain the existing strengths of the system and ensure that the private sector continues to provide services to Australians, while at the same time focusing resources where they are needed – in the public sector – so that both the number of people and the scope of practice are expanded to meet need more efficiently.

Focusing resources on both oral health professionals and infrastructure will help retain and attract public sector professionals, contribute to overall training of new oral health practitioners and, through infrastructure support, increase the number of services.

Rural and regional Australians are more reliant on public dental services, especially where no private services are available. These services will need to be developed by encouraging the workforce to work in areas outside well-served major cities and by providing appropriate infrastructure so that the oral health outcomes for Australians living in under-served cities and in regional and remote areas will be improved.

Aspiration Seven

Building workforce capacity for better service delivery and improved access

The Council understands that equity and access will be difficult to achieve unless workforce supply and distribution is considered. Providing timely, affordable and appropriate oral health care to all Australians requires an appropriate dental workforce. Maldistribution of the dental workforce remains a key problem for rural and regional Australia – an issue which is consistent across the health system. Maldistribution between sectors and settings is also a significant issue. As a result of workforce maldistribution, service delivery for certain groups is insufficient to meet current needs and can impact on oral health outcomes for these population groups.

Improving workforce capacity and flexibility is essential to meeting existing and increasing service delivery demands. There is a need for an adequate number of appropriately educated and skilled dental practitioners who can assist in improving the efficiency, productivity and responsiveness of the dental system. This includes an appropriate mix of dental practitioners across the public and private sectors and across geographical locations to help prevent, identify and treat oral health conditions. Increased funding for services alone will not necessarily improve this situation. More flexible use of different oral health practitioners should be encouraged. Workforce incentives and increased support for public sector services will be important, as will support for academic and clinical staff to educate and train the dental workforce.

At present, larger numbers of dental practitioners work in urban areas as opposed to rural and remote areas. This has implications for access to dental services for Australians who live outside urban areas. Given the increasing number of dental practitioners graduating each year (and some from rural dental schools), there is the chance that more would be willing to work in rural, regional and remote areas. Without concerted effort this outcome is not assured. A pipeline approach with multiple strategies will be required to support workforce to move to areas of under-service. This includes recruitment of marginalised groups (such as through Puggy Hunter Memorial Scholarships and affirmative rural entry schemes for all dental professionals); supported rural clinical placements and support for dental academics within University Departments of Rural Health and Rural Clinical Schools; and support to provide dental graduates with opportunities to move to regional areas (accommodation and academic support).

Following graduation, by providing incentives for dental practitioners to work outside of capital cities, through schemes such as those provided to medical practitioners who work in rural areas, it might be possible to increase the overall number of dental practitioners

practising in or servicing rural areas. Additionally, maximising the scope of practice of dental therapists, oral health therapists and dental hygienists (with appropriate DBA approved formal education and training programs) and ensuring that all oral health practitioners can work to the full scope in which they are competent, which may allow them to provide treatment to more people, noting that this would need to be considered by HWA and AHPRA. This may alleviate access pressures for rural and remote areas by increasing the use of the whole dental workforce (although there is no evidence to support the arguments that this is not already occurring).

Innovative workforce initiatives, not necessarily limited to increasing the supply of oral health practitioners, will need to be explored. This could include consideration of appropriate incentives for the whole workforce, both financial and non-financial. Service delivery models for rural and remote areas (such as mobile services) will need infrastructure support. This could include hub and spoke models with training and research as core elements. This will provide opportunities to train dental practitioners in a team-based environment.

Further targeted research is required to consider the factors that influence dental practitioners to work in rural and remote specialist areas. This work can be integrated with the existing wider health workforce initiatives and knowledge but the level of infrastructure and the workforce models that relate to dental services should be reviewed specifically, as the dental workforce requires a high level of planning and co-ordination to address both capacity and distribution issues.

Relevant government workforce bodies, such as the HWA, AHPRA and the DBA, should collaborate on better understanding and, if appropriate, shaping a future dental workforce. As noted in Chapter 2, HWA is undertaking analysis in 2012 of the dental health workforce and related issues as part of the National Training Plan Mark II. This will inform broader strategic consideration of dental workforce issues, such as co-ordination of education, employment, accreditation and regulation of workforce. However, until HWA reports, there is still scope for government to address immediate issues such as maldistribution of the workforce.

Aspiration Eight

Enhancing data collection, research and analysis

Data collection, research and analysis play an important role in policy development, program design and evaluation. The Council believes this area does not receive sufficient emphasis and resourcing, which limits the ability to positively influence policy development, program design and evaluation. While population-level data are collected through a range of activities supported by the Commonwealth Government through the AIHW, programmatic or patient-level data are far less available.

There are also inconsistencies in the way program data is collected, which makes comparison across states and territories difficult. By collecting patient-level data in the

same way and in creating nationally consistent data, any improvements that are made in delivering dental services in the public system can be accurately compared and contrasted. Improving consistency in data collection will also aid in population-level research. Over the longer term, the Council believes more consistent data collection across the public dental system will help improve analysis and outcomes for oral health policy in Australia.

There is also evidence that delays in treatment for oral diseases are having a significant effect on the health system and economy. In particular, there may be significant health costs to the government from people seeking treatment for pain and infection. Beyond the principle of treating individuals who are in need of care, there is a policy obligation to try and ensure that existing expenditure is allocated efficiently. Further data and research into these issues will not necessarily reduce overall costs to the health system, but could improve the way dollars are spent.

Improvements in data collection in the public system need to be matched by the provision of patient-level data in the private system. This information would help to identify service patterns for public patients receiving their treatment in the private sector as well as provide information on private sector patients.

Australia is fortunate to have broad-based population data from research institutions such as ARCPOH. Population-based research of ARCPOH has been partly funded by the Commonwealth through AIHW and in-kind co-operation from several jurisdictions. However the value of population-level data is enhanced by building information on long-term trends which requires sustained data collection activity. Further, there are gaps in population-level data collected which should be identified and considered for new activity.

At the broad population level, the Council believes that funding should be provided for more regular national surveys for children and adults, where data about visiting patterns and access can be measured against clinical indicators of oral health. Clinical collections should be undertaken every ten years or so to measure improvements or declines in population-wide oral health. As oral health is slow to change, more regular clinical surveys are less crucial. However, national surveys are held too infrequently due to uncertain funding. For example, Australia has had two adult surveys one in 1987-88 and the last in 2004-06. The Council would like to see national surveys become an expected part of understanding the oral health of Australians.

Chapter Six – Options for Reform

Introduction

Consistent with the Terms of Reference, this chapter provides a range of options for the Government to consider for the 2012-13 Budget.

As a first step, we have identified two priority groups: children and lower income adults. This chapter sets out options for these groups.

For children we have proposed two options for a universal scheme:

- **An individual capped benefit entitlement (Option 1)**, which would cover basic preventive and treatment services. The benefit could be used in the public or the private sector.
- **Enhanced access to public dental services (Option 2)**, which would increase access for all children to basic dental services by enhancing existing public sector services.

These options have been developed as alternatives, with a choice required between them. Both options include an additional measure to provide services to those children who do not currently access adequate services.

For lower income adults we have also proposed two options:

- **A means tested individual capped benefit entitlement (Option 3)**, which could build on the legislative framework for existing programs. Access to higher level services or caps could be provided in exceptional circumstances.
- **Enhanced access to public dental services (Option 4).**

These options have been developed as alternatives, with a choice required between them. These options are designed as a stepping stone on a path to a universal access program. Both options include a short-term measure to help provide access to services for people who have faced long waits for public dental services.

Any of the four options could potentially be scaled and/or phased in over time. The Council's view is that while the options could be implemented gradually, it is important to understand that this would be a step on the road to full implementation, not an end point in itself. The challenge with scaled options is to ensure that targeting is not so narrow as to adversely impact on the development of a broader and better resourced population-based framework.

The Council has also considered an example of an integrated option combining enhanced access to public dental services for children and a means tested capped benefit entitlement for adults. This model looks at the responsibilities for funding and service delivery of states and territories and the Commonwealth.

The cost estimates presented in this chapter are indicative only, enabling broad comparisons between the options. The assumptions include complex interactions, covering: relationships between private and public dental sectors; private dental practices acceptance of scheme design and benefits; and changes in incentives for and behaviours of

individuals. Establishing more precise cost estimates will involve further discussion with the dental sector.

We further recommend fundamental supporting measures as an integral component for all options. These include:

- building workforce and infrastructure capacity;
- improving data and research capacity;
- oral health promotion and prevention; and
- specific measures for population groups with special oral health care and treatment needs.

Basic Preventive and Treatment Services

For the proposals set out below, the Council considers that basic preventive and treatment services should include diagnostic, preventive and routine services, but exclude ‘elective’ services such as crowns and implants. This approach allows for a focus on oral health prevention and early intervention. These account for approximately 90 per cent of services, but only two-thirds to three-quarters of the total costs. For more detail refer to Appendix K.

However, some patients may require more complex high-end dental care which is not categorised as diagnostic, preventive or routine. Patients would be given access to clinically necessary complex care items in exceptional circumstances.

Options for Children

The options for children are based on the Council’s aspirations in Chapter Five that investment in children will provide long-term benefits for population oral health. As noted in Chapter One, although children have relatively high visiting rates, there are worrying signs of increased dental caries, with 45.1 per cent of 12 year olds having decay in their permanent teeth and 24.8 per cent with untreated decay. Recent studies have also revealed that there is a social gradient in the prevalence of child caries, with those children in the least advantaged areas experiencing approximately 1.5 times the number of caries than children in the most advantaged areas.¹¹⁶ However, the Council does not support an option to focus only on low income children. Caries and untreated caries are evident across all socioeconomic groups. Surprising proportions of those children affected are found in middle and upper socioeconomic groups. A universal program is the best option for reaching all children and establishing a foundation for good oral health throughout life.

A universal scheme for children, including an additional measure to reach out to those who do not presently access dental care will address this. States have indicated that in their experience, the treatment of children actually becomes less costly on a per capita basis over time as regular preventive services and promotion reduce the need for more complex procedures.

¹¹⁶ Spencer, A.J. and Harford, J. (2008), *Improving Oral Health and dental care for Australians*, Prepared for the NHHRC, p.35.

The Council has developed two alternative approaches for a universal children's scheme:

- An individual capped benefit entitlement for individuals to be funded by the Commonwealth.
- The states and territories delivering services for children. This could be funded and managed by the Commonwealth, or by a partnership between the Commonwealth and the states and territories through intergovernmental agreements.

These options have been developed as alternatives, with a choice required between them.¹¹⁷

Option 1 – An individual capped benefit entitlement

The objective of this option is to improve access to dental services for all children through a scheme which funds the provision of basic preventive and treatment services.

Operation

This option would provide an individual capped benefit entitlement for basic dental services for all children aged up to 18 years. This would be funded by the Commonwealth.

This entitlement could be used for a range of basic dental services, covering preventive and restorative treatments. The services available would be listed on a dental benefits schedule. The Dental Benefits Schedule already in place for the MTDP could be used as a starting point. An example of a schedule has also been developed by experts from the Council (refer to Appendix K).

The benefit could be used to access care in the private or public sector. This would complement existing arrangements under the MTDP and allows patient choice as to the location of care.

Services provided in the public sector would be free to the patient. Private dentists could choose to charge above the item benefit. In these circumstances patients would need to meet any additional charges out of their own pockets.

The entitlement would be available on a calendar year basis. Dental practitioners would provide services based on the schedule of benefits, up to the value of the entitlement.

A significant group of children are missing out on adequate dental services. These children are difficult to identify and reach. Due to the differences in infrastructure across the country, the Council proposes a fore-runner program for those children. This program would demonstrate ways to engage these individuals, through, but not limited to, Medicare Locals and other community organisations. Those individuals identified by this program would then receive treatment through the public dental system. The program could then be evaluated and the most successful methods incorporated into the universal scheme.

Some members of the Council are experienced in local delivery of services and community development and could be consulted in the development of such a program.

¹¹⁷ The interaction of the children's options with the MTDP is considered on page 76-77.

Timing of implementation

Moving to a system where all children visit a dental practitioner regularly will mean addressing current workforce and infrastructure capacity constraints. The Council recognises that full implementation will take some time. For this reason, the indicative costings assume that foundational activities and the programs to reach children commence in 2012-13 and the roll out of the capped benefit entitlement option would commence no later than 1 July 2013.

Scalability

This option could be implemented in stages. The timeframe for scaling depends on many factors, including workforce constraints and the Government's decision on fiscal considerations. This option could be scaled down in cost by initially limiting access through a means test – for example focusing on concession card holders (two million children) and expanding access to all children (five million) at a later date. This approach would mean the option would not offer universal access in the first instance. The Council does not see a narrower scheme as a permanent stand-alone measure but rather as a staged approach to a more comprehensive universal measure.

Scaling in this way would reduce the indicative cost of the program from \$2.5 billion to \$827 million over four years from 2012-13. It would result in the same fully implemented cost as the universal access scheme (approximately \$904 million per year) from 2017-18, when the scaled scheme would include all children.

The indicative costing below includes: treatment costs for all children, and development costs for improving and expanding capacity to reach those children who do not receive appropriate care.

Table 6.1 - Projected expenditure for Option 1

Option 1 (\$ million)	2012-13	2013-14	2014-15	2015-16	Total cost over the forward estimates	Annual cost once fully implemented
Option — Universal access (treatment costs)	*51	888	970	1,038	2,946	904
<i>Plus development costs</i>	5	5	5	5	21	
TOTAL	56	893	975	1,043	2,967	
Option — Phased introduction starting with concession card holders (treatment costs)	*51	133	426	466	1,311	904
<i>Plus development costs</i>	5	5	5	5	21	
TOTAL	56	138	431	471	1,332	

Note: Estimates do not include the transitional costs associated with any affected legacy programs. Numbers may not add to totals due to rounding.

*In 2012-13, treatment is only costed for the children who currently do not receive appropriate care. The broader population would receive treatment from 2013-14.

Comments

Under this approach the Commonwealth has funding and policy responsibility for the program. The states and territories retain a service delivery role and the details of how this would work in practice would require consideration at a formal intergovernmental level.

If states and territories continue to be responsible for particular population sub-groups with special oral health care needs, where the new outreach activities will draw more people into active participation in dental service programs, this would require consideration at the intergovernmental level.

This option uses both public and private sector service delivery. States could continue to operate their existing models and approaches, while providing services under the scheme. This would also provide some flexibility for the public sector, allowing states to use either community clinics and/or dedicated school dental programs to provide services.

Under this option, the Commonwealth Government would gain wide-ranging patient-based service data which would be available to inform planning and improvements to the scheme.

A key risk of this option is that some children are already covered by private health insurance for these services. In these cases the scheme may not improve access but instead simply replace a private health benefit with a government benefit.

Option 2 - Enhanced public sector child dental services

The objective of this option is to improve access to dental services for all children through a scheme which funds basic preventive and treatment services.

Operation

All children up to 18 years would be eligible for public dental services. The Commonwealth would fund the states and territories to deliver the services, through their existing systems including school dental services, community clinics and the private sector. The dollar value of dental services per child would be set at the cost of providing the services in the public system. Services to concession card holder children would be free of charge, while non-card holders may need to make a co-payment.

Timing of implementation

This option would require agreements to be made between the Commonwealth and the state and territories. The Council expects that these agreements and further implementation arrangements would take at least 12 months.

In the short- to medium-term, the take-up of the scheme is expected to be limited by the capacity constraints of the public sector. As this capacity is built up through the foundational support activities, there will be a gradual increase in take-up. Full implementation and capacity is expected to be reached around the end of 2016.

As noted in Option 1 above, a fore-runner program could be implemented to identify and reach those children who are missing out on adequate dental care.

Scalability

There is some potential to scale the implementation of this option.

The indicative costing below includes: treatment costs for all children, and development costs for building capacity to reach those children who do not access care.

Table 6.2 - Projected expenditure for Option 2

Option 2 (\$ million)	2012-13	2013-14	2014-15	2015-16	Total cost over the forward estimates	Annual cost once fully implemented
Option — Universal access (treatment costs)	*51	727	801	860	2,437	717
Plus development costs	5	5	5	5	21	
TOTAL	56	732	806	865	2,458	

Note: Estimates do not include the transitional costs associated with any affected legacy programs. Numbers may not add to totals due to rounding.

*In 2012-13, treatment is only costed for the children who currently do not receive appropriate care. The broader population would receive treatment from 2013-14.

Comments

As with Option 1, this assumes the Commonwealth would take policy and funding responsibility for children's treatment. The states and territories would be responsible for the delivery of services. These arrangements would need to be formally negotiated at an intergovernmental level.

By using state and territory expertise, infrastructure, workforce and system arrangements this option is less costly than the universal individual capped benefit entitlement for two reasons:

- the public system can provide a similar service to the private system at a lower cost thereby reducing the per capita expenditure; and
- there are likely to be a significant number of families who will not participate in the program as they will continue their existing visiting patterns to private dental practitioners.

This arrangement reduces expenditure by approximately \$511 million over the forward estimates and is also \$187 million less per annum once fully implemented, compared to the universal individual capped benefit entitlement.

It would also be possible for states and territories to redirect their previous investments in child dental programs to more targeted approaches aimed at reaching the children who receive inadequate dental services as described below.

Options for Low Income Adults

There are significant barriers to dental care for lower income adults. As noted in Chapter Three, around 42 per cent of adults eligible for public sector dental care have an unfavourable visiting pattern and up to 400,000 adults are on public dental waiting lists.

The main objective of the adult options is to improve oral health by dealing with the existing oral health problems, thereby laying a foundation for more effective preventive measures into the future.

The Council has developed two options to addressing the oral health needs of lower income adults, based on current systems for dental service delivery. The first would use a means tested individual capped benefit entitlement, building on existing legislative frameworks. Alternatively, the second would provide basic preventive and treatment services through the public dental system. These options are designed as a stepping stone on a path to a universal access program.¹¹⁸

Option 3 – Access to a means tested individual capped benefit entitlement

The objective of this option is to improve access to dental services to concession cardholder adults by funding access to basic preventive and treatment.

Operation

This option would provide an individual capped benefit entitlement for all concession card holder adults. This would be funded by the Commonwealth.

Limited access to more complex high end items (e.g. bridges, crowns and implants) could be provided through a separate ‘exceptional circumstances’ mechanism.

The benefit entitlement could be used to access care in the private or public sector. This would complement existing arrangements under the CDDS and allows patient choice as to the location of care.

Patients would access clinically necessary services on a calendar year basis from either the public or private sector. Dental practitioners would be able to provide services based on the schedule of benefits, up to the value of the entitlement. Services provided in the public sector would be free to the patient.

The individual capped benefit entitlement would cover a schedule of services. An example of a schedule has also been developed by experts from the Council (refer to Appendix K). Access would be means tested to include only cardholder adults.

As discussed in Chapter Two, there are more than 400,000 patients on public dental waiting lists. As they wait, these patients’ oral health is deteriorating, and they may end up with other medical conditions as a result. Therefore, as a first step, an option that can be implemented before the broader adult option described above, is to provide additional funding to states and territories for treatment for these patients. The majority of the Council believe that this must be implemented as an integral part of broader dental reform. Without an ongoing major investment in a broader program, this measure would create increased demand for public dental services and result in longer public dental waiting times.

¹¹⁸ The interaction of the adult options with the CDDS is considered on page 77.

Timing of implementation

In the short term, workforce and infrastructure capacity constraints will limit the extent to which demand can be met. The take-up rate of the scheme is expected to gradually increase, as capacity to provide services increases. The foundational support measures described later in this chapter will contribute to this increase in capacity.

Scalability

This option sets the foundation for longer-term increased coverage. The eligibility criteria should be expanded over time to include other groups such as chronic disease sufferers (who are currently receiving services under the CDDS program) and lower income, non-concessional patients. The addition of both of these groups would provide benefits for over 7.6 million people: 5.1 million concession card holders; 2.3 million low income non-concessional patients; and an estimated 176,000 chronic disease sufferers currently accessing Commonwealth dental benefits,¹¹⁹ noting that the majority of current chronic disease patients would be included in the first two groups.

There may be natural scaling of this option, as some proportion of concession card holders hold private health insurance and they may prefer to access private services through this mechanism.

The indicative costing below includes both the individual capped benefit entitlement program and a measure to address waiting lists. The measure for addressing waiting list patients would be an additional \$343 million in 2012-13.

Table 6.3 - Projected expenditure for Option 3

Option 3 (\$ billion)	2012-13	2013-14	2014-15	2015-16	Total cost over the forward estimates	Annual cost once fully implemented
Option —access for concession card adults, plus a waiting list measure	0.3	2.1	2.3	2.5	7.1	2.6
Option – including chronic disease patients, plus a waiting list measure	0.3	2.3	2.7	2.9	8.3	3.1
Option – including chronic disease and other low income adults, plus a waiting list measure	0.3	3.2	3.7	4.0	11.4	4.2

Note: Estimates do not include the transitional costs associated with any affected legacy programs. Numbers may not add due to rounding.

Comments

The key advantage of this option is that it is a simple and coherent scheme, that operates on the scale and scope required to redress current deficits in access to dental services and the

¹¹⁹ Estimated number of CDDS patients at time of administering a new scheme.

population's oral health, starting with concession card holders and moving to support for all adults.

Under this approach the Commonwealth has funding and policy responsibility for the program. The states and territories retain a service delivery role and the details of how this would work in practice would require consideration at a formal intergovernmental level.

If states and territories continue to be responsible for particular population sub-groups with special oral health care needs, where the new outreach activities will draw more people into active participation in dental service programs, this would also need consideration at the intergovernmental level.

Under this option, the Commonwealth Government would gain wide-ranging patient-based service data which would be available to inform planning and improvements to the scheme.

Option 4 – Enhanced access to public dental services

This option is aimed at increasing access for lower income adults to basic preventive and treatment services by enhancing the public sector.

Operation

All concession card holder adults would be eligible for public dental services, including basic preventive and treatment services.

The Commonwealth would fund services and the states and territories would deliver them. Per capita costs of the program would be set at the value of providing basic preventive and treatment services in the public system.

Services would be provided free of charge or with limited co-payments. States and territories could purchase services in the private system where extra capacity is required (as is the current practice).

An 'exceptional circumstances' mechanism could be implemented to allow access to higher end services, which could be provided in the private sector and in teaching institutions.

Timing of implementation

This option has the same objectives as the individual capped benefit entitlement; the key difference is the model chosen to deliver the services.

In the short term, program requirements and the funding model would need to be developed through agreements with the states and territories negotiated through a formal intergovernmental process. Such agreements would need to cover: funding; data reporting; accountability for outcomes; building increased capacity in the public system; and requiring consistent service levels across the states and territories. The Council expects that these agreements and further implementation arrangements would take at least 12 months to finalise.

During this period, the Council would expect that broad consultation with the public and profession would take place. In the short to medium term, the take-up is likely to be limited by the capacity constraints of the public sector, although work could be contracted out to the private sector as required. As this capacity is built up through the foundational support activities (see below), there would be a gradual increase in take-up, with full implementation and capacity expected to be reached around the end of 2016.

As noted in Option 3, an option can be implemented to provide additional funding to states and territories for treatment for waiting list patients.

Scalability

This option could potentially be expanded to include non-card holder chronic disease patients, who account for around 20 per cent of those who currently access the CDDS. Additional low income groups that are not eligible for public dental services could also potentially be given access. Together this would cover over 7.6 million patients. Such an approach would only be possible in the medium- to long-term, requiring agreement from states and territories and significant additional capital funding for public infrastructure.

The indicative costing below includes both the individual capped benefit entitlement program and a measure to address waiting lists. The measure for addressing waiting list patients would be an additional \$343 million in 2012-13.

Table 6.4 - Projected expenditure for Option 4

Option 4 (\$ billion)	2012-13	2013-14	2014-15	2015-16	Total cost over the forward estimates	Annual cost once fully implemented
Option as described above, plus a waiting list measure	0.3	0.7	0.9	1.1	3.0	1.3
Option including chronic disease patients, plus a waiting list measure	0.3	1.1	1.3	1.6	4.3	1.8

Note: Estimates do not include the transitional costs associated with any affected legacy programs. Numbers may not add due to rounding.

Comments

As with Option 3, the Commonwealth would take policy and funding responsibility for concession cardholder adult treatment. The states and territories would be responsible for delivery. This would need to be formally negotiated at an intergovernmental level.

By using state and territory expertise, infrastructure, workforce and system arrangements this option is less costly than the individual capped benefit entitlement. Compared to the capped benefit entitlement option, this arrangement reduces expenditure by \$4.1 billion over the forward estimates period. On an ongoing basis it would cost \$1.3 billion less per annum at full implementation.

Integrated Adult and Child Options

The Council considers that, to improve services across all age cohorts, action should be taken to address both the needs of children and low-income adults by integrating selected options. Four integrated combinations of the child and adult options, which demonstrate various divisions of responsibility between the Commonwealth and the states, are below.

The extent to which each level of government is responsible for the funding and provision of dental services depends on the policy options pursued. Entitlement options (Options 1 and Option 3) would place the Commonwealth government in a direct relationship with providers and users of dental services. The government would bear the dominant responsibility for such programs (e.g. MTDP and CDDS). Alternatively, the Commonwealth Government might transfer payments or provide block grants to the states for the provision of services (e.g. CDHP).

In line with the frameworks already described, these integrated options should utilise existing systems in the short term with the potential to expand their reach over time.

Table 6.5 - Possible combinations of child and adult options

	Combination		Summary description
1	Option 1 (individual capped benefit entitlement for all children)	Option 3 (access to a means tested individual capped benefit for concession cardholder adults)	Both children's and adult's dental services would be directly funded to eligible individuals by the Commonwealth. Services would be provided in the public and private sectors by states and private providers respectively.
2	Option 1 (individual capped benefit entitlement for all children)	Option 4 (enhanced access to public dental services for lower income adults)	Children's services would be directly funded to eligible individuals by the Commonwealth. Services would be provided in the public and private sectors by states and private providers respectively. Services for adults would be funded by the Commonwealth through states. Services would be provided in the public sector by states and contracted to the private sector when necessary.
3	Option 2 (enhanced public sector child dental services)	Option 3 (access to a means tested individual capped benefit for concession cardholder adults)	Children's services would be funded by the Commonwealth through states. Services would be provided in the public sector by states or contracted to the private sector when necessary. Service for adults would be directly funded to eligible individuals by the Commonwealth. Services would be provided in the private sector or by states respectively.
4	Option 2 (enhanced public sector child dental services)	Option 4 (enhanced access to public dental services for lower income adults)	Children's services would be funded by the Commonwealth through states. Services would be provided in the public sector by states or contracted to the private sector when necessary. Services for adults would be funded by the Commonwealth through states. Services would be provided in the public sector by states and contracted to the private sector when necessary.

For example, in *Combination 3* ('Option2/Option3') the states would be responsible for child services (5.4 million children under 18 years of age), on the basis of a COAG agreement that includes consistency of standards and service levels for dental care. The Commonwealth would take responsibility for concession card holder adults (5.1 million adults).

The states have a long standing involvement in school dental services and could develop the capacity to care for all children, particularly focused on those in most need. This would involve some contracting of dental services to the private sector. The states would be responsible for child services, on the basis of a COAG agreement. The Government could also consider transferring funding for the MTDP to the states and territories as part of their taking responsibility for child dental services. This could assist with freeing up the existing public dental system and state and territory funding to improve services to eligible adults. The Commonwealth would take responsibility for low-income adults and fund adult concession card holders through a dental benefit entitlement scheme with a defined dental benefit schedule. This would be an extension of the framework used by the Commonwealth for the CDDS, but with altered eligibility and scope of dental services provision. The public dental sector could also access the benefit entitlement to provide services to eligible adults.

This integrated option would use private sector workforce and infrastructure capacity for the highest need and public sector expertise in providing services to children.

The Commonwealth could also expand eligibility for this entitlement benefit and provide it to chronic disease patients as well as non-concession card low income adults (approximately 2.5 million additional adults). The Commonwealth could also provide short-term assistance to those concession card holders currently on public dental waiting lists (approximately 400,000 additional adults). The total estimated cost for this option as outlined above would be in the order of \$10.1 billion over the forward estimates from 2012-13.

The Council has used the above combination of responsibilities as an example. Other combinations and lines of responsibility are outlined in the table above. Each has a level of plausibility and possible advantages. For instance, *Combination One* is closest to the Commonwealth's current involvement in the MTDP and CDDS. *Combination Two* is the reverse of the combination outlined in more detail above. It would recognise the current limited capacity in some states in directly providing dental services to children. *Combination Four* would be consistent with the states historical role in dental service provision to children and low income adults, albeit with substantial Commonwealth funding. More detail on such combinations was beyond the scope of the Council in this report. Part of the dental reform process could include discussions between states and territories and the Commonwealth through COAG on responsibility for children and adults or other arrangements including shared responsibility for particular groups.

Future of Government Dental Programs

Medicare Teen Dental Plan

Under the individual capped benefit entitlement option proposed for children, (Option 1) the MTDP would continue to operate, albeit with modifications. As a basic benefit entitlement scheme, the MTDP could be used as the vehicle to provide a benefit

entitlement that could be expanded to include a broader eligibility base – all children under the age of 18 and not just teenagers – as well as include a broader schedule of benefits for dental treatment – not just preventive checks. The schedule of benefits would be set at the cost of providing services in public system. The benefit entitlement could potentially be increased to reflect the higher cost of treatment outside metropolitan and regional centres. The MTDP would also no longer include a means test, as the option proposes universal access to all children.

Under the public sector approach in Option 2, funding for the MTDP would be bundled into the funding for the states and territories.

However, whether the MTDP continues or is modified, there could be an evaluation of the program's efficiency, effectiveness and appropriateness in the context of future dental policy directions. The Council is aware that the second review of the *Dental Benefits Acts 2008* noted that there should be an evaluation of the program, given the take-up was lower than originally anticipated at only 30 per cent in 2010-11.

Medicare Chronic Disease Dental Scheme

Under a public sector approach for adults as outlined under Option 4, the Government would cease funding services through the CDDS and move to funding services through the states.

If the Government chose to use a benefit entitlement approach as outlined in Option 3, a modified version of the CDDS could be the vehicle for service delivery, resulting in a significant reduction in expenditure. Features of a modified program could include:

- restricting the program to essential dental services. This still allows for the provision of 'high end' level services (crowns, bridges, implants) where basic treatments are insufficient and high-cost items are vital for patient health. Access to 'high-end' services could be controlled through an 'exceptional circumstances' mechanism, based on advice from an expert group;
- in the short term, introducing a means test to restrict access to concession card holders. As dental workforce capacity increases, eligibility could be scaled up in the medium to long term to include broader groups who suffer from poor access to dental services (e.g. low income non-concession card holders);
- providing for a higher benefit entitlement to reflect the higher cost of treatment outside metropolitan and regional centres and/or to account for increase service costs for certain groups, e.g. denture patients;
- allowing the benefit entitlement to be used in the public or private sector, with schedule benefits set at the cost of providing services in public system; and
- ensuring that any supporting legislation allows for all dental practitioners to provide dental services to the full extent of their scope of practice.

There are further matters relating to potential modifications to the CDDS that would benefit from expert consideration for example: how the clinical guidelines could be set; how the 'exceptional circumstances' for high-end items could operate; and the scope of chronic diseases included in the scheme.

Private health insurance rebate

The Council recognises the role private health insurance plays in the assisting 11.9 million Australians with financing of health care, including dentistry. The Council was not able to consider private health insurance in any depth. The Council has concluded that further consideration needs to be given to the interactions between the options pursued and private health insurance. This includes consideration of the potential for overlap in public subsidies for dental services and private health insurance. The Council agreed that such consideration could extend to future reforms and incentives for private health insurance as well as other methods of financing dental services.

Other Commonwealth and State dental programs

It is unlikely that there will be any advantage in changing other Commonwealth supported measures or rolling them into broader dental reform in the short term. Such programs are outlined in Chapter Two and include: the Cleft Lip and Cleft Palate Scheme; dental services for the Australian Defence Force, the Army Reserve and eligible veterans; and HELP-supported university courses.

States would need to maintain existing resourcing for service delivery through the public sector. However, state investment could be redirected to high need groups depending on the options chosen. For example, if the Commonwealth takes funding responsibility for child dental services, state and territory expenditure in this area could be freed up and directed toward improvements to services for adults. This would be a significant increase in expenditure which could help reduce public waiting times for adults. Further, states would be better placed to use freed up resources for special activities for the child population who are not currently receiving adequate access to services.

Foundational Activities

All four major service delivery options would need to be supported by foundational activities around workforce and infrastructure, oral health promotion and special access programs. These activities would be specifically designed to support successful and sustainable improvements in oral health for the identified priority groups, and eventually universal access.

Building on the longer term aspirations in Chapter Five, the Council suggests some specific activities that Government could consider.

Table 6.6 – Summary of key foundational activities

Core Activity	Key Suggested Activities
Dental workforce and infrastructure	<ul style="list-style-type: none"> - Support for workforce to move to areas of under-service, including rural areas and the public sector generally. - Enable dental practitioners to expand and/or fully utilise their scope of practice in order to treat broader populations. - Consideration of a pause on additional dental education programs pending finalisation of the current HWA review of workforce supply and demand. - Increased investment in university and public sector facilities, clinical placement facilities, and capital infrastructure.
Data and research	<ul style="list-style-type: none"> - Improving the evidence base for workforce planning. - More regular national surveys for children and adults. - Identify and address gaps in population-level monitoring and surveillance. - Ongoing funding by Government of oral health and workforce research. - Increase in funding for clinical research in dentistry. - Consideration of e-health initiatives in managing dental health records.
Oral health promotion	<ul style="list-style-type: none"> - Significant increase in expenditure on oral health promotion. - Development of a National Oral Health Promotion Plan. - Implementation of a supportive legislative and regulatory environment. - Co-ordination of oral health messages across the country.
Targeting groups with special oral health care needs	<ul style="list-style-type: none"> - The use of Medicare Locals and community organisations to facilitate access for groups with special oral health care needs. - Improvements in programs to provide services to Indigenous people, rural and remote communities and aged care facilities.

Possible mechanism for delivering foundational activities

The Medicare Local Network forms part of the Government's National Health Reform agenda. Medicare Locals function as co-ordination units within the community and have a role in identifying local health care needs and service gaps. They aim to assist patients in better managing their health conditions and to prevent disease in the community.

Key Medicare Local activities include: linking GP, allied health, hospital and aged care services; training of GPs and allied health professionals; maintaining up-to-date local service directory information; working closely with local health organisations such as Aboriginal Medical Services, Local Hospital Networks and hospitals to improve co-ordination; identifying and addressing gaps in local service delivery; supporting after-hours GP services; and supporting initiatives aimed at improving prevention and management of disease.

The Council notes that each Medicare Local is unique in its operation and has different programs, funding and capacity.

Appendix H outlines some case study examples of the type of role that could be further investigated, including the WentWest Medicare Local in New South Wales and the Marion GP Super Centre in South Australia.

Dental workforce and infrastructure

The terrain of the dental workforce has changed in recent years with the establishment of HWA, DBA, AHPRA and additional universities (including rural dental schools) for educating dental practitioners. This has provided the context to re-examine pathways for co-ordinated analysis and planning for the dental workforce.

The main issues relating to the dental workforce are an under supply, maldistribution and mix of practitioners. These create particular barriers to access for rural and remote, urban fringe areas and special needs patients. The Council notes the potential for utilisation of the diversification of the workforce to address the needs of these patients. It is also important that the work of HWA in assessing and modelling the dental workforce is concluded in a timely way to address these issues.

Workforce utilisation, supply and maldistribution

The Council recognises the important work of oral health therapists, dental hygienists and dental therapists. The Council strongly recommends the removal of legislative restrictions on the provision of dental services by dental therapists, dental hygienists and oral health therapists for government programs such as CDDS and DVA Dental Program.

The Council notes the HWA is currently reviewing the scope of practice of oral health therapists, dental therapists and dental hygienists. The Council suggests that the scope of practice of dental practitioners be considered, specifically that the scope of practice of oral health therapists, dental therapists and dental hygienists be expanded, with approval by the DBA, to allow for treatment and services to broader population groups. This would include appropriate DBA approved formal education and training, ensuring that all oral health practitioners can work within the full scope in which they are competent. These may relieve the time and cost pressures of heavily relying on dentists to perform basic services.

In addition to the aggregate supply and demand balance there is significant maldistribution between urban and rural areas, and across urban areas as well as between private and public dentistry.

The Council suggests a multipronged approach to support workforce redistribution to areas of relative under service:

- recruitment of marginalised groups (through scholarships and affirmative rural entry schemes for all dental professionals);
- supported rural clinical placements and support for dental academics within University Departments of Rural Health (UDRHs) and Rural Clinical Schools,;
- enhancement of the foundation year for dental graduates with opportunities to move to regional areas (accommodation and academic support); and
- further expansion of the DTERP program for rural clinical schools, including increasing the support for dental undergraduates training in rural and regional areas.

The Government could also consider the use of incentives and reward payments for various sectors of the workforce:

- to help support public dental services to develop retention strategies;
- to cater for patients with special oral health care needs; and
- infrastructure grants for clinics, mobile dental infrastructure, or for relocation grants for rural and remote areas.

Co-ordination and planning around the dental workforce

In terms of long-term planning and co-ordination of the workforce, HWA propose to develop the National Training Plan Mark II in 2012, to be considered by Health Ministers. In addition to this work, the Council considers that there needs to be improved co-operation into the future across relevant bodies such as HWA, AHPRA, DBA and the Australasian Council on Dental Schools.

The Council also supports using the HWA's national training plan to guide the tertiary sector on the education of dental practitioners, potentially to modify the recruitment of international dental graduates and to stimulate reform measures within the dental workforce. The Council also suggests that HWA work explicitly consider the development of a rural dental workforce strategy.

The establishment of three new dental schools puts extra strain on the capacity of clinical and training infrastructure. The Council's Workforce and Infrastructure Working Group suggests a pause on new schools and programs until a new round of supply and demand projections are available and the HWA has prepared its national workforce plan and submitted it to Health Ministers.

Academic and clinical training and infrastructure

The rapid expansion of the numbers of dental practitioners in training, as well as introduction of the Voluntary Dental Intern Program, will put increasing pressure on the training staff and infrastructure available for students in university training. To deal with these pressures the Council proposes that the Government increase funding for both capital infrastructure, facilities and staff for universities, public dental hospital and community placement clinical facilities.

Data and research

Policy development, program design and evaluation needs to be supported by sufficient ongoing funding for data and research. The Council would like to see a maintenance of existing support for population-level monitoring and surveillance of oral health, use of dental services and practice activity.

Appropriate research activities include:

- more regular national surveys for children and adults, so that they become an expected part of understanding the oral health of Australians;
- the identification of gaps in population-level monitoring and surveillance and implementation of activities to fill them;
- capturing a greater scope of process, output and outcome measures on individuals within existing and new dental programs;

- targeted research in priority areas of emerging need; and
- targeted research on the factors that influence dental practitioners to work in rural and remote specialist areas.

The Council supports improving the evidence-base for workforce planning – through ongoing research. The recent publication of new data on practitioner registrations highlights the need for ongoing monitoring of the dental workforce and the periodic revision of dental workforce supply projections. The Council believes it would be appropriate for the Government to fund periodic research and analysis.

Oral health promotion

Australia has a world class record in health promotion in some areas, including tackling road accidents (i.e. drink driving), smoking and HIV/AIDS. We already have the capacity to be highly effective in delivering oral health strategies if funding and other supports are provided. The value of such an investment is readily seen in the Commonwealth Government's 2003 publication, *Returns on Investment in Public Health*,¹²⁰ which also highlights another key principle of successful health promotion work: planning collaborative approaches using multiple strategies at different levels.

Expenditure on oral health promotion and non clinical prevention activities is very low – estimated to be around one per cent of expenditure, compared to even the highly modest two per cent of expenditure across the whole health system. This could be significantly increased to reduce the incidence of dental caries and periodontal disease. This will both improve the quality of life of Australians and reduce the demand for future dental care.

Broader systemic support for oral health promotion requires legislative, regulatory and fiscal policies to assist in making healthy choices easier– examples in the oral health area include health promoting foods in schools or removal of taxes on fluoride toothpaste.

As is the case for many other health issues, oral health status is influenced not only by individual behaviours but structural or social factors. For example, access to care is crucial and the inequities in this are discussed. Other structural issues include those influencing diet in general, e.g. access to affordable healthy foods, heavy promotion of high sugar foods on television and at point of sale, and the way sugar treats are seen as rewards in our culture. These and other factors need consideration when designing health promotion programs.

The Council proposes the development of a National Oral Health Promotion Plan as the cornerstone for future promotional activities. This Plan could investigate various opportunities and pathways for oral health promotion and would include developing:

- a multi-strategy approach to oral health promotion through co-ordination with the states and territories – based on current evidence, underpinned by social research, and underpinned by common themes, principles and oral health messaging;

¹²⁰ Applied Economics (2003), *Returns on Investment in Public Health: An Epidemiological and Economic Analysis*, 2003. Prepared for the Department of Health and Ageing.

- close links to the general health promotion activities of the Australian National Preventive Health Agency, i.e. the Expert Committee on Obesity, with an increased focus on oral health;
- a strategic system to encompass and support all oral health promotion activities, such as:
 - targeted approaches involving conveying information and supporting healthy choices to be organised around a settings approach, for example day care centres or residential aged care facilities;
 - with information and healthier behaviour reinforced through mass campaigns and encounters with public and private dental services;
 - embedding oral health promotion in service delivery models in the education of the future dental workforce;
 - oral health screening and education:
 - upon admission to residential aged care, and incorporated as part of the client's overall care plan;
 - prior to or upon commencement of treatment for diseases requiring lengthy treatment (e.g. cancer), and regular oral health checks and preventive treatment throughout treatment as well as for a post-treatment; and
 - prior to or upon commencement of treatment for chronic conditions by including oral health assessments and preventive activities in care plans;
 - ongoing support for oral health promotion and prevention, including education, activities and campaigns to ensure that improvements in oral health are sustained over time;
- expertise in research that is centred on oral health problems;
- regular funding for the National Oral Health Promotion Clearing House and Steering Group and recognition of their role as the co-ordinating advisory body for oral health promotion projects;
- designated positions for oral health champions (such as dental assistants, dental practitioners or other health workers) within state oral health services to link in to communities and schools to raise the profile of oral health and to deliver consistent national messages;
- proposals to extend water fluoridation across the whole country; and
- scope for leveraging the Medicare Locals network for targeted activities.

Targeting groups with special oral health care needs

The Medicare Local Network could facilitate access to oral health services for special needs patients by: arranging patient transportation for visits; and assigning a case manager to patients to manage appointments and follow-up visits. Medicare Locals could also act as an information gateway between the states and territories and local oral health providers. This could assist the states in identifying and addressing oral health service delivery.

A pilot program to deliver oral health promotion could be trialled in a particular state or region to identify special needs groups (refer to Appendix H for a case study on Medicare Locals).

To further assist these special needs groups to access care, centres of excellence could be established for developing public dental capacity to specialise in managing special cases.

Indigenous people

Increased access to dental services for Indigenous people could include:

- improvements to the co-ordination of services through Aboriginal Medical Services and the states and territories;
- upskilling Indigenous health workers in oral health education, utilising oral health competencies developed for Indigenous health workers by the Community Services and Health Industry Skills Council;
- support for Indigenous students across dental disciplines, including developing access programs for Indigenous students to study dentistry;
- updating the *Dentistry in Remote Aboriginal Communities* manual, which provides information on cultural and clinical orientation for oral health professionals working in remote Indigenous settings; and
- Medicare Locals co-ordinating services in urban areas as well as particularly for rural and remote communities. Where appropriate, Medicare Locals could identify service needs and co-ordinate Aboriginal Medical Services to make arrangements with private and public dentists to extend the reach of services to Indigenous people.

In addition, the Council also suggests investigating a possible national expansion of successful regional Indigenous liaison programs. These programs link with Indigenous communities and train public dental staff to work with Indigenous people, with Aboriginal workers acting as a link. These programs have been successful in making mainstream public dental services more acceptable to Indigenous people, with the number of Indigenous people treated in main stream public clinics increasing significantly.

People residing in rural and remote areas

The proposals to address work force maldistribution would also improve access for rural and remote areas. In addition, rural Medicare Locals could be used to identify dental service gaps in those areas and to assist with the co-ordination of dental service delivery.

A preferred service delivery model would have dental practitioners reside in remote and rural locations on a more permanent basis. This could be supported by retention incentives and infrastructure grants. For small communities, however, fly-in-fly out models like the Medical Specialist Outreach Assistance Program could be appropriate, but with designated communication strategies with existing dental and non-dental professionals.

Frail older people in the community and residential care

These people in the community and aged care residents have difficulties maintaining oral hygiene and accessing dental care. The following strategies could be investigated and developed:

- wider use of all dental practitioners in home and aged care facilities;
- the non-dental workforce, which are providing health services to older Australians, could receive further training in oral health, including reintroducing the successful Nursing Home Oral and Dental Health Plan (and including referral pathways for active treatment) and using oral health competencies developed by Community Services and Health Industry Skills Council;

- existing oral health screening, assessment and simple care planning could be evaluated and improvements could be built into existing assessment and care planning processes such as those undertaken by Aged Care Assessment Teams (ACAT);
 - Many of the existing ACAT Comprehensive Assessment Forms (CAFs) have some standard questions to determine the basic Oral/Dental Hygiene status of the client.
 - The Department of Health and Ageing has developed an Aged Care Assessment Program Toolkit for use by ACAT assessors and includes an 'Oral Health Assessment Tool'. At this time the use of the toolkit is not mandatory. However, the Department is in the process of developing a standardised National ACAT CAF.
- current accreditation standards, under expected outcome 2.6 and 2.15 the *Aged Care Act 1997*, could be assessed to see if they are effective in assessing and care planning for oral health and in the implementation of these care plans in aged care facilities. This could be examined as part of the Department of Health and Ageing's pilot of revised Accreditation Standards, which is anticipated to be undertaken this year.
- greater employment of mobile dental clinics and dental equipment in providing services to aged care residents with mobility and transport issues;
- attention could be given to including oral health as part of TAFE and university nursing course curriculums; and
- a strategy to educate the dental workforce in managing aged care. This could include the use of scholarships, such as those available through relevant Funds established by the Commonwealth in the 2011-12 Budget and administered by the Department of Health and Ageing. This could include specific scholarships for dental therapists and oral health therapists to work in aged care facilities, with a particular emphasis on working in rural and remote facilities.

The Council is also aware that the Government provides funding to the Department of Education, Employment and Workplace Relations under the National Workforce Development Fund, which allows eligible organisations to apply for funding to support the training of existing workers and new workers in the areas of identified business and workforce development need. Aged Care training has been specifically identified as an area for development through this funding and has been allocated \$25 million towards skills development in 2011-12.

The Council also is aware of other policy initiatives for improving overall clinical health, including dental health, for residents in aged care facilities. Opportunities for synergies between this and other activities could be investigated to strengthen the reach and effectiveness of dental health interventions for this vulnerable group.

Homeless people

These population groups not only face barriers accessing dental services but also have difficulty accessing other health services. This will require strategies for marshalling social assets in the community, e.g. the Medicare Locals, the Local Hospital Networks, Community Health Services, and non-government organisations.

It would be worth investigating an expansion of the current programs that provide targeted promotional and dental treatment to all Supported Residential Facilities.

The Council also notes the philanthropic work undertaken by the ADA, its members and other organisations in delivering services to homeless people (see Appendix J).

People with disabilities

Some people in the community face significant access barriers which vary greatly in scope and complexity. Access to services may require specific programs designed to meet their needs, which could require co-ordinating services through new and existing social assets and systems of service, e.g. Medicare Local networks, community health services, and non-government organisations, relevant state departments and universities.

In addition, education and information could be developed and provided to assist dental practitioners in working with various disabled people.

Prisoners

The Council noted that reports of the oral health of prisoners give cause for concern. While states are responsible for the dental treatment, Council recommends that this issue is raised in the Australian Health Ministers Advisory Council (AHMAC).

Appendix A – Terms of Reference

National Advisory Council on Dental Health

The National Advisory Council on Dental Health (the Council) is being established as a time-limited group to provide strategic, independent advice on dental health issues, as requested by Minister for Health and Ageing, to the Government.

Role and Function:

The objective of the Council will be to provide timely, expert, balanced advice on dental health issues as requested by the Minister for Health and Ageing.

The Council's priority task is to provide advice on dental policy options and priorities for consideration in the 2012-13 Budget.

In acquitting this task, the Council will consider:

- dental health programs currently funded by the Australian, State and Territory governments, and the mix and coverage of services currently provided by in the private sector;
- how to improve these programs and better support people with dental illness, in a cost-effective manner, including through better co-ordination and integration of existing dental health programs and services; and
- how to focus dental health programs for people with particular needs, including younger people, older people including people with chronic illness and co-morbid conditions, people from diverse cultural and linguistic backgrounds, Indigenous Australians, and people in rural and remote areas.

The Council may commission targeted research as appropriate on dental health policy and service delivery issues; and consult and liaise with the dental health and related sectors, including dental health consumers and carers, professionals and the non-government sector. In formulating advice the Council should give consideration to how improvements in dental health could be phased in over time.

Other

The Minister for Health and Ageing may also convey to the Council requests for advice from the Prime Minister, other ministers whose portfolio responsibilities relate to dental health issues. The Minister may also convey requests for advice from the Leader of the Australian Greens that have been agreed with the Minister.

All advice and reports from the Council will be provided to the Leader of the Australian Greens within 2 days of being received by the Minister.

The Council will provide an interim report by the end of November 2011, and a final report on options and priorities for the 2012-13 Budget by the end of January 2012.

The Council will initially be established for one year. Consideration will be given to an ongoing role for the Council or a similar body to advise on implementation of dental health reform in the 2012-13 Budget context.

Appendix B - Principles

In providing advice to the Commonwealth Government on dental health issues, the National Advisory Council on Dental Health recognises certain guiding principles.

- Oral health is an important part of general health, well-being and quality of life and should be considered in the context of broader health reform.
- Oral disease has implications for the day-to-day life of the individual and results in economic costs to the community due to reduced social and economic participation and broader costs to the health system.
- Oral health promotion will be an integral part of improving health across the population.
- Child oral health is a vital foundation for lifelong oral health.
- Equitable access to appropriate, timely and affordable services is important for preventing oral disease and improving oral health across the population as well as managing infection and pain and restoring function, noting there is a very significant lack of access for some groups, particularly low income groups and regional and remote populations.
- Available resources should first focus on these groups via targeted approaches for prevention, early intervention and management of established disease.
- Targeted approaches should appropriately address the differing oral health needs of children and adults, and other groups such as the aged, the disabled, Indigenous Australians, and people with chronic conditions.
- Jurisdictions and other sectors have particular roles and responsibilities in the funding and delivery of oral health services:
 - the Commonwealth through leadership and funding; the states and territories through funding and public sector service delivery, training and education; and the private and non-government sectors through service delivery.
- Dental educational institutions have a particular role in the education of the oral health workforce, including through the provision of dental services.
- Improvements in access to appropriate oral health services will involve improvements in the dental workforce, including the capacity and better utilisation of dental practitioners, and the geographic distribution of services.
- Expansion in dental infrastructure will lead to improvements in access to dental health services.

- Regular undertakings of data collection, research, and evaluation of dental programs will help to identify gaps in service provision and will help to improve understanding of the oral health status of Australians.

Appendix C - Service Delivery Options

Group	There would be special arrangements in all options to overcome barriers to access for some sections of Indigenous, those with mental health issues or disabilities, homeless, aged care residents and rural and regional areas.		
	Options	Costs	Issues
Children	<u>Need:</u> <ul style="list-style-type: none">There is an increasing prevalence of caries in children.20% of all children do not have adequate access to services. <u>Objective:</u> <ul style="list-style-type: none">Improved access for all children up to the age of 18 (5.4 million children), covering basic dental, including preventive and treatment services.	Final costs will depend on level of service, entitlement, and implementation. All estimates should be taken as indicative only.	<u>General</u> <ul style="list-style-type: none">This option would involve an increased investment in child dental services.Would require measures to develop workforce capacity to meet increased service demands and address gaps in access to services.Note variations in how services are delivered between states, varying from dedicated school dental service arrangements to community-based only, such as NSW and Vic.Full implementation would need several years to build child dental system across all states and territories, including building infrastructure and data systems, and establishing standards of care.Would require engagement through COAG on funding and service delivery.Some states and territories already offer services for all children without means test. <u>All Scaled Options</u> <ul style="list-style-type: none">As some states and territories offer universal access to services, a scaled introduction would need to consider how funding could be provided to ensure target groups have access to agreed service levels.Children from families not meeting means test may still have difficulties affording appropriate dental treatment services – this could put pressure on states and territories that provide non-means tested access to public dental services. <u>Scaled Option A and B</u> <ul style="list-style-type: none">Means test is inconsistent with MTDP means test, which subsidises access to preventive care for those meeting higher FTB-A thresholds.
	Option 1. Universal Individual Capped Benefit Entitlement for Children <i>Estimated cost over the forward estimates from 2012-13 – \$3.0b</i> <i>Fully implemented cost– \$904m per year</i> <u>Operation:</u> <ul style="list-style-type: none">Use an individual capped benefit entitlement system to allow access to basic dental preventive and treatment services (to be defined) through a schedule of benefits.Existing MTDP could be a modified and expanded as the vehicle for service delivery.Entitlement could be scaled to reflect costs outside metro/regional centres.Entitlement could be used in public or private sectors, with schedule benefits set to cost of providing services in public system.Use of the public sector free for services in the schedule.As part of this option, measures to identify and reach children who face access barriers would be implemented, which may include separate investment in additional infrastructure (e.g. through Medicare Locals, State and Territory Child/School Dental Services).	Implementation Implementation could be scaled over time to recognise context of fiscal environment and need for phased introduction to allow development of capacity and systems. Scaling of options applies to a capped benefit entitlement (Option 1) as some states and territories already provide universal access to services. <u>Options for Scaling (indicative costs over the forward estimates from 2012-13)</u> A. Eligibility set to children in concession card families: 2 million children: \$1.3b B. Include children up to low income non-concession card threshold (to be defined):* 2.9 million children: \$1.7b C. Include children up to FTB-A threshold: 3.4 million children: \$2.0b D. Include all children: 5.4 million children: Option 1 – \$3.0b Option 2 – \$2.5b *population estimate indicative only – to be further developed	
	Option 2. Universal Public Dental Access for Children <i>Estimated cost over the forward estimates from 2012-13 – \$2.5b</i> <i>Fully implemented cost – \$717m per year</i> <u>Operation:</u> <ul style="list-style-type: none">Use public dental system to provide access to nationally consistent basic dental preventive and treatment services (to be defined) – this would be an enhancement to the existing public dental system.States and territories would be able to purchase from private sector services as they build nationally consistent services and coverage.Children from card holder families would be provided with access to free basic dental preventive and treatment services.Could have limited co-pays for non-card holders, noting that some states and territories already have co-payments.As part of this option, measures to identify and reach children who face access barriers would be implemented, which may include separate investment in additional infrastructure (e.g. through Medicare Locals, State and Territory Child/School Dental Services).Modelling of cost is based on the public system acting as a limiter of services due to capacity constraints of the system and expectation that some patients will maintain private sector access and not switch to the public system. This results in lower overall costs than the benefit entitlement option.Additional measures to reach children who are receiving inadequate service.		

Group	<i>There would be special arrangements in all options to overcome barriers to access for some sections of Indigenous, those with mental health issues or disabilities, homeless, aged care residents and rural and regional areas.</i>		
	Options	Costs	Issues
Adult Card holders	<p><u>Need:</u></p> <ul style="list-style-type: none"> Estimated up to 400,000 adults on public dental waiting lists. 42% of card holders have an unfavourable visiting pattern (i.e., do not visit the dentist every year). Only 10% of card holders receive treatment in the public system in any one year. <p><u>Objective:</u></p> <ul style="list-style-type: none"> Improved access for all adult card holders (5.1 million adults), covering basic dental, including preventive and treatment services. 	<p>Final costs will depend on level of service, entitlement, and implementation. All estimates should be taken as indicative only.</p>	<p><u>General</u></p> <ul style="list-style-type: none"> This option would involve an increased investment in adult dental services. Would require measures to develop workforce capacity to meet increased service demands and address gaps in access to services. Implementation would need several years to build public dental system across all states and territories, including building infrastructure and data systems, and establishing standards of care. Would require engagement through COAG on funding and service delivery. Administering an exceptional circumstances scheme for access to higher level services would be costly at a population level. <p><u>Scaled Options B and C</u></p> <ul style="list-style-type: none"> Introduction of chronic disease population group is unlikely to be able to occur in the short term – increased capacity would need to be developed to ensure service and access standards could be met. Any differential access for chronic disease patients would put pressure for equity of services levels and funding for the rest of the population. Still to be determined how the chronic disease eligibility gateway would operate. Tightening of chronic disease test would need to be determined based on clinical advice from an expert group. Extent of access to exceptional circumstances gateway to be determined (access to higher level restorative items not included in costings). <p><u>Scaled Option C</u></p> <ul style="list-style-type: none"> Unlikely public dental system in Option 2 (Means Tested Public Dental Access for Adults) would be able to absorb low income non-concession card holder adults in the short or even middle term and has not been costed – increased capacity would need to be developed to ensure service and access standards could be met.
	<p>Option 3. Means Tested Individual Capped Benefit Entitlement for Adults - Concession card eligible only <i>Estimated cost over the forward estimates from 2012-13 – \$7.1b</i> <i>Fully implemented cost – \$2.6b per year</i></p> <p><u>Operation:</u></p> <ul style="list-style-type: none"> Use an individual capped benefit entitlement system for adult card holders to allow access to basic dental preventive and treatment services (to be defined) through a schedule of benefits. Existing CDDS could be modified as the vehicle for service delivery if chronic disease patients included as a target group. Entitlement could be scaled to reflect costs outside metro and regional centres, and/or to account for increase service costs for certain groups, e.g. chronic disease patients, denture patients. Entitlement could be used in public or private sectors, with schedule benefits set to cost of providing services in public system. Use of the public sector free for services in the schedule. Eligibility could be scaled up to include other groups, e.g., chronic disease patients, low income non-concession card holders. Access to higher level services (e.g., crowns, bridges, implants) could be controlled through an exceptional circumstances application process based on advice from expert group. Introduce measures to fast track services to patients on public dental waiting lists. <p>Option 4. Means Tested Public Dental Access for Adults – Concession card eligible only <i>Estimated cost over the forward estimates from 2012-13 – \$3.0b</i> <i>Fully implemented cost – \$1.3b per year</i></p> <p><u>Operation:</u></p> <ul style="list-style-type: none"> Use public dental system to provide access to free, or limited fee, nationally consistent basic dental preventive and treatment services (to be defined) – this would be an enhancement to the existing public dental system. States and territories would be able to purchase from private sector services as they build nationally consistent services and coverage, including access to higher level services in exceptional circumstances. Eligibility could be scaled up to include other groups, e.g. chronic disease patients, low income non-concession card holders, but would require similarly scaled increased investment in public system for infrastructure and workforce. Access to higher level services (e.g., crowns, bridges, implants) could be controlled through an exceptional circumstances application process based on advice from expert group. Introduce measures to fast track services to patients on public dental waiting lists. Modelling of cost is based on the public system acting as a limiter of services due to capacity constraints of the system and expectation that some patients will maintain private sector access and not switch to the public system. This results in lower overall costs than the benefit entitlement option. 	<p>Implementation</p> <p>Implementation could be scaled over time to recognise context of fiscal environment and need for phased introduction to allow development of capacity and systems.</p> <p>Access to entitlement can also be scaled up from concession card holders (below). Inclusion of low income non-concession card holders only applies to a capped benefit entitlement (Option 1) as it is not expected that the public system would build capacity for delivering services to this additional group within the 4 year Budget period.</p> <p><u>Options for Scaling (indicative costs over the forward estimates from 2012-13)</u></p> <p>A. Eligibility set to concession card holders: 5.1 million adults: Option 1 – \$7.1b Option 2 – \$3.0b</p> <p>B. Include chronic disease dental patients (eligibility to be defined): ^ 5.1 million adults + chronic disease patients: Option 1 – \$8.3b Option 2 – \$4.3b</p> <p>C. Include chronic disease patients and low income non-concession card holders (to be defined):* 7.6 million adults + chronic disease patients: Option 1 – \$11.4b</p> <p>^ Estimated costs of including chronic disease patients include broad assumptions about measures to constrain expenditure.</p> <p>*Population estimate indicative only – to be modelled. Low income non-concession card holder numbers indicative of those on threshold incomes of \$60,000 for couples and \$30,000 for singles.</p>	

Group	<i>There would be special arrangements in all options to overcome barriers to access for some sections of Indigenous, those with mental health issues or disabilities, homeless, aged care residents and rural and regional areas.</i>		
	Options	Costs	Issues
Adult Card holders and Children (An example of an Integrated Option)	<p><u>Need:</u></p> <ul style="list-style-type: none"> Estimated up to 400,000 adults on public dental waiting lists. 42% of card holders have an unfavourable visiting pattern (i.e., do not visit the dentist every year). Only 10% of card holders receive treatment in the public system in any one year. There is an increasing prevalence of caries in children. 20% of all children do not have adequate access to services. <p><u>Objective:</u></p> <ul style="list-style-type: none"> Improved access for all adult card holders (5.1 million adults) and all children to the age of 18 (5.4 million children), covering basic dental, including preventive and treatment services. 	<p>Final costs will depend on level of service, entitlement, and implementation. All estimates should be taken as indicative only.</p>	<p><u>General</u></p> <ul style="list-style-type: none"> This option would involve an increased investment in adult and child services. Would require measures to develop workforce capacity to meet increased service demands and address gaps in access to services. Note variations in how services are delivered between states, varying from dedicated school dental service arrangements to community-based only, such as NSW and Vic. Implementation would need several years to build public dental system across all states and territories, including building infrastructure and data systems, and establishing standards of care. Would require engagement through COAG on funding and service delivery. Administering an exceptional circumstances scheme for access for adults to higher level services would be costly at a population level.
	<p>Example Integrated Option. Improved access to basic dental services for adult card holders and all children – means tested capped benefit entitlement for concession card adults only and universal public dental access for children – <i>Estimated cost over the forward estimates from 2012-13 – \$10.1b</i> <i>Fully Implemented cost – \$3.3b per year</i></p> <p><u>Operation:</u></p> <ul style="list-style-type: none"> The Commonwealth would fund a capped benefit entitlement system for adult card holders to allow access to basic dental preventive and treatment services (to be defined) through a schedule of benefits. <ul style="list-style-type: none"> Existing CDDS could be modified as the vehicle for service delivery if chronic disease patients included as a target group. Entitlement could be scaled to reflect costs outside metro and regional centres, and/or to account for increase service costs for certain groups, e.g. chronic disease patients, denture patients. Entitlement could be used in public or private sectors, with schedule benefits set to cost of providing services in public system. Use of the public sector free for services in the schedule. Eligibility could be scaled up to include other groups, e.g., chronic disease patients, low income non-concession card holders. Access to higher level services (e.g., crowns, bridges, implants) could be controlled through an application process based on advice from expert group. Measures to fast track services to patients on public dental waiting lists. The states and territories would maintain existing funding levels for all children to access nationally consistent basic dental preventive and treatment services (to be defined) – this would be an enhancement to the existing public dental system. <ul style="list-style-type: none"> States and territories would be able to purchase from private sector services as they build nationally consistent services and coverage. Children from card holder families would be provided with access to free basic dental preventive and treatment services. Could have limited co-pays for non-card holders, noting that some states and territories already have co-payments. As part of this option, measures to identify and reach children who face access barriers would be implemented, which may include separate investment in additional infrastructure (e.g., Medicare Locals, State and Territory Child/School Dental Services). 	<p>Implementation</p> <p>Implementation could be scaled over time to recognise context of fiscal environment and need for phased introduction to allow development of capacity and systems.</p> <p>Access to entitlement for adults can also be scaled up from concession card holders (below). <u>Options for Scaling Adults (indicative costs over the forward estimates from 2012-13)</u></p> <p>A. Eligibility set to concession card holders: 5.1 million adults: \$7.1b</p> <p>B. Include chronic disease dental patients (to be defined):[^] 5.1 million adults + chronic disease patients: \$8.3b</p> <p>C. Include chronic disease patients and low income non-concession card holders (to be defined):[*] 7.6 million adults + chronic disease patients: \$11.4b</p> <p>No scaling options have been provided for child portion of option as some states and territories already provide universal access to services.</p> <p><u>Universal Public Access for Children (indicative costs over the forward estimates from 2012-13)–</u> 5.4 million children: \$2.5b</p> <p>[^] Estimated costs of including chronic disease patients include broad assumptions about measures to constrain expenditure.</p> <p>[*]Population estimate indicative only – to be modelled. Low income non-concession card holder numbers indicative of those on threshold incomes of \$60,000 for couples and \$30,000 for singles.</p>	

Appendix D - Adult Dental Services Provided by the States and Territories

	Eligibility criteria		Services offered	Cost
	Age	Card holders*		
QLD	Above the age of completion of Year 10.	<ul style="list-style-type: none"> • Pensioner Concession Card • Health Care Card • Pensioner Concession Card (Department of Veterans' Affairs) • Queensland Seniors Card • Commonwealth Senior Health Card. 	<p>Emergency and general dental care – check-ups, oral hygiene, fillings, endodontics, extraction dentures, oral surgery and dentures</p> <p>Treatment is provided through teaching dental facilities, community clinics and the private sector.</p> <p>Limited specialist dental services are available.</p>	No cost to patient.
NSW	18 years of age and older.	<ul style="list-style-type: none"> • Health Care Card • Pensioner Concession Card • Commonwealth Seniors Health Care Card <p>Must be normally resident within the boundary of the providing Area Health Service.</p>	<p>Emergency and general dental care – check-ups, oral hygiene, fillings, endodontics, extraction dentures, oral surgery and dentures.</p> <p>Treatment is provided through teaching dental facilities, community clinics and the private sector.</p> <p>Limited specialist dental services are available primarily through two teaching hospitals.</p>	<p>No cost to patient for emergency and general dental care.</p> <p>Co-payments may apply for patients of some teaching services, specialist dental services and some denture services.</p>
VIC	18 years of age and older.	<ul style="list-style-type: none"> • Pensioner Concession Card • Health Care Card holders • Refugees and asylum seekers <p>Priority access is given to a number of groups, including:</p> <ul style="list-style-type: none"> - Aboriginal and Torres Strait Islanders (ATSI); - homeless; - pregnant women; - refugees and asylum seekers; and - registered clients of mental health and disability services. 	<p>Emergency and general dental care – check-ups, oral hygiene, fillings, endodontics, extraction dentures, oral surgery and dentures.</p> <p>Treatment is provided through community dental clinics, the Royal Dental Hospital of Melbourne and the private sector.</p> <p>Limited specialist dental services are available primarily through the Royal Dental Hospital of Melbourne.</p>	<p>Emergency course of care: \$25 flat fee.</p> <p>General Course of care: \$100.</p> <p>Up to \$120 for dentures.</p> <p>Some exemptions apply (e.g. ATSI clients, homeless, refugees and asylum seekers).</p> <p>Co-payments for specialist services are dependant on service – up to a maximum of \$300 per course of care.</p>

	Eligibility criteria			
	Age	Card holders*	Services offered	Cost
TAS	18 years of age and older.	<ul style="list-style-type: none"> Health Care Card Pension Card 	<p>Emergency and general dental care – check-ups, oral hygiene, fillings, endodontics, extraction dentures, oral surgery and dentures.</p> <p>Special Care Dental Units in two acute hospitals provide medically necessary dental care</p> <p>Very limited specialist dental services are available (e.g. oral and maxillo facial surgery through the Royal Hobart Hospital). Some patients needing other specialist services are referred to Victoria, SA and NSW via the <i>Patient Transport Assistance Scheme</i>.</p>	<p>Co-payment of 25% of the DVA Local Dental Officers (LDO) Fee to a maximum of \$366 per course of care.</p> <p>Treatment in Special Care Dental Units is free.</p>
SA	18 years of age and older.	<ul style="list-style-type: none"> Pensioner Concession Card Health Care Card some Pensioner Concession Cards (DVA). 	<p>Emergency and general dental care – check-ups, oral hygiene, fillings, endodontics, extraction dentures, oral surgery and dentures.</p> <p>Referral to the Adelaide Dental Hospital for specialist dental care as required.</p>	<p>Emergency course of care: \$52 flat fee.</p> <p>General dental care check-up and preventive treatment is free.</p> <p>15% of the DVA LDO Fee for general restorative treatment to a maximum of \$146 for a completed course of care.</p> <p>Denture co-payments up to \$325.50 for full dentures.</p> <p>For specialist services, a co-payment of 20% of the DVA LDO Fee applies.</p> <p>Some exemptions apply to all co-payments</p>

	Eligibility criteria			
	Age	Card holders*	Services offered	Cost
NT	18 years of age and older.	<ul style="list-style-type: none"> Pensioner Concession Card Health Care Card. 	<p>Emergency and general dental care – check-ups, oral hygiene, fillings, endodontics, extraction, dentures oral surgery and dentures.</p> <p>Referral for oral surgery and special needs dentistry as required including in hospital treatment under general anaesthesia.</p>	No co-payment.
WA	18 years of age and older.	<ul style="list-style-type: none"> Health Care Card Pensioner Concession Card <p>In remote locations where Dental Health Service is the sole health provider, all are able to access care (although those without concession cards are required to pay the full fee).</p>	<p>Emergency and general dental care – check-ups, oral hygiene, fillings, endodontics, extraction, dentures, oral surgery and dentures.</p> <p>Referral to the Oral Health Centre of Western Australia for specialist dental care as required.</p>	<p>Treatment is subsidised by the West Commonwealth Government up to a maximum of 75% of the cost of the treatment.</p> <p>Level of subsidy is based upon the eligibility of the person and is assessed at the dental clinic.</p>
ACT	18 years of age and older.	<ul style="list-style-type: none"> ACT Centrelink issued Pension Concession Card Health Care Card. Blue DVA Card Refugees 	Emergency and general dental care – check-ups, oral hygiene, fillings, endodontics, extraction, dentures, oral surgery and dentures.	<p>Maximum co-payment of \$300 for restorative treatment in any year.</p> <p>Free for special needs groups, including homeless, refugees and some rehabilitation clients.</p>

Appendix E - Child Dental Services Provided by the States and Territories

	Eligibility criteria			
	Age	Card holder	Services offered	Co-payment
QLD	<p>Children over the age of four and those who have not completed Year 10 of secondary school.</p> <p>Children under four years of age and those who have completed Year 10 are also eligible for publicly funded oral health care if they hold a Concession Card or are dependents of Concession Card holders</p>	N/A – All children who meet the age eligibility are able to access this program.	<p><i>Child and Adolescent Oral Health Services</i> (formerly known as the School Dental Program).</p> <p>Dental check-up, information on oral health and nutrition, x-rays, cleaning teeth, fluoride application, fissure sealants, fillings and extractions and referral to dental specialist where necessary.</p> <p>Usually provided on-site at schools through fixed or mobile dental clinics.</p> <p>Limited specialist services in some districts - means-tested and priority based.</p>	No co-payment.
NSW	All children under the age of 18 years.	N/A – All children who meet the age eligibility are able to access this program.	<p>General dental services are available. The <i>NSW Priority Oral Health Program</i> weights access to dental services on the basis of severity and urgency of the condition. Priority access is given to children and those aged 0-5 years referred under the <i>Early Childhood Oral Health Program</i>.</p> <p>Services are delivered in dental clinics based in schools, community health centres and hospitals.</p> <p>Referral to a private dentist (via a voucher) may occur where public dental services are not available.</p> <p>Limited specialist dental services in some districts – means-tested and priority based.</p>	No co-payment.

	Eligibility criteria			
	Age	Card holder	Services offered	Co-payment
VIC	<p>Children aged 0-12 years.</p> <p>Young people aged 13-17 years who are Health Care or Pensioner Concession Card holders or dependants of Concession Card holders.</p> <p>Children and people up to 18 years of age in residential care provided by the Children Youth and Families division of the Department of Human Services.</p> <p>Youth justice clients in custodial care up to 18 years of age.</p>	<p>After age 12, Health Care Card and Pensioner Concession Card holders have access to free care and priority access to public dental clinics.</p>	<p>Dental check-up, information on oral health and nutrition, x-rays, cleaning teeth, fluoride application, fissure sealants, fillings and extractions where necessary, referral to dental specialist.</p> <p>General dental services are delivered through community dental clinics in community health services, rural hospitals and the Royal Dental Hospital of Melbourne.</p> <p>Specialist dental services are available for children whose parents hold a Concession Card (mostly provided at the Royal Melbourne Dental Hospital).</p>	<p>Fees for public dental services apply to children aged 0-12 years who are not Health Care or Pensioner Concession Card holders or dependants of Concession Card holders.</p> <p>Flat fee of \$29 per child for a general course of care, which includes an examination and all general dental treatment. Fees per family will not exceed \$116.</p> <p>Co-payments apply for specialist dental services up to a maximum of \$300 per course of specialist care (some exemptions apply).</p>

	Eligibility criteria			
	Age	Card holder	Services offered	Co-payment
TAS	Children 0-18 years of age.	The dental treatment following examination will be free if the child is covered by a Health Care Card.	<p>Dental check-up, information on oral health and nutrition, x-rays, cleaning teeth, fluoride application, fissure sealants, fillings and extractions where necessary, referral to private dental specialist.</p> <p>Services are provided at Community Dental Clinics and in acute hospitals (where general anaesthetic is required).</p> <p>No public specialist dental services are available for children within Tasmania. Children requiring specialist care have to use the private sector (although a small number with significant needs are referred interstate).</p>	<p>Free examination for all.</p> <p>No co-payment for those covered by a Concession Card or under school age (0-5 years).</p> <p>For all other children a \$50 co-payment for non-card holders needing treatment.</p> <p>All clients needing dental treatment outside general treatment guidelines (including specialist dental care) incur a further co-payment (dependent on treatment required).</p> <p>A small number of children have interstate specialist treatment subsidised.</p>
SA	<p>All preschool, primary school and secondary school students, aged less than 18 years, are eligible for oral health care with the School Dental Service.</p> <p>Children over the age of 16 who do not attend an educational institution and do not have a Health Care Card are not eligible to attend school dental clinics.</p>	<p>Children who are dependants of or holders of the following concessions are eligible to receive free dental care:</p> <ul style="list-style-type: none"> • Centrelink Concession Card • DVA Pensioner Concession Card • School Card • Teen Dental Plan Voucher 	<p>Dental check-up, information on oral health and nutrition, x-rays, cleaning teeth, fluoride application, fissure sealants, fillings and extractions where necessary, referral to dental specialist.</p> <p>Limited specialist dental services are available for children whose parents hold a Concession Card (mostly provided at the Adelaide Dental Hospital).</p>	<p>No co-payment for preschool children and. children who are dependents of Concession Card holders.</p> <p>Those who are not covered by a Concession Card must pay a fee of \$39 for each course of general dental care provided.</p> <p>For specialist dental care co-payments of 20% of the DVA Local Dental Officers (LDO) Fee apply. Some exemptions apply.</p>

	Eligibility criteria			
	Age	Card holder	Services offered	Co-payment
NT	Infants up to and including primary school age through school-based clinics, community clinics and mobile services. Older children (up to high school) can access free dental services at community clinics.	N/A - All children who meet the age eligibility are able to access this program.	Dental check-up, information on oral health and nutrition, x-rays, cleaning teeth, fluoride application, fissure sealants, fillings and extractions where necessary, referral to dental specialist if necessary. Children whose parents hold a Concession Card with significant need are eligible for publicly funded specialist orthodontic treatment.	No co-payment.
WA	Children from pre-primary through to Year 11 (Year 12 in remote locations) receive free preventive, emergency and general dental care.	N/A - All children who meet the age eligibility and attend a recognised educational institution are able to access this program.	Dental check-up, information on oral health and nutrition, x-rays, cleaning teeth, fluoride application, fissure sealants, fillings and extractions where necessary, referral to dental specialist. Services are provided from fixed and mobile school dental service located at schools. Specialist dental services are available for children whose parents hold a Concession Card (mostly provided at the Oral Health Centre of Western Australia).	No co-payment.
ACT	Children under 5 who live in the ACT. Children 5-13 years of age who live or attend school in the ACT. Children under the age of 18 years living or attending school in the ACT and who are covered by a Centrelink Concession Card.	N/A - All children who meet the age eligibility and attend a recognised educational institution are able to access the program. Centrelink Concession Card holders can access some additional services.	Dental check-up, information on oral health and nutrition, x-rays, cleaning teeth, fluoride application, fissure sealants, fillings and extractions where necessary, referral to dental specialist Dental treatments, such as removable orthodontic appliances, are available to Concession Card holders.	There is a co-payment for children whose parents do not have a Concession Card. Children aged 5-13 whose parents do not hold a Concession Card pay a co-payment of \$55 per course of care. Children under 5 years of age pay a co-payment of \$55 for restorative or invasive treatment.

Appendix F – Current Commonwealth Government Dental Programs

Medicare Chronic Disease Dental Scheme (CDDS)

The CDDS provides dental care for people with chronic diseases and complex care needs. Eligible patients may receive Medicare benefits of up to \$4,250 per person over two calendar years for dental treatment.

To be eligible for the CDDS, patients must have a GP Management Plan (Medicare item 721) and Team Care Arrangements (Medicare item 723) in place to manage their condition and must be referred to a dentist by their GP.

A broad range of preventive and restorative dental services are available under the scheme. In 2010-11, expenditure under the CDDS was \$726.4 million – increasing from \$576.5 million in 2009-10 and \$364.1 million in 2008-09.

Medicare Teen Dental Plan (MTDP)

The MTDP was implemented on 1 July 2008 and provides up to \$163.05 per eligible teenager towards an annual preventive dental check, under the *Dental Benefits Act 2008*.

Approximately 1.3 million teenagers are eligible for the MTDP each year. To be eligible, a teenager must, for at least some part of the calendar year:

- be aged between 12 and 17 years; and
- satisfy the means test for the program:
 - the teenager must be receiving either Abstudy, Carer Payment, Disability Support Pension, Parenting Payment, Special Benefit, or Youth Allowance; or
 - the teenager's family/carer/guardian must be receiving either Family Tax Benefit Part A, Parenting Payment, or the Double Orphan Pension in respect of the teenager; or
 - the teenager's partner must be receiving Family Tax Benefit Part A or Parenting Payment; or
 - the teenager must be receiving financial assistance under the Veterans' Children Education Scheme or the Military Rehabilitation and Compensation Act Education and Training Scheme.

In 2010-11, expenditure under the MTDP was \$59.8 million – slightly decreasing from \$63.4 million in 2009-10 and \$66.7 million in 2008-09.

Defence Personnel and Veterans

Members of the Australian Defence Force and Army Reserve are provided with free dental services as part of their access to a range of health services. Dental services are also provided to eligible veterans but entitlements vary between White Card and Gold Card holders. A full range of dental services are available under these programs.

In 2008-09, expenditure for dental services provided by the Department of Veterans' Affairs was \$103 million. The Department of Defence does not release figures on funding attributable to dental services for service personnel.

Private Health Insurance Rebate

The Commonwealth Government provides a rebate of 30-40 per cent on the premium charged to people with private health insurance.

The rebate was introduced on 1 January 1999. Although the rebate is based on the health insurance premium payable, it is treated as a subsidy by the Commonwealth Government on the expenses incurred by individual Australians towards their private health insurance, including benefits for health services. In 2010-11, expenditure under the Private Health Insurance Rebate attributable to dental services was \$555 million (which equates to \$46 per person).

The Commonwealth Government is legislating to introduce means testing for recipients of the private health insurance rebates. The means test would proportionally lower the private health insurance rebate for those in higher income tiers, and increase the Medicare Levy Surcharge for those on higher incomes who elect not to purchase a hospital product.

Mr Adam Longshaw's view was that since general treatment policies, including those that pay dental benefits, are not subject to the penalties associated with the Medicare Levy Surcharge, the impacts associated with downgrades or cancellations of these policies are likely to be greater than those modelled for the impact on the number of individuals who may drop or reduce their hospital cover. Should this occur, Mr Longshaw considered it will adversely impact dentistry for those individuals and subsequently lead to increased personal costs for dental care. This view was not shared by the majority of the Council.

Appendix G - A List of Centrelink-supported Pensions and their Eligibility for Concession Cards¹²¹

Pensioner Concession Card (PCC)

A PCC is automatically issued to:

- All income support pensioners, which includes: Age Pension, Disability Support Pension, Wife Pension, Carer Payment, Parenting Payment (Single), Bereavement Allowance and Widow B Pension.
- Department of Veterans' Affairs service pensioners and war widows receiving an income support supplement.
- Newstart Allowance, Parenting Payment (Partnered) and Youth Allowance (job seeker) customers assessed as having a partial capacity to work or who are a single principal carer of a dependent child.
- Older benefit customers, that is:
 - customers aged 60 and over who are receiving Newstart Allowance, Partner Allowance, Widow Allowance, Parenting Payment (Partnered), Sickness Allowance, or Special Benefit, and have been in continuous receipt of one or more of the above payments (or an income support pension) for nine months or more.
- Participants of the Pension Loans Scheme who are qualified to receive a part-rate pension.
- Community Development Employment Project (CDEP) participants who are qualified for an income support pension but that payment is not payable due to the result of either the assets test or the rules relating to seasonal or intermittent workers, and who therefore qualify for the CDEP Scheme Participant Supplement (CPS).
- CDEP participants who are qualified for Newstart Allowance, Partner Allowance, Widow Allowance, Parenting Payment (Partnered), Youth Allowance or Special Benefit, but where that payment is not payable due to the result of either the asset test or rules relating to seasonal or intermittent workers, and who therefore qualify for the CDEP CPS. Note that these customers must be aged 60 years or over, and have been in continuous receipt, or have been taken to be in continuous receipt of one or more of the above payments (or an income support pension) for nine months or more.

Once customers are no longer qualified for these payments, they must generally stop using their PCC. However, in some circumstances, certain customers can retain their PCC for a short period after returning to work. These provisions are designed to assist customers to make the transition from income support to work.

¹²¹ Taken from: A guide to Australian Government payments: on behalf of the Department of Families, Housing, Community Services and Indigenous Affairs and the Department of Education, Employment and Workplace Relations (20 September – 31 December 2011).

Disability Support Pensioners (DSP)

- Retain their PCC for 52 weeks after losing qualification for the pension due to commencing employment of 15 hours or more per week or because of the level of earnings from employment.

Wife Pension (DSP) customers

- Retain their PCC for 52 weeks after losing qualification for payment if their partner has been receiving DSP, and their partner loses qualification for the pension due to commencing employment of 30 hours or more per week, or because their partner's income from employment causes them to lose qualification for DSP.

Older benefit customers (as defined earlier)

- Retain their PCC for a further 26 weeks if their payment stops due to the person or their partner commencing employment, or due to the level of earnings from this employment.

Parenting Payment (Single) customers

- Retain their PCC for 12 weeks after losing entitlement to Parenting Payment (Single) due to an increase in income due to employment. A Health Care Card is issued for the balance of 26 weeks, that is a further 14 weeks provided the customer has been in continuous receipt for the last 12 months of either:
 - an income support pension (except for a Special Needs Pension), or
 - an income support benefit (other than Austudy or Youth Allowance paid to students).

Newstart and Youth Allowance (job seeker)

- Retain their PCC for 52 weeks after losing qualification due to employment income, if they have been assessed as having a partial capacity to work, or
- Retain their PCC under the same provisions as Parenting Payment (Single) customers (see above), if they are the single principal carer of a dependent child.

A PCC extension is also available, under certain circumstances, to people under pension age who remain qualified for certain payments during a nil rate period under the Working Credit Scheme.

Automatic issue Health Care Card (HCC)

The HCC is automatically issued to people who are not qualified for a Pensioner Concession Card who are receiving:

- Newstart Allowance (NSA), Partner Allowance (PA), Sickness Allowance (SA), Special Benefit (SpB), Widow Allowance (WA) and Youth Allowance (job seeker only) (YA)
- Parenting Payment (Partnered), Exceptional Circumstances Relief Payment, Farm Help Income Support and those entitled to receive the maximum rate of Family Tax Benefit Part A by fortnightly instalments.
- Mobility Allowance.

- Carer Allowance (CA), paid to parents/carers in respect of a child with a disability. The card is issued in the child's name. Other parents/carers of children with a disability who do not receive CA may receive a HCC subject to less stringent disability-related eligibility criteria.
- Community Development Employment Project Scheme Participant Supplement where the recipient is qualified for an income support payment (attracting a HCC), but that payment is not payable due to either the assets test, or the rules relating to seasonal or intermittent workers. These customers receive the HCC applicable to the payment type for which they are qualified.

Once people are no longer receiving these payments, they must generally stop using their HCC. However, in some instances, people can retain their HCC for up to 26 weeks after returning to work. This provision is designed to assist people to make the transition from income support to work. The provision applies to long-term recipients of NSA, SA, PA, SpB, WA, and YA (job seeker). Former long-term recipients of PPS, NSA and YA (job seeker) who are a single principal carer of a dependent child also qualify for a HCC extension (in addition to a 12-week PCC extension).

A HCC extension is also available, under certain circumstances, to people who remain qualified for certain payments during a nil rate period under the Working Credit scheme.

Claim required Health Care Card (HCC)

Specific types of HCCs can be claimed in the following circumstances:

- A low income HCC is available on application to people with income below certain levels. Once eligible, the qualifying income limits may be exceeded by up to 25 per cent before eligibility for the card is lost. The income test applies to average weekly gross income for the eight weeks immediately prior to applying for the card. Income limits for the period 20 March 2011 to 19 September 2011 are:

– single (no children)	\$480.00 pw
– couple, combined (no children)	\$834.00 pw
– single, one dependent child	\$834.00 pw
– for each additional dependent child add	\$34.00 pw

These limits (except for the child add-on) are indexed twice yearly, in March and September, based on movements in the Consumer Price Index.

There is no assets test for the low-income HCC.

- A foster child HCC is available, on application, to assist foster children and carers. The card can be claimed by the foster carer on behalf of the child. The foster child HCC is issued only in the name of the child, and can only be used to obtain concessions on services used by the child. The foster child HCC is not means tested.
- An ex-CA HCC is available, on application, to 16-25 year old full-time students with a disability or a severe medical condition. The card can be claimed by students who were in receipt of a CA HCC on the day before their 16th birthday. The ex-CA HCC is issued in the name of the student and is not means tested.

Commonwealth Seniors Health Card (CSHC)

The CSHC is targeted at self-funded retirees of age pension age (see chart under Age Pension) who do not qualify for an Age Pension because of assets or income levels. To qualify for a CSHC a person must make a claim for the card, and meet the following criteria:

- not be receiving an income support pension or benefit or a Department of Veterans' Affairs service pension or income support supplement, and
- be of age pension age, and
- be living permanently in Australia and be:
 - an Australian citizen, or
 - a holder of a permanent visa, or
 - New Zealand citizen who arrived on a New Zealand passport.
- available to newly arrived migrants after 104 weeks in Australia as an Australian resident or Special Category Visa holder (some exemptions may apply).
- must be in Australia to retain card, or temporarily absent for not more than 13 weeks.
- have an annual adjusted income of less than \$50,000 for singles; \$80,000 for couples (combined income); and \$100,000 combined for couples separated by illness, respite care or prison. An amount of \$639.60 per year is added for each dependent child. There is no assets test.

Residence requirements

- Certain residence requirements must be met to qualify for any type of HCC.

Appendix H - National Advisory Council on Dental Health Consultation Process

To help inform our deliberations, we have undertaken a consultation process with key dental health bodies, consumer group representatives, peak Indigenous organisations and leading academics in the field. We were interested in consulting as widely as possible, but given the short timeframes for our deliverables, we have conducted a private consultation process limited to key stakeholders. To date, the consultation process has involved round table consultation sessions, written submissions, direct engagement with clinicians and other key stakeholders, and visits to public dental facilities.

The following stakeholders were invited to take part in our consultation process:

- Australian Dental Council
- Australian Dental Board of Australia
- The Royal Australasian College of Dental Surgeons
- Dental Hygienists' Association of Australia
- Australian Dental Prosthetists Association
- Australian Dental Prosthetists and Dental Technicians Educational Advisory Council
- National Aboriginal Community Controlled Health Organisation
- National Oral Health Promotion Steering Group
- Consumers Health Forum of Australia
- Australian Preventive Health Agency
- Health Workforce Australia, CEO Mr Mark Cormack
- Indigenous Dentists' Association of Australia
- National Congress of Australia's First Peoples
- State and Territory Dental Directors
- Australian Research Centre for Population Oral Health
- Adelaide Dental Hospital, South Australia
- Marion GP Plus Clinic, South Australia
- New South Wales Ministerial Taskforce on Dental Health
- Westmead Hospital, New South Wales
- WentWest Medicare Local, New South Wales
- Royal Dental Hospital of Melbourne
- Dental Health Services Victoria
- Dr Sandra Meihubers, Dentist and Independent Dental Health Consultant
- Dr Glen Hughes, Dentist, Casino Aboriginal Medical Service

In conducting the consultation process we were particularly interested in seeking views on:

- the gaps in service delivery and unmet need;
- how current dental programs could be improved;
- how the current dental workforce could be improved;
- oral health promotion and prevention strategies;
- the capacity of the public dental sector; and
- how the dental system could be improved as a whole.

Unmet need

Throughout the consultation process Indigenous Australians, special needs adults, children and the aged were identified as priority groups in need of accessible and affordable oral health care.

Indigenous Australians

Stakeholders acknowledged that Indigenous Australians in both urban and rural and remote areas experience poorer oral health than their non-Indigenous counterparts.

Stakeholders identified several issues with the current system of service delivery for Indigenous patients. For rural and remote Indigenous communities in particular, stakeholders noted that most models of service delivery are intermittent, do not receive ongoing funding and involve the use of different locum dentists. It was acknowledged that such models create distrust between the community members and the providers and inconsistencies in patient records. To help reduce these inconsistencies, stakeholders identified the need for the Commonwealth's role in the oral health sector to be clearly defined and for better co-ordination between Commonwealth, state, university and Aboriginal Medical Services/Aboriginal Community Controlled Health Organisations oral health activities. It was also suggested that the Commonwealth fund the development of a manual to assist dental practitioners, particularly locum staff, in servicing Indigenous communities in rural and remote Australia.

Several issues relating to the dental workforce and its impact on Indigenous oral health care were also raised. It was recommended that models of care use a multi-disciplinary care approach and the scope of service provision for Aboriginal Health Workers be extended to cover oral health preventive services. Stakeholders also expressed concerns about the difficulties in recruiting and retaining staff.

As a further priority group within the Indigenous community, peak Indigenous organisations suggested future action for improving the oral health of Indigenous children. Stakeholders identified that in some Indigenous communities, children that require important, but not urgent, oral health care can be waiting for up to four years to receive treatment. Improving the oral health of Indigenous children will help in improving the oral health of Indigenous Australians into the future. It was recommended that Indigenous child oral health be targeted through the use of effective and consistent school dental programs.

Adult with special oral health needs

Special needs adults include those patients who, in addition to their oral health condition, suffer from a complex medical condition such as cancer, HIV, hepatitis, mental illness and other chronic diseases. The delivery of treatment to special needs patients is resource intensive, complex and often limited to the public sector. The facilitation of such treatment needs to be delivered by specialist providers who understand the medical implications of the patient's health condition – unfortunately there is a shortage of these specialists in the public sector. To help this target group, stakeholders recommended increasing Commonwealth funding to the public sector.

Frail older people in the community and aged care residents

The aged were consistently identified as a priority group in great need of accessible oral health care. It was noted that access to oral health services is of particular concern for those aged Australians in nursing homes and residential aged care facilities. Stakeholders suggested: including an oral health check as part of the entry assessment to aged care facilities; embedding oral health benchmarks into the aged care best practice standards; and educating related professionals such as carers and aged care workers to perform basic oral health checks. Some stakeholders recommended the implementation of a mobile dental program utilising both the public and private sectors, whereby dentists could travel to aged care facilities and use mobile dental equipment to treat the residents on site.

Children

All stakeholders acknowledged children as a priority target group. Stakeholders communicated the need to instil good oral health habits in children as early as possible in their lifetime. The need for a universal program for children was identified and stakeholders noted that particular attention needs to be paid to those children aged 0-4 years who are currently missing out on public oral health services in some state and territories.

Targeted approach

Some stakeholders suggested that non government organisations could be used to aggressively target these groups and that future strategies could be built upon existing programs that have proved to be successful in this space – e.g. 'Lift the Lip', 'Sip and Crunch', Supported Residential Services Program.

Below is a case study of a facility that was consulted in the course of the Council's work and could be used to target special needs groups.

Case Study 1: Marion GP Plus Health Care Centre, South Australia

The Marion GP Plus Health Care Centre (the GP Plus Centre) serves as a good model for integrating oral health into broader primary health care initiatives.

The GP Plus Centre contains a 24 chair dental facility, 12 chairs of which are reserved for permanent staff, and the remaining 12 used by dental students undertaking community based clinical placements as part of their undergraduate

clinical training program. The dental clinic employs a range of dental professionals, including: dentists; dental therapists; and dental hygienists together with support staff which includes dental technicians. In order to be eligible for oral health services at the clinic, patients must be eligible for public dental services. This includes all children and those adults who hold a concession card issued by CentreLink.

In addition to providing oral health services, the GP Plus Centre also provides services by allied health professionals, nurses, doctors and community health workers. The clinic adopts a coordinated approach using streamlined referral processes for services between these different health care providers. The GP Plus Centre also works in close partnership with local general practices and serves as a referral point for doctors and other health professionals and services within the community.

One of the benefits of the GP Plus Centre is its prime location – the Centre is located next to a major transport hub in Oaklands Park in South Australia, which makes it highly accessible to patients. It is also close to a major shopping centre and other community service centres which makes it an attractive and convenient site for patients.

The GP Plus Centre is particularly helpful for patients who suffer from complex and chronic health conditions and require a range of health services to manage their condition. Given the emerging evidence linking oral health to several major chronic diseases, enabling patients to access the dental clinic at the same site where they may receive treatment for their general health condition assists in the better coordination of their treatment

Dental programs

Medicare Chronic Disease Dental Scheme

Some stakeholders made recommendations on how the CDDS could be improved.

Recommendations included:

- limiting the services to basic dental care items;
- implementing a special approval process for all high end dental items;
- reducing the cap;
- streamlining the paperwork involved in the general approval process;
- limiting the eligibility criteria to certain chronic conditions;
- including chronic oral health disease as part of the eligibility criteria;
- introducing a means test;
- adding hygienists to the list of providers under the legislation for the scheme; and
- quarantining a percentage of the capped benefit for preventive oral health services.

Medicare Teen Dental Plan

Recommendations on how the MTDP could be improved included:

- extending the range of services to cover dental treatment; and
- introducing a rule that requires providers to give oral hygiene advice as part of the preventive check.

Dental workforce

Stakeholders raised concerns about the distribution, composition and utilisation of the dental workforce and queried whether the public and private sectors have the capacity and infrastructure to support the current and future dental workforce.

Stakeholders noted that the dental workforce is expanding, with higher numbers of students graduating from dental courses and increasing numbers of overseas dentists registering to practice in Australia. With the expanding workforce, stakeholders expressed concern about the need to ensure there is sufficient infrastructure to meet the demand and that student clinical placements are supported.

Stakeholders highlighted the difficulty in recruiting dental staff to work in rural and remote locations. Issues surrounding the retention of staff in the public sector were also raised. Some stakeholders acknowledged that the new Commonwealth Voluntary Dental Intern Program may help in addressing some of the workforce distribution issues and suggested the implementation of further incentive programs. Some suggestions included compulsory rotations for public sector staff and housing reimbursements for dental hygienists and therapists.

With regard to the composition and utilisation of the dental workforce, stakeholders commented on the need to review the scope of practice for certain practitioners. In particular, stakeholders recommended an expansion of the types of oral health services and a lift on the age restrictions for service provision by oral health therapists and hygienists. This would allow for better utilisation of the whole dental workforce, provide efficiency of service and reduce costs to consumers. On this note, stakeholders recommended that the ideal number and mix of dental health providers be identified and strategies put in place to reach this.

It was also recommended that other professionals and health providers, such as General Practitioners, maternal health workers, Aboriginal Health Workers, carers, aged care workers and school teachers be trained to provide basic oral health checks and possible preventive services to assist in promoting good oral health amongst target groups. This would also assist with integrating oral health into general health.

Mr Mark Cormack, CEO of HWA, addressed the Council on the work that HWA would be undertaking over the next 18 months on assessing the supply and demand of the dental workforce.

Oral health promotion and prevention

In order for oral health promotion to be successful stakeholders recommended including multiple interlinked strategies supported by strong policy and social

marketing. Reaching these goals would require strong working partnerships between governments, providers and industry.

One of the multiple strategies recommended by stakeholders was to integrate oral health into broader population health campaigns, such as those targeting obesity, alcohol consumption and smoking. To ensure oral health is considered as part of general health promotion, stakeholders also recommended taking steps to train other health professionals to perform oral health checks.

Some stakeholders suggested that one step could involve funding the Medicare Local Network to include oral health education in its programs that train GPs and allied health professionals. Health professionals in each Medicare Local Network would then have the skills to educate patients on good oral health practices, and check patients and refer them on to local dentists for any treatment needed. The Medicare Local Network was also recommended as an avenue to promote oral health and target special needs groups. One role of the Medicare Local Network is to identify service gaps and take steps to address those gaps. It was suggested that any primary health care initiatives already being administered by Medicare Locals could be used to send out consistent and comprehensive oral health promotion messages. This would not only improve oral health promotion but target priority groups. A case study is below of one Medicare Local consulted in the course of the Council's work.

Case Study 2: Western Sydney Medicare Local

The WentWest Health Division in New South Wales was established in 2002 to provide General Practice vocational training in Western Sydney. From 2006 WentWest also took on the role of providing Division of General Practice support services and worked in close partnerships with organisations in Western Sydney to not only support GPs but also primary health care workers.

From 1 July 2011, the WentWest Division became the Western Sydney Medicare Local, covering an area with a population of over 800,000 people. The Western Sydney Medicare Local (WS Medicare Local) continues to provide training to GPs and support for GPs and primary health care workers, but the WS Medicare Local has a more community approach to health care.

As a Medicare Local, it is expected to develop a key role over time in building effective collaborations across primary health and with Local Hospital Networks, and support the implementation of key initiatives in areas such as e-health, after hours primary care and aged care.

The WS Medicare Local works closely with local health professionals and community organisations to create a more streamlined and efficient primary health care system. This involves using local partnership networks – the WS Medicare Local has established six local partnership networks and works closely with the Local Health District and other organisations such as the Aboriginal Medical Service Western Sydney, the Local Health District, HealthOne and Local Councils.

It also involves integrating and expanding new and existing services which are well targeted to the residents of the Western Sydney community. For example, the WS Medicare Local manages programs specifically targeted at priority groups such as school children, the Aged and pregnant teenagers. Some of these programs include: the Keep Fit School Program, which aims to educate children about nutrition and the importance of physical activity; Aged Care Programs which provide on site support to aged care people living in their home, to delay entry in to costly aged care facilities; and programs that encourage maternal health care workers to manage and coordinate service delivery and appointments for young pregnant women.

The WS Medicare Local services patients residing in the Blacktown, Baulkham Hills, Parramatta, Holroyd and Auburn communities. These communities have a high number of Indigenous residents, socially disadvantaged residents and residents from culturally and linguistically diverse backgrounds. By adopting a coordinated and community focused approach to health care, the WS Medicare Local is providing residents in great need with the best chance of managing their health conditions.

As a priority, stakeholders recommended targeting oral health promotion to children. Stakeholders recommended that the best way to target children is to use the school network, noting that a holistic approach encompassing healthy food at the school canteen, oral health education in the school curriculum, on-site visits by oral health professionals is essential. Stakeholders also suggested the implementation of programs like 'Lift the Lip' and 'Crunch and Sip' on a national level. Stakeholders also stressed the importance of targeting children as early as possible and recommended including an oral health check as part of a child's 18 month immunisation appointment as one mechanism to target infants. Targeting young children and educating parents early increases the probability of children carrying good oral health habits into adolescence and adulthood.

The value of oral health prevention strategies in closing the gap in incidence of oral health disease amongst Indigenous Australians was acknowledged. Stakeholders emphasised the importance of preventive activities such as water fluoridation and the application of fluoride varnishes and recommended the implementation of additional preventive activities. For example, it was suggested that the Government work closely with community stores on issues affecting oral health, such as nutrition, and for oral health to be integrated into broader population health campaigns.

To improve oral health promotion and prevention strategies into the future, stakeholders identified the need for effective research and for nationally consistent oral health messages. To this end, stakeholders recommended the continuation of funding for the National Oral Health Promotion Clearing House and the administration of national consensus workshops.

Capacity of the public dental sector

Consultations with the state and territory Dental Directors raised several issues regarding the capacity of the public dental system to deliver timely services. The demand for services in the public sector is high and as a result the waiting lists for

treatment are long, with patients in some states waiting up to 25 months for general oral health treatment. Directors suggested increased funding from the Commonwealth to assist the state and territories to reduce these long waiting lists.

Concerns about workforce in the public sector were also raised. Directors noted the difficulties in retaining staff in the public sector as a whole and in encouraging staff to work in rural and remote public facilities. The need to ensure there is sufficient infrastructure to meet demand and to support student clinical placements were also identified. Directors noted that the relationship between the public sector and universities needs to be improved in order for student placements to be effectively planned and supported. One recommendation to improve support for students was to implement a tutoring program to encourage private dentists to take on supervisory roles in the public sector.

Another potential avenue to increase public sector capacity involves reshaping the public sector approach to service delivery. It was suggested that the public sector could be moulded into a specialised unit servicing the complex special needs cases only and the private sector used for more general courses of care.

The dental system

When providing recommendations on the dental system as a whole, some stakeholders expressed support for the implementation of a universal dental model. However, it was noted that a universal system would need to be phased in over time and there would need to be adequate workforce and infrastructure to support the system. As a first step, stakeholders recommended providing universal access to children.

On commenting on the current system, stakeholders raised concerns about the intermittent funding and operation of dental programs and advised that the system needs to have continuity. Stakeholders also advised that there needs to be better communication and integration between the existing Commonwealth and State programs to prevent patients 'double dipping' and ensure appropriate use of resources. It was also noted that communication between public dental facilities and dental educational facilities also needs to be improved.

The Medicare Local Network was identified as one mechanism for improving patient access to oral health care on a local level. It was suggested that Medicare Locals could act as a 'co-ordination unit' and assign a case manager to patients to manage appointments, arrange patient transportation for dental visits and outsource services to private dentists.

It was also noted that the current system focuses on treatment, with patients mainly visiting a dentist when a problem arises. It was suggested that the system adopt a population oral health approach which includes preventive strategies.

Appendix I – Letter from the Minister for Health and Ageing regarding the Interim Report



**THE HON NICOLA ROXON MP
MINISTER FOR HEALTH AND AGEING**

Ms Mary Murnane
Chair
National Advisory Council on Dental Health
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

Dear Ms Murnane

A handwritten signature in cursive script that reads 'May'.

Thank you for providing me the Interim Report of the National Advisory Council on Dental Health.

I appreciate the work which has been undertaken by the Council in compiling its interim report. In particular, I appreciate the Council's detailed analysis of the state of Australia's dental health and current issues facing the dental health system. I have also noted the range of service delivery options which the Council is potentially considering.

As you would be aware, the Commonwealth is committed to a disciplined approach to the 2012-13 Budget process, in the context of a difficult fiscal environment and uncertain domestic and international economic conditions. I would ask that the Council be mindful of these fiscal circumstances when developing its advice on service delivery options.

In particular, I would also be grateful if the Council could, in developing its final advice, include options that can be scaled and staged in such a way so as to be consistent with the Government's fiscal constraints.

I also ask that the Council consider options for leveraging the current capacity of the private dental system, and insurance for dental health currently provided through the private health insurance system, in considering its final advice on options for expanding access to dental services.

Thank you, once again, for your work in chairing the Council.

Yours in friendship

A handwritten signature in cursive script, likely belonging to Nicola Roxon.

NICOLA ROXON

Appendix J – Pro-Bono Services Provided by Dental Practitioners

Dental practitioners provide a range of pro-bono services across the country. These are provided in various geographic areas and target different social groups depending on the needs of the particular community. The dental profession is supportive of volunteer work in order to ensure that Australians in need are able to receive appropriate dental care.

It is not possible to calculate with precision the dollar value of dental practitioners' pro-bono work. Any such calculation must recognise that the benefits are not only to the patients' immediate oral health, but that it flows on to impact on their overall health and mental wellbeing. Assistance in patients' oral health also has a positive bearing on patients' self-esteem, work, family and community relationships.

Dental practitioners appropriately provide a range of pro-bono assistance, commensurate with their capacity and resources. The profession has and will always aim to provide oral health care to those in the community that are most in need. The kind of assistance dentists provide ranges from:

- delivering services within their own clinic to provide pro-bono / free dental services. In this situations, it is dental practitioner themselves that pay for the running costs of the practice, thus receiving no other compensatory benefit; to
- dental practitioners providing their time to perform a dental service or an educational function – this is a donation of time, which dental practitioners could otherwise be dedicating to seeing patients at commercial rates.

Current activities

The National Dental Foundation coordinates some pro-bono work in most states and territories, providing services through charities to those individuals in need of dental care who would otherwise be unable to afford it. This organisation receives funding from a range of sources in order to undertake this work.¹²² A primary aim of the Foundation is to coordinate the involvement of all parties who are involved in philanthropic work within the Australian dental industry.¹²³

Filling the Gap provide services to Aboriginal and Torres Strait Islander communities through a partnership with Wuchopperen Health Services in Cairns. Volunteer dentists and hygienists provide the services.¹²⁴

The School of Dentistry at the University of Adelaide began a community outreach project in 2009 to provide education and clinical services to Adelaide residents, in particular vulnerable and disparate people in the community. This project has also involved research to identify the needs of the community, as well as funding for capital

¹²² <http://www.nationaldentalfoundation.org.au/index.html>

¹²³ Shane Fryer, pers. comm. 09/02/2012.

¹²⁴ <http://www.fillingthegap.com.au/>

works. However, it has identified that ongoing funding is required to ensure remuneration for management staff.

Additionally, the Australian Dental Association (ADA) supports pro-bono work by dentists. They have identified a range of schemes and arrangements whereby dentists undertake pro-bono work:

- ‘Give a Smile’ (GAS) is the charitable arm of the Australian Society of Orthodontists. GAS orthodontists treat public patients requiring orthodontic treatment. Their treatment takes approximately two years. This reduces pressure from public waiting lists – these patients are treated privately.
- Volunteer dentists treat refugees through the Tzu Chi Foundation.
- Pro-bono services provided to clients of various charities.

While dental practitioners may provide these services at no cost, the services themselves are not free; instead, there are a range of costs (i.e. infrastructure, consumable materials, etc.) that must be funded. These costs are generally covered by grants from research organisations and universities. The ability for pro-bono activities to continue is constrained by the availability of this funding – without it the programs and those like it are likely to be unsustainable in the longer term.

Appendix K – Schedule of Dental Services

In principle, the scope of necessary dental services should be determined by requirements for consultation and comprehensive examinations, followed by decisions on what diagnoses are of dental and public health importance (including both preventive and treatment services for those diagnoses), as well as established standards of care. However, there is considerable debate within the dental profession on these areas and what constitutes ‘necessary care’.

The approach taken by the Council has been to classify dental services into three broad tiers: diagnosis and preventive; routine; and elective. The areas of service which might be included against each tier are noted in Table 7.1 below.

Upon examining the three tiers, it is the Council’s view that an essential dental care schedule should include diagnostic and preventive as well as routine services. This approach allows for a focus on oral health prevention and early intervention. These are the bulk of existing services, with diagnostic, preventive and routine services accounting for approximately 90 per cent of all dental services. However, only approximately two thirds to three quarters of the total costs of dental services are due to these two tiers.

However, some patients may require more complex high end dental care which is not categorised as diagnostic, preventive or routine. In this case, we believe that any program using a primary dental care schedule would need to have a mechanism where by patients could access a category of complex care items in exceptional circumstances.

Importantly, the inclusion or exclusion of specific tiers of services should be guided by the philosophy behind a dental program – for example, the philosophy might be to emphasise preventive clinical services, diagnose dental diseases early and encourage prompt low level interventions to address disease and restore function in the most cost-effective manner.

Table 7.1 Scope of dental services—diagnostic and preventive, routine and elective services

Tiers of service	Areas of service	% of current services	% of current costs
Diagnostic and preventive	Consultations	1.7	0.7
	Dental examinations	18.2	6.7
	Radiographs	13.1	3.9
	Scaling/cleaning	11.6	8.0
	Specific preventive services, including fluoride treatments	6.3	1.9
Routine	Consultations	0.1	0.1
	Services associated with dental caries	34.9	37.6
	– Restorations and endodontics (some)		
	Services associated with periodontal disease	0.5	0.4
	– Periodontics (some)		
	Services associated with replacement of lost teeth	2.7	6.5
	– Partial and complete dentures (some)		
Sub-total		89.1	65.8
Elective	Crowns and Inlays	2.5	19.8
	Bridgework	0.2	0.9
	Implants	0.1	0.8
	Orthodontics	1.0	0.4
	Cosmetic dentistry	1.2	1.7
	including restorations placed without a diagnosis of caries and issues like tooth whitening		
	Laser dentistry	0	0
	Other	5.9	10.6
Sub-total		10.9	34.2

Source: Spencer, AJ & Harford, J 2008, *Improving oral health and dental care for Australians*, discussion paper commissioned by the National Health and Hospitals Reform Commission, ARCPOH, based on LSDPA 2003/04; DVA Fee Schedule of Dental Services for Dentists and Dental Specialists. Note: totals will not add due to rounding

Using the academic and practical clinical expertise of Council members, a schedule of diagnostic, preventive and routine dental services has been developed by the Council (see Table 7.2 below).

However, depending on the specific reform options the Government chooses to implement, this schedule may need to be further refined. Such follow-on analysis would cover also cover the high-end services that should be provided under exceptional circumstances.

Table 7.2 Schedule of dental services

Service Type	Description	Item Number
Examination Diagnostic Services	Comprehensive oral examination	011
	Periodic oral examination	012
	Oral examination – limited	013
	Consultation	014
Extended Consultation Diagnostic Services	Consultation – extended (30 minutes or more)	015
Referral Consultation Diagnostic Services	Consultation by referral	016
Letter of referral Diagnostic Services	Letter of referral	019
Radiograph Diagnostic Services	Intraoral periapical or bitewing radiograph – per exposure	022
	Intraoral radiograph – occlusal, maxillary, mandibular – per exposure	025
	Panoramic radiograph – per exposure	037
Examination Diagnostic Services	Biopsy of tissue	051
Preventive and Prophylactic Services	Removal of plaque and/or stain	111
	Recontouring restorations	113
	Removal of calculus – first visit	114
	Removal of calculus – subsequent visit	115
	Topical application of remineralizing and/or cariostatic agents, one treatment	121
	Concentrated remineralizing and/or cariostatic agent, application – single tooth	123
	Dietary advice	131
	Oral hygiene instruction	141
	Fissure sealing – per tooth	161
Periodontics	Treatment of acute periodontal infection – per visit	213
	Root planing and subgingival curettage – per tooth	222
Extraction Oral Surgery	Removal of a tooth or part(s) thereof	311
	Sectional removal of a tooth	314
	Surgical removal of a tooth or tooth fragment not requiring removal of bone or tooth division	322
	Surgical removal of a tooth or tooth fragment requiring removal of bone	323
	Surgical removal of a tooth or tooth fragment requiring both removal of bone and tooth division	324
Emergency Surgery Oral Surgery	Repositioning of displaced tooth/teeth – per tooth	384
	Splinting of displaced tooth/teeth – per tooth	386
	Replantation and splinting of a tooth	387
	Drainage of abscess	392
Endodontics	Direct pulp capping	411
	Pulpotomy	414

Service Type	Description	Item Number
Endodontics	Complete chemo-mechanical preparation of root canal – one canal	415
	Complete chemo-mechanical preparation of root canal – each additional canal	416
	Root canal obturation – one canal	417
	Root canal obturation – each additional canal	418
	Extirpation of pulp or debridement of root canal(s) – emergency or palliative	419
	Resorbable root canal filling – primary tooth	421
	Additional visit for irrigation and/or dressing of the root canal system – per tooth	455
	Interim therapeutic root filling – per tooth	458
Restoration Restorative Services	Metallic restoration – one surface – direct	511
	Metallic restoration – two surfaces – direct	512
	Metallic restoration – three surfaces – direct	513
	Metallic restoration – four surfaces – direct	514
	Metallic restoration – five surfaces – direct	515
	Adhesive restoration – one surface – anterior tooth – direct	521
	Adhesive restoration – two surfaces – anterior tooth – direct	522
	Adhesive restoration – three surfaces – anterior tooth – direct	523
	Adhesive restoration – four surfaces – anterior tooth – direct	524
	Adhesive restoration – five surfaces – anterior tooth – direct	525
	Adhesive restoration – one surface – posterior tooth – direct	531
	Adhesive restoration – two surfaces – posterior tooth – direct	532
	Adhesive restoration – three surfaces – posterior tooth – direct	533
	Adhesive restoration – four surfaces – posterior tooth – direct	534
	Adhesive restoration – five surfaces – posterior tooth – direct	535
	Provisional (Intermediate/temporary) restoration	572
	Metal band	574
	Pin retention – per pin	575
	Metallic crown – direct	576
	Cusp capping – per cusp	577
	Restoration of an incisal corner – per corner	578
	Bonding of tooth fragment	579
Recementing Restorative Services	Recementing of inlay/onlay	596
Restoration Restorative Services	Post – direct	597

Service Type	Description	Item Number
Restoration Prosthodontics	Preliminary restoration for crown – direct	627
Recementing Prosthodontics	Recementing crown or veneer	651
Recementing Prosthodontics	Recementing bridge or splint – per abutment	652
Other restorative Prosthodontics	Removal of bridge or splint	656
New denture Prosthodontics	Complete maxillary denture	711
	Complete mandibular denture	712
	Complete maxillary and mandibular dentures	719
	Partial maxillary denture – resin base	721
	Partial mandibular denture – resin base	722
	Partial maxillary denture – cast metal framework	727
	Partial mandibular denture – cast metal framework	728
Other denture Prosthodontics	Provision for casting	730
New denture Prosthodontics	Retainer – per tooth	731
	Occlusal rest – per rest	732
	Tooth/teeth (partial denture)	733
	Immediate tooth replacement – per tooth	736
	Metal backing – per backing	739
Denture ease Prosthodontics	Adjustment of a denture	741
Denture reline Prosthodontics	Relining – complete denture – processed	743
	Relining – partial denture – processed	744
	Reline complete denture direct	751
Denture repair Prosthodontics	Reattaching pre-existing tooth or clasp to denture	761
	Replacing/adding clasp to denture – per clasp	762
	Repairing broken base of a complete denture	763
	Repairing broken base of a partial denture	764
	Replacing tooth on denture – per tooth	765
	Adding tooth to partial denture to replace an extracted or decoronated tooth –per tooth	768
	Repair or addition to metal casting	769
	Impression – dental appliance repair/modification	776
	Identification (ie labelling denture)	777
Miscellaneous General Services	Palliative care	911
	Provision of medication/medicament	927
	Splinting and stabilization – direct – per tooth	981
	Post-operative care not otherwise included	986

Abbreviations and Acronyms

ACAT	Aged Care Assessment Teams
ACHI	Australian Classification of Health Interventions
ACOSS	Australian Council of Social Service
ADA	Australian Dental Association
ADC	Australian Dental Council
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AIHW DSRU	Australian Institute of Health and Welfare's Dental Statistics Research Unit
ARCPHO	Australian Research Centre for Population Oral Health
ATSI	Aboriginal and Torres Strait Islanders
CA	Carer Allowance
CAFS	Comprehensive Assessment Forms
CDDS	Medicare Chronic Disease Dental Scheme
CDEP	Community Development Employment Project
CDHP	Commonwealth Dental Health Program
CHCI	Child Health Check Initiative
CSHS	Commonwealth Seniors Health Card
COAG	Council of Australian Governments
CPS	CDEP Scheme Participant Supplement
DBA	Dental Board of Australia
dmft	decayed, missing and filled teeth (deciduous teeth)
DMFT	decayed, missing and filled teeth (permanent teeth)
DSP	Disability Support Pensioners
DTERP	Dental Training Expanding Rural Placements
DVA	Department of Veterans' Affairs
DVA LDO	Department of Veterans' Affairs Local Dental Officers
FTB-A	Family Tax Benefit Part A
GAS	Give a Smile
GP	general practitioner
HCC	Automatic issue Health Care Card
HELP	Higher Education Loan Program

Abbreviations and Acronyms

HWA	Health Workforce Australia
MBS	Medicare Benefits Schedule
MTDP	Medicare Teen Dental Plan
NHHRC	National Health and Hospitals Reform Commission
NRAS	National Registration and Accreditation Scheme
NSA	Newstart Allowance
PA	Partner Allowance
PBS	Pharmaceutical Benefits Scheme
PCC	Pensioner Concession Card
PPH	potentially preventable hospitalisations
SA	Sickness Allowance
SpB	Special Benefit Allowance
the Council	National Advisory Council on Dental Health
the Rebate	Private Health Insurance Rebate
UDRH	University Departments of Rural Health
WA	Widow Allowance
YA	Youth Allowance (job seeker)