3

Priority areas for adult dental services

3.1 This chapter examines dental priorities for adults raised in submissions. It considers the needs of particular population groups and issues to be taken into account in providing dental care to these groups. It also considers workforce maldistribution, scope of practice issues, and the interface between the public and private dental systems.

Priority populations

3.2 There are some groups within the community that struggle to receive adequate dental care. This can lead to a range of poor dental health outcomes which often result in comorbidities requiring more extensive medical treatment.

3.3 There is a wide range of people that fall into the category of 'special needs' for dental services. The February 2013 report of the National Advisory Council on Dental Health identified the following as adult priority groups 'missing out' on dental services:

- Concession card holders – including priority groups that do not receive treatment due to low income being: the elderly; the unemployed; disability pensioners; and Indigenous Australians.
  - ⇒ whilst eligible for public dental services, '41.7 per cent of concession card holders have unfavourable visiting patterns compared with 23.7 per cent of non-concession card holders.'
- Rural and regional residents – 38 per cent have unfavourable visiting patterns compared to 27 per cent of urban residents.

- Indigenous Australians – this group shows significantly worse dental outcomes, for example, 49.3 per cent suffering from untreated decay compared with 25.3 per cent of non-Indigenous Australians.
- Frail and elderly people – while those over 65 years of age have favourable visiting patterns compared to the general community, those within this cohort who are at high risk, such as those on low income and in residential aged care, present with poor oral health.
- Low-income workers – those workers who are ineligible for concessional treatment and unable to afford private health insurance.
- Homeless people – dental survey data does not currently take into account data on the homeless.[1]
- People with disability – this group does not have sound population level data; small scale surveys have revealed that people in this group have poor oral health and have difficulties accessing services.[2]

3.4 The aforementioned groups have broad reasons why they are unable to access appropriate dental care and submissions to the inquiry suggested that there is no 'one size fits all' solution. Nonetheless, the affordability and availability of dental care is a common reason these groups do not access dental services.

Low-income earners

3.5 A broad range of people fall into the category of low-income earners including the elderly, those with chronic health conditions and disabilities, refugees, the unemployed and the homeless. While some of these groups have specific issues which impact on dental care, low-income is a common feature across all groups that compromises their access to appropriate care.

3.6 Because low-income earners are less likely to receive preventive care, they are more likely to have more extensive treatment when it is received, for example, teeth extracted rather than filled.[3] Waiting lists for public dental services are also lengthy which 'exacerbate the oral health problems of the eligible population because they receive no advice or interventions during their time on the waiting list.'[4]

3.7 The Australian Healthcare and Hospitals Association submitted:

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1 *Report of the National Advisory Council on Dental Health*, February 2012, pp. 43–45.

2 Dr Kerrilee Punshon, Australian Society of Special Care in Dentistry, *Official Committee Hansard,* Canberra, 23 April 2013, p. 5.

3 Consumers Health Forum of Australia, *Submission 15*, p. 7.

4 Grampians Regional Oral Health Network, *Submission 9*, p. 1.

> One-off allocations of funding for waiting lists blitzes can achieve temporary reductions to waiting times however it does not address the fundamental structural barriers to care and waiting time will inevitably increase after completion of a blitz. Funding allocations and programs which promote a focus on throughput do little if anything to address underlying barriers to care or to improve oral health at a population level.[5]

3.8 Some low-income groups face specific barriers to care. There is no data on the rate of dental treatment or oral health of homeless people. However, the Australian Research Centre for Oral Health (ARCPOH) reports that:

> … a recent Adelaide study showed that homeless adults reported poorer oral health and higher rates of smoking than the general population. They also have lower rates of dental visiting, fewer check-ups and very high rates of avoidance of dental care due to cost, as well as a very high perceived need for fillings or extractions. Three times as many homeless adults rated their oral health as 'fair' or 'poor'.[6]

The elderly

3.9 The elderly face several issues in relation to access to oral health care: age-related health conditions and affordability of care on reduced income. Of the population aged 65 and over, 82 per cent have one or more chronic medical conditions that either impact on oral health or can lead to a decline in oral health. In addition, those over 65 have decreased rates of tooth loss, leading greater risk of other oral health issues.[7] These issues mean that oral health care in elderly people can be complex.

3.10 Alongside these risk factors, it is claimed that those people living in residential aged care have 'up to three times more untreated decay than those residing in the general community.'[8] The unmet treatment needs for people in residential aged care results in a higher cost to address chronic dental issues. As with other risk groups, submissions emphasised the need for a focus on preventive oral health care and delivery of this care within residential facilities.[9]

3.11 Dr Peter Foltyn submitted:

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5 Australian Healthcare and Hospitals Association (AHHA), *Submission 5*, p. 2.

6 Australia Research Centre for Population Oral Health (ARCPOH), *Submission 18,* p. 5.

7 Professor Frederick Clive Wright, *Submission 28*, p. 1.

8 AHHA, *Submission 5*, p. 5.

9 ARCPOH, *Submission 18*, p. 4.

> Oral neglect by a nursing home or other facility will see teeth deteriorate significantly within twelve months of entry to that facility. Unless there is a complete reversal of attitude towards oral health, the needs of the most disadvantaged members of the community are probably going to have to be met through existing public health funding, private means or the generosity of volunteers, care organisations and family members. Education and prevention strategies in oral health care must be put in place now in order to limit a disaster amongst our aged and disabled.[10]

3.12 In addition, elderly people, whether they be pensioners or self-funded retirees, tend to have the same difficulties accessing affordable dental care as other low-income people.[11]

People with a disability

3.13 People living with a disability face a range of barriers in accessing appropriate oral health care. Not only can they have the barrier of low income, but those in residential facilities or dependant on carers may find these barriers exacerbated.

3.14 A dental hygienist reported:

> There was a man named Steve. He was 32 years of age. I immediately took a liking to him because of his big smile and his willingness to interact with me. He had a sharp mental capacity but also a high level of physical disability. He also had a hypersensitive reflex, which meant that his facial reflexes (including his mouth) were not well controlled, dependent on how firmly his face was touched. His mouth could snap shut at any time whilst oral hygiene or treatment was being carried out if the touch was too gentle. The carers informed me that Steve had never had his teeth brushed! I was horrified! I spoke to Steve and asked him if I could have a look inside his mouth. I explained to him that he needed to open wide so that I could place my mirror in his mouth. To everyone's amazement Steve opened his mouth for me for as long as I needed him to. His teeth and gums were in a state of complete neglect. His teeth were indistinguishable as they were covered with thick calculus and there was an accompanying, incomparable stench. I was extremely sad as I knew Steve was very interested in having as normal a life as possible. He loved going shopping and to the pub. Unfortunately there are many

10 Dr Peter Foltyn, *Submission 23*, p. [2].

11 See: Mr Clarrie Griffiths, *Submission 13*.

> Steves out there whose only dental experience consists of being placed under general anaesthetic for emergency treatment to relieve pain![12]

3.15 The Australian and New Zealand Academy of Special Needs Dentistry (ANZSND) submitted that preventive oral health training for paid and unpaid carers, and a cultural shift in residential care that recognises the importance of preventive oral care, is an essential measure to improve the oral health of people in care.[13]

3.16 The individual ramifications and the cost to the public dental system of untreated dental issues or lack of preventive care for people with a disability are significant. ANZSND submitted that it is necessary to increase the workforce in this area with a specific focus on preventive care.[14]

Indigenous Australians

3.17 The National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that the evidence linking poor oral health with overall poor health is such that improvement in oral health will improve overall health outcomes.[15]

3.18 In addition, NACCHO submitted that the causal factors for poor oral health outcomes such as nutrition, diabetes, smoking, injury, poor oral hygiene and fluoridated water supply must be addressed as a part of any Indigenous oral health strategy.[16]

3.19 NACCHO submitted that oral health services should be part of the basic service provision of Aboriginal Community Controlled Health Services (ACCHS) recognising the integral nature of oral health to general health and wellbeing. Further solutions include:

- increasing the workforce trained in Aboriginal and Torres Strait Islander cultural awareness;
- increase the willingness of oral health workers to work in ACCHSs;
- increase the total workforce available ; and

12 The Dental Hygienists Association of Australia (DHAA), *Submission 2*, p. 8.

13 Australian and New Zealand Academy of Special Needs Dentistry (ANZSND), *Submission 21*, p. 5.

14 ANZSND, *Submission 21,* p. 6.

15 National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 25,* p. 7.

16 NACCHO, *Submission 25,* pp. 8–10, 13.

- reduce the cost of services to Aboriginal and Torres Strait Islander clients.[17]

3.20 The Aboriginal Medical Services Alliance Northern Territory (AMSANT) further submitted that:

> … funding provided to states for oral health services should include a weighting for both Aboriginality and for remoteness as both will increase the cost of equitable service delivery. We also believe that the Commonwealth should provide funding directly to ACCHSs for dental service provision given that this is the successful funding model used for the rest of Aboriginal primary health care.[18]

3.21 The lack of Indigenous oral health workers and concomitant lack of culturally appropriate services was identified by a number of submitters as a key reason why some Indigenous people are reluctant to access dental care and as a result, these services should be a part of core Indigenous health delivery.[19]

3.22 As such, the integration of dental health into general health has been important in providing services. Mr James Newman, CEO of Orange Aboriginal Medical Service, explained:

> Aboriginal people who come in to use our services do not just get access to our dental team, they also have to have a comprehensive health check… So we are providing comprehensive health care and not, as Sandra said earlier, just providing dental care. It is comprehensive health care that is going to improve the health of our people.[20]

3.23 The development of partnerships within the community can also help to deliver dental services to Indigenous people and others in rural and remote communities.[21] Ms Jennifer Floyd from Western New South Wales Local Health District stated:

> We also work in partnership with Aboriginal medical services in our region, and together with all of our partner organisations we aim to maximise the availability of services to our communities.

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17 NACCHO, *Submission 25,* p. 14

18 Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Submission 29,* p. 2.

19 NACCHO, *Submission 25*; AMSANT, *Submission 29;* ARCPOH, *Submission 18*; Services for Australian Rural and Remote Allied Health (SARRAH), *Submission 3;* Bila Muuji Aboriginal Health Services Incorporated, *Submission 44*.

20 Mr Jamie Newman, Orange Aboriginal Medical Service, *Proof Transcript of Evidence*, Dubbo, 17 May 2013, p. 24.

21 Walgett Aboriginal Medical Service, *Submission 46*, p. 2–3.

> We work together rather than in competition, and we avoid duplication.[22]

3.24 These partnerships should be seen as a reliable method of delivering services to Indigenous Australians, and states and territories may wish to consider similar partnerships in their jurisdictions.

Remote, rural and regional residents

3.25 Naturally, some remote, rural and regional residents also fall into other special needs categories as outlined above. However, rural and regional residents face a geographic challenge in accessing appropriate dental care and this increases the likelihood of dental disease irrespective of socioeconomic or other risk status.

3.26 Dental Health Services Victoria (DHSV) submitted:

- Oral health issues are compounded in rural and remote communities, as shown by rural people reporting the highest level of complete tooth loss and being most likely to have had a tooth extracted in any given year. Research has also shown they are most likely to be dissatisfied with their dental health.
- People living in rural and remote locations are more likely to have untreated decay than people living in metropolitan areas, and were less like to have check-ups, prevention treatment such as clean and scales, and more likely to have teeth extracted.[23]

3.27 DHSV further noted:

> … in general, access to dental services reduces by distance from Melbourne and size of the community. New innovative models need to be developed to increase accessibility for these communities.[24]

3.28 The NSW Government confirmed similar difficulties in that state, noting that those living in regional areas also pay more for 'home health care resources such as toothbrushes and fluoride toothpaste.'[25]

3.29 Dental prosthetist Mr Peter Muller submitted:

> Those patients in Lightning Ridge and surrounding areas travel long distances with the travel time being up to 12 hours requiring 3 to 6 visits until treatment is completed. This costs time and causes financial pressure, which is the initial reason why they

22 Ms Jennifer Floyd, Western NSW Local Health District, *Proof Transcript of Evidence*, Dubbo, 17 May 2013, p. 8.

23 Dental Health Services Victoria (DHSV), *Submission 32,* p. 13.

24 DHSV, *Submission 32,* p. 15.

25 NSW Ministry of Health, *Submission 24*, p. 5.

> need care. The lack of access to areas that provide treatment only gives the individual. The lack of facilities places pressure on the waiting list and the health centre in Lightning Ridge, which is only for emergency cases.
>
> Those with a health care card and low income end up on the waiting list for years with no dental treatment. What was once a small problem has developed into a larger one which was preventable in the first place had treatment been sought.[26]

3.30 In addition to the lack of dental workforce in regional areas as discussed later in this chapter, access to care is the primary deterrent for regional people. Even where services are available, distance and a lack of transport can prevent people from accessing treatment.[27]

3.31 For those residents with complex needs, such as people with a disability, there is no option but to travel to metropolitan areas for treatment. There are only 15 special needs dental specialists in Australia and all of them practice in metropolitan areas.[28] The lack of government assistance for geographically disadvantaged patients to travel for dental care places a further impediment to care.[29]

3.32 It was generally submitted that innovative modes of remote, rural and regional service delivery will need to be considered in order to provide access to oral health care in a cost-effective manner to the maximum number of people. Issues such as the cost of and access to transport, and minimising visits and waiting times must be key considerations in providing regional services.

3.33 Place of residence has a significant impact on the rate of hospitalisation for potentially preventable dental conditions (Table 3.1). In 2009-10 the separation (completed episode of care) rate was 2.8 per 1 000 population. However, this rate increased markedly depending on the patient's residential status.[30]

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26 Mr Peter Muller, *Submission 10*, p. [1].

27 Loddon Mallee Regional Oral Health Network, *Submission 20*, p. 2.

28 ANZSND, *Submission 21*, p. 5.

29 SARRAH, *Submission 3,* p. 8; Royal Flying Doctor Service, *Submission 11*, p. 2.

30 Chrisopoulos S, Beckwith K & Harford JE 2011. *Oral health and dental care in Australia: key facts and figures 2011*. Cat. no. DEN 214. Canberra: AIHW, p. 16.

Table 3.1 Hospital separations for potentially preventable hospitalisations due to dental conditions, remoteness area of usual residence, 2009-10

	Major cities	Inner regional	Outer regional	Remote	Very remote	Total
Number	30 383	13 508	6 450	1 143	736	60 251
Separation rate	2.6	3.2	3.1	3.4	3.7	2.8

Source *Australian Institute of Health and Welfare (2011), 'Oral health and dental care in Australia: Key facts and figures 2011', Canberra, p. 16.*

3.34 The higher rate of hospital separations for remote residents indicates that there is a need to have a greater focus on preventive dental treatment in regional and remote areas.

3.35 In addition, there is a need to support initiatives that promote regional practice. The Australian Rural Health Education Network (ARHEN) submitted that the training initiatives for medical students aimed at increasing practice in remote, rural and regional areas have proved successful in increasing student interest in rural training and practice. These initiatives include:

- recruiting students from rural backgrounds;
- delivering training in rural areas; and
- providing all students with some rural exposure during their training.[31]

3.36 ARHEN submitted that, based on the success of the medical student program, a similar initiative for dental students would provide:

- expansion of public dental services in remote and rural areas;
- supervision of final year dental students in the first instance;
- support for existing dental and oral health workforce; and
- increased access to much needed oral health services for people in remote and rural communities.[32]

3.37 Charles Sturt University has begun to address these issues, establishing the School of Dentistry and Health Sciences to:

> … address chronic mal-distribution of dentists and oral health therapists in inland rural and regional Australia, the low numbers of rural and regional students admitted to city university-based dental programs, and consequently the low number of city dental graduates moving into rural and regional practice.[33]

31 Australian Rural Health Education Network (ARHEN), *Submission 1*, p. [2].

32 ARHEN, *Submission 1,* p. [3].

33 Charles Sturt University, *Submission 45*, p. 1.

3.38 As a result of this, there are currently 201 students across all years undertaking the dentistry course at Charles Sturt University, and approximately 55 per cent of the students in the 2013 intake were from rural areas. The University is aiming for 70 per cent of their dentistry course to be from rural areas in the future. Further, the majority of the 2011 Oral Health Therapy graduate students from Charles Sturt University are employed in rural and regional New South Wales.[34]

3.39 The strategies proposed by ARHEN, as well as the model of dental education demonstrated by Charles Sturt University, should be considered as part of a preventive model of care that focusses on reducing the need for intensive specialist treatment.

People with chronic disease

3.40 The closure of the Chronic Disease Dental Scheme (CDDS) was raised as an issue of concern by some submitters concerned with the provision of dental services to people with special needs.

3.41 The CDDS was closed to new patients on 8 September 2012 and all patients from 30 November 2012. The Commonwealth Department of Health and Ageing noted that 76.7 per cent of CDDS patients are also eligible for public dental services and so are expected to be able to receive treatment by state and territory services.

3.42 The Department of Health and Ageing advised the Committee that those not eligible for public dental services are expected to access services in the private system.[35] The Dental Waiting List NPA is now implemented in all states and territories, with the full Adult Dental Services NPA to be implemented from July 2014.

3.43 Anya, a former CDDS patient, expressed her dismay at the scheme having closed in the following terms:

> I am a young person suffering chronic illness and on a disability pension. I MUST see the dentist every 4 months but without the CDDS I can't afford to see my family dentist. I am currently on a MINIMUM 2 year waiting list at my local public dentist but I cannot wait that long. Please can you help get the CDDS back so many people desperately need this.[36]

3.44 Ms Lynne Forde, a chronic disease sufferer, summarised her experience, noting her disappointment that the CDDS has been discontinued:

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34 Charles Sturt University, *Submission 45*, p. 2–3.

35 Department of Health and Ageing (DoHA), *Submission 34*, p. 6.

36 Anya, *Submission 39*, p. 1.

> I have had chronic diseases for years, am 44 and have been walking around with several front teeth missing and a heap of lower ones for a few years. I have Diabetes and riddled with Osteoarthritis. The Diabetes has ruined my gums and teeth. I never knew about the dental scheme as my Dr didn't inform me. I was told by a friend a month before the service was cancelled. Excitedly I made an appointment to see my Dr and she had left the practice. I was unable to get an appointment in time and now have been told the dental scheme has been scrapped.
>
> I need to have my teeth removed, what few I have left, I am in constant pain with them but can't afford to pay a dentist to remove them. I am in constant agony. The scheme was like a godsend to me. I walk around looking like a circus freak. This is not your fault I know, but I need help and now it's been scrapped I am devastated.[37]

3.45 Mr Peter Muller, a dental prosthetist, provided a practitioner's point of view, observing:

> When the CDDS closed a big problem was left with many patients not having treatment completed and many left on the waiting list. This has resulted in patients losing trust and faith in the system and also the professional.[38]

3.46 In addition, the extensive waiting lists for public dental services have former CDDS patients concerned that they will have already chronic conditions compounded by this delay.[39]

3.47 Dental Hygienists Association of Australia (DHAA) advocated for a replacement of the CDDS that focuses on patients with chronic disease:

> DHAA Inc. would like to see a replacement for the recently abandoned Chronic Disease Dental Scheme (CDDS). The Australian Government has not outlined any viable replacement for this scheme. As a result, many chronically ill patients are without a scheme focused on their needs.[40]

3.48 The ANZSND acknowledged that the CDDS was an unsustainable scheme but noted similarly that 'it has left a group of patients with far more limited access to oral health care as a result'.[41]

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37 Ms Lynne Forde, *Submission 42*, p. [1].

38 Mr Peter Muller, *Submission 10,* p. [2].

39 Ms Anya, *Submission 39*, p. [1]; National Seniors Australia, *Submission 38,* p. 1.

40 Dental Hygienists Association of Australia (DHAA), *Submission 2*, p. 4.

41 DHAA, *Submission 2*, p. 4; ANZSND, *Submission 21*, p. 4.

3.49 While the CDDS provided worthy dental services to some patients, it was poorly targeted and had a range of problems with its implementation and administrative requirements.[42] For some time prior to the CDDS ceasing, the Government had intended to close the CDDS in order to take on a greater role in providing dental services to concession card holders.[43]

3.50 While the Government has now implemented its policy decision to close the CDDS, evidence presented to this inquiry indicates that the Adult Dental Services NPA should consider individuals with a chronic illness that exacerbates dental health issues as a priority population group.

Committee comment

3.51 The evidence submitted to this inquiry is largely consistent with previous evaluations of priority groups for dental services in Australia, including the groups identified by the National Advisory Council on Dental Health.

3.52 The Committee understands that the majority of dental care in Australia is delivered by private dentists with cost borne by individuals. Those individuals with private health insurance receive a government contribution to the cost of dental care through the Private Health Insurance Rebate.

3.53 Low-income earners are represented in a range of priority groups, and as such face a range of barriers to accessing dental care. To address this lack of access, programs to target this priority group will need to take into account those other factors which may also be limiting their access to dental care.

3.54 Elderly people live in a range of residential settings with different levels of personal and dental care needs. As the evidence suggests, it will be important for this group to receive appropriate preventive care to avoid having to provide more costly and painful services in the longer term.

3.55 People with a disability must be able to access preventive dental care. It will be important for dental care to be linked with their general care to ensure that services are delivered and for their oral health to be improved.

3.56 Indigenous Australians in metropolitan and rural areas often have difficulty accessing dental services. The role of Aboriginal Medical Services and other non-government organisations in providing dental services to this group has proven successful and the Committee encourages the ongoing role of these organisations in this area.

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42 Ms Carol Bennett, Consumer Health Forum of Australia, *Official Committee Hansard*, Canberra, 22 April 2013, p. 34; Australian Dental Association (ADA), *Submission 37*, p. 4.

43 *Report of the National Advisory Council on Dental Health*, February 2012, p. 24.

3.57 As presented in the evidence, the lack of dental practitioners in rural and remote areas presents the greatest barrier to people in these areas accessing dental services. As discussed later in this chapter, states and territories may wish to consider innovative linkages with other private providers of dental services and not-for-profit organisations to better ensure the delivery of dental services to people in rural and remote areas.

3.58 The Committee understands that the CDDS provided vital dental services in some circumstances for people with chronic diseases. However, the Committee heard that the CDDS had problems with implementation and that certain sectors of the community in need were not able to access dental services. The Committee also notes that prior to closure of the CDDS and based on advice from dental professionals, a three month period was allowed for patients being treated under the CDDS to complete the course of treatment.[44] The provision of funding under the Dental Waiting List NPA which has already commenced means that those people currently on public dental waiting lists should be able to access dental services more quickly. Additional funding for the Adult Dental Services NPA from July 2014 will improve targeting, and provide better access to public dental services based on the needs of a wider range of priority population groups.

3.59 The Committee notes that the Commonwealth Government is aware of the issues facing these priority population groups and the importance of the Adult Dental Services NPA in addressing the needs of these groups. The additional funding committed by the Commonwealth should provide state and territory governments with increased capacity to extend services to these groups. However, it is clear that the delivery of these services needs to be structured in a way that can deliver:

- a preventive oral health care focus;
- a culturally appropriate service delivery; and
- built-in capacity to deliver on-site care (for example, in Aboriginal Heath Centres, residential aged care, homelessness support services).

3.60 Recognising that states and territories must be allowed to flexibly develop their own Implementation Plans under the Adult Dental Services NPA, the Committee has not made specific recommendations. Rather, the Committee urges states and territory governments to make use of the evidence submitted to this inquiry to consider how best address the needs of priority groups and to inform development of their Implementation Plans.

44 Ms Kerry Flanagan, DoHA, *Official Committee Hansard*, Canberra, 12 March 2013, p. 7.

Workforce distribution

3.61 One of the major challenges facing access to dental care is workforce distribution. Submissions raised several key issues regarding workforce 'maldistribution':

- dentists and specialists are concentrated in metropolitan areas;
- demand for public dental services is not adequately quantified due to the number of people who access no form of treatment; and
- limitation on the scope of practice for oral health technicians compromises the extent of services available in the public system.

3.62 The majority of the 10 404 (2006 figures) or 78.1 per cent of practicing dentists in Australia work exclusively in private practice. A further 895 (8.6 per cent) dentists work in both private and public practice and the remaining 13.3 per cent of dentists work exclusively in public practice (1 386 dentists).[45]

3.63 These figures broadly reflect visit rates, with 88.3 per cent of people visiting a dentist in 2010 attending a private dental practice and six per cent attending a public dental service. However, visit rates decline markedly with income level, with just under 40 per cent of people earning $60 000 or less citing cost as a barrier to treatment.[46] This indicates that the real demand for dental services is unknown and available data cannot accurately predict future workforce needs.[47]

3.64 Nonetheless, it is recognised that the workforce is not growing at a rate to meet known demand. Based on a 'medium' level of current per capita demand data, the projected capacity of the dental labour force will experience a shortfall of 800-900 dentists by 2020, a shortfall of 2 million visits.[48]

3.65 The majority of dentists work in major metropolitan areas. However, while low in numbers, there is a reasonably even spread of dental and oral health therapists practising across metropolitan and regional areas, but all other practitioners are poorly represented in outer regional and remote areas (Table 3.2).

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45 Chrisopoulos S, Beckwith K & Harford JE 2011. *Oral health and dental care in Australia: key facts and figures 2011*. Cat. no. DEN 214. Canberra: AIHW, p. 45

46 Chrisopoulos S, Beckwith K & Harford JE 2011. *Oral health and dental care in Australia: key facts and figures 2011*. Cat. no. DEN 214. Canberra: AIHW, p. 22, 26, 31.

47 Association for the Promotion of Oral Health (APOH), *Submission 4*, p. 10.

48 Chrisopoulos S, Beckwith K & Harford JE 2011. *Oral health and dental care in Australia: key facts and figures 2011*. Cat. no. DEN 214. Canberra: AIHW, p. 45.

Table 3.2 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 practicing in the NT.

Source *AIHW/DRSU Dental Labour Force Survey 2006* in National Advisory Council on Dental Health, *Report*, February 2013, p. 32.

3.66 The comparative lack of dental workforce in inner-regional/outer metropolitan areas is attributed to the income levels necessary to support private dental practices. The Association for the Promotion of Oral Health (APOH) submitted:

> For example, while the number of dentists per 100 000 population in rural NSW is only about 28, compared with 88 in the eastern suburbs of Sydney, there are only 32 dentists per 100 000 population in the south western suburbs of Sydney, so that highly populous south western Sydney has comparable access to dentists to that of rural NSW.
>
> The maldistribution of workforce between these two highly populous parts of Sydney reflect the fact that despite high clinical need, there is simply not enough money in south western Sydney to support more private dental practices. In the absence of demand, private dental practices cannot be established or maintained.[49]

3.67 Compounding the general shortage of practitioners in some areas is the national shortage of specialist needs dentists (those with specialist training to treat patients with physical or intellectual disability). The Australian and New Zealand Academy of Special Needs Dentistry (ANZSND) submitted that of the fifteen special needs dentistry specialists, none are

49 APOH, *Submission 4*, p. 10.

located in Western Australia, Tasmania, the Northern Territory or the ACT and all are located within major metropolitan areas.[50]

3.68 The ANZSND argued that there is a growing need for special needs dentistry but there is no national data on the demand for these services as many clients have little oral communication so are unable to communicate their needs. Alongside the need to travel to a major centre for treatment, this means that this cohort is less likely to receive appropriate treatment.[51]

3.69 The Department of Health and Ageing's Dental Relocation and Infrastructure Support Scheme has been developed to address the maldistribution of in dental practitioners in regional and remote areas.[52] Its implementation will need to be monitored to evaluate whether or not its aims are met.

Scope of practice

3.70 Excluding dentists and dental prosthetists, the dental workforce is comprised of a range of therapists who perform duties under the supervision of a dentist (see Table 3.3). It was argued by some submitters that the scope of practice for dental and oral health therapists needs to be widened in order to provide more preventive services, with an aim to reduce waiting lists and the burden on dentists.

50 ANZSND, *Submission 21*, p. 5.

51 ANZSND, *Submission 21,* pp. 1-2.

52 DoHA, *Submission 34,* p. 5.

Table 3.3 Dental workforce – roles and numbers of practicing professionals (2006)

Dental Practitioners	Role Description	Number Practicing
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 is available for prosthetists practicing in the NT.

Source: *Balasubramanian M, Teusner D 2011. 'Dentists, specialists and allied practitioners in Australia: Dental Force Labour Collection, 2006'. Dental statistics and research series no. 53. Cat. No. DEN 202. Canberra AIHW* in National Advisory Council on Dental Health, *Report*, February 2013, p. 28.

3.71 As noted in Table 3.2, there is a more even spread of some therapists across metropolitan and regional areas, however, the limitation on the scope of practice for therapists means that this does not increase the availability of services. Particularly in remote areas with no resident dentist, this means that no services are available to some:

> With a limitation on services, dental therapists in these regions can see a child under the age of 18, but if their parent comes in with a toothache the adult is unable to be seen by the dental therapist. This is an inconceivable waste of resources, given the time and effort that is put in by the dental therapist getting to these regions, many of which are not frequently visited by a dentist.[53]

53 Australian Dental and Oral Health Therapists' Association (ADOHTA), *Submission 19,* p. 3.

3.72 The Australian Dental and Oral Health Therapists' Association (ADOHTA) argued that removing impediments to the provision of care for dental therapists, dental hygienists and oral health therapists to provide services to adults including remedial and restorative treatment will reduce waiting lists and the number of patients waiting untreated before seeing a dentist.[54]

3.73 Recognising the shortage of special needs dentists, the ANZSND also proposed better utilisation of dental hygienists and oral health therapists for:

> … routine maintenance of oral hygiene and ongoing educational and hands-on training for carers. …Under current scope of practice, oral health therapists could provide far more care to special needs patients and yet they have limited employment opportunities presently in the public sector.[55]

3.74 DHAA argued that providing dental hygienists with Medicare provider numbers, similar to other allied health professionals, would allow them to work to the capacity of their existing scope of practice. It would also allow them to offer services more widely, focus on preventive health and therefore alleviate some of the pressure on public dental practices.[56]

3.75 The NSW Government submitted that addressing scope of practice issues will be one of the measures necessary to improve skill mix and workforce distribution.[57] The Victorian Government also submitted that expanding the scope of practice for oral health therapists allows for an expansion of services and, key to maintaining employment within the public sector, prevents de-skilling these professionals, noting:

> The Oral Health Workforce needs to have a model of care that allows all practitioners to work to their full scope of practice and to use the full range of Oral Health practitioners like oral health therapists, dental therapists, dental hygienists and dental prosthetists. In addition, non-registered dental workforce members like dental assistants and technicians need to be able to provide services that will improve oral health.[58]

3.76 Alongside concerns about scope of practice within the dental profession, the Australian Healthcare and Hospitals Association noted that the 'historic state and territory based regulation of practitioners resulted in

54 ADOHTA, *Submission 19*, p. 3.
55 ANZSND, *Submission 21*, p. 6.
56 DHAA, *Submission 2*, p. 5.
57 NSW Government, *Submission 24*, p. 7.
58 DHSV, *Submission 32*, p. 20.

differences in the legislated scope of practice, particularly for dental therapists', further adding:

> While the establishment of national registration and reviews of scope of practice have improved clarity of scope of practice issues and the current [Health Workforce Australia] oral health workforce project will further inform the development of oral health workforce plans and structures, considerable work is still required to achieve the National Oral Health Plan action of removing barriers to the full use of the skills of the whole dental team. [59]

Public/private interface

3.77 There is a history of collaboration between the public and private sectors to help address workforce shortages and maldistribution.

3.78 Some services in some states are provided to public patients by private practitioners through the operation of an 'Oral Health Fee for Service' (or similar scheme), commonly known as a 'voucher' system. This system engages private dentists and dental prosthetists to provide services in order to increase access and reduce waiting times for public patients. Patient co-payments for voucher services are not permitted.

3.79 The voucher system is seen as an effective method of managing the delivery of care, particularly in regional areas where there are workforce shortages in the public system or where metropolitan dental waiting lists are extensive.[60] Dental Health Services Victoria reported that approximately eight per cent of services to adults are delivered through the private system via a voucher[61] and the Western NSW Local Health District reported very good participation by local dentists in the voucher system.[62]

3.80 The voucher scheme has the added benefit of bringing private dentists in contact with the public system and raising awareness of the level of unmet need in the community:

> I have been treating patients under the OHFFS voucher system for the first time this month. I understand the patients I have treated under this scheme are vetted to ensure I see the "best" patients. To say that I am astounded at the unmet oral health needs of these patients is an understatement. I believe publicity around any

59 AHHA, *Submission 5*, p. 7.

60 Western Region Health Centre, *Submission 14,* p. 5.

61 DHSV, *Submission 32*, p. 9.

62 Western NSW Local Health District, *Submission 33*, p. 4.

> increased availability or improved range of services available in coming months will only exacerbate the waiting list problem in my area. I believe many of the patients around this area have given up on the public system entirely. The treatment they receive often just exacerbates their existing poor oral health. I believe the public in our area is disenfranchised and that this hides an enormous volume of work which goes untreated.[63]

3.81 While the voucher system does provide greater access to services, in regional areas distance is still an obstacle to service provision. For example, the Lake Cargelligo Health Service reported that the closest voucher provider is in Forbes, two hours by car from the service.[64]

3.82 The Australian Dental Prosthetists Association (South Australia) reported that their members wait for 'up to three months or more for payment of work performed through' vouchers.[65] This is a significant deterrent to these private practitioners participating in the scheme and an issue which must be addressed by scheme administrators.

3.83 Nonetheless, the approach of bringing private dentists into the public system through a voucher system is a valuable one which has the capacity to contribute to meeting needs in metropolitan and regional areas. Dentists in the private sector need to be remunerated at an appropriate level and in a timely manner to ensure they are not disadvantaged by contributing this public service.

Committee comment

3.84 The Committee was not surprised to learn that there is a general shortage of dental practitioners outside of metropolitan areas. There is evidence suggesting that dental workforce shortages are also typical in lower socio-economic areas, both metropolitan and regional. These issues make it more difficult for people in those areas to access dental services when they most need it.

3.85 The Voluntary Dental Graduate Year Program and the Oral Health Therapists Graduate Year Program aim to increase workforce capacity in the public sector.[66] Increased numbers of dental practitioners in the public sector should help to alleviate pressure on public dental waiting lists. It would be encouraging if those completing the programs chose to stay in the public sector. A better understanding of the current oral health supply

63 ADA (NSW Branch), *Submission 40*, pp. 8-9.

64 Lake Cargelligo Multi-Purpose Health Services Advisory Committee, *Submission 35*.

65 Australian Dental Prosthetists Association, *Submission 27*, p. 9.

66 DoHA, *Submission 34*, pp. 4–5.

and distribution, and of projected demand, will be forthcoming when Health Workforce Australia completes its *Health Workforce 2025 – Oral Health* study.[67]

3.86 State and territory public dental systems tend to report on voucher systems favourably, however, that is not always the case with private dentists. Given that these vouchers allow eligible patients to access dental services more quickly than they would be able to in the public system, jurisdictions should ensure that private dentists are remunerated for their services in a timely manner through streamlining existing payment systems. This will encourage the ongoing professional relationship between the public and private dental systems.

3.87 The Committee supports an approach which improves and extends opportunities for linkages with the providers of private dental services and not-for-profit organisations to increase access to services for people in need.

Recommendation 1

3.88 **The Australian Government include principles in the Adult Dental Services National Partnership Agreement which require state and territory governments to develop improved linkages with private providers of dental services and not-for-profit organisations to help deliver dental services to patients in need.**

3.89 The Committee notes that provision of services is being hampered by limitations on the scope of practice for some practitioners, namely dental hygienists, dental therapists and oral health therapists. If public dental services are to be delivered widely, these barriers to service delivery must be eliminated. Although the National Registration and Accreditation Scheme for health professionals, including dental and oral health professionals, was introduced in 2010, some states and territories have more restrictive conditions associated with scope of practice than others, particularly relating to age groups that can be treated. Those jurisdictions with restrictive conditions may wish to consider expanding their guidelines so that they are consistent across Australia. This will allow oral health practitioners to more fully utilise the full scope of their skills.

67 Health Workforce Australia, <http://www.hwa.gov.au/work-programs/information-analysis-and-planning/health-workforce-planning/oral-health-workforce> viewed 31May 2013.

3.90 To alleviate service delivery pressure in the public dental system the Committee believes that an investigation into the viability of dental hygienists, dental therapists and oral health therapists providing services as solo practitioners is warranted. As such, there are two issues that need to be addressed. Firstly, the Dental Board of Australia's (DBA) scope of practice registration standards will need to be amended to allow dental hygienists, dental therapists and oral health therapists to practice as independent practitioners in those areas in which they have been formally educated and trained.

3.91 Secondly, DoHA would need to allow dental hygienists, dental therapists and oral health therapists to hold a Medicare provider number. This recommendation is predicated on amendment of the DBA scope of practice registration standards to allow dental hygienists, dental therapists and oral health therapists to practice independently. A pilot program could be initiated in rural and remote areas for these practitioners to help alleviate the burden of dental and oral disease of people living in these areas.

Recommendation 2

3.92 **The Department of Health and Ageing and Health Workforce Australia work with the Dental Board of Australia to amend the professional scope of practice registration standards to allow dental hygienists, dental therapists and oral health therapists to practice independently.**

Recommendation 3

3.93 **The Department of Health and Ageing investigate enabling dental hygienists, dental therapists and oral health therapists to hold Medicare provider numbers so that they can practice independently as solo practitioners within the scope of practice parameters stipulated by their professional practice registration standards.**

The provision of Medicare provider numbers to these practitioners could be piloted.

Mix and coverage of services

3.94 While state and territory public dental systems provide both emergency and general dental treatment, the National Advisory Council on Dental Health identified 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'.[68] Further, 'many public patients start on public dental waiting lists seeking preventive or restorative treatment but become emergency cases by the time they receive treatment'.[69] This 'skew' is due to both emergency cases being prioritised for care (as they should be) and a lack of resources to treat patients on waiting lists.[70]

3.95 As submitted by the Association for the Promotion of Oral Health:

> … preventive treatment is rarely delivered, and early problems such as early decay, or early periodontal disease, are not treated in time to save teeth. Without early intervention, public dental patients more frequently present for emergency treatment and extraction of badly infected teeth.[71]

3.96 States and territories, while providing important emergency dental care to those in need, recognise the benefits to be gained by providing preventive services to the eligible population. However, there are sometimes limits the reach of public dental services.

3.97 As noted earlier in the chapter, people in rural and regional areas are often unable to access dental services. Lack of access to dental services in either the public or private sectors can lead to poorer oral health outcomes for rural and regional residents.

3.98 In order to better provide services to people in rural and regional areas, Charles Sturt University and New South Wales Health have signed a Service Level Agreement so that dental students are able to provide services to individuals on NSW dental waiting lists.[72] This model could be applied across Australia to aid in treating patients on public dental waiting lists.

3.99 In terms of remote service delivery, the Royal Flying Doctors Service has advocated for the inclusion of remote areas as a priority for service

68 *Report of the National Advisory Council on Dental Health*, February 2012, p. 61.

69 *Report of the National Advisory Council on Dental Health*, February 2012, p. 50.

70 ADA (Qld), *Submission 8,* p. 1.

71 APOH, *Submission 4,* p. 6.

72 Charles Sturt University, *Submission 45*, p. 4.

delivery.[73] Services in these areas could be provided through existing structures and organisations and included in the development of Implementation Plans.

Preventive services

3.100 A number of submitters argued that delivery of public dental care must be addressed at the most basic oral health care level and focus on preventive care. As noted by the Lake Cargelligo Multi-Purpose Health Services Advisory Committee:

> … preventative dental services are non-existent, which leads to the acute dental problems experienced by many people in this community.'[74]

3.101 It was extensively argued that, particularly in remote and regional areas, measures such as fluoridation of the water supply and education on preventive care and diet can reduce the necessity for more invasive and expensive treatments.[75] It was also argued that the Adult Dental Services NPA funding structure should support evidence-based preventive programs.[76]

3.102 Indeed, it was argued that 'fluoridation of reticulated water supplies is the most effective, equitable and efficient measure of controlling dental disease'[77] and recent decisions by some Queensland councils to cease fluoridation of water supplies are concerning.[78]

3.103 Dental Health Services Victoria noted that public delivery of dental care needs to have the same approach as other health care models, but one that is not based on a private dentistry model:

> In health you hear about models of care all the time, but it is fairly new in the oral health area. That involves talking about the basic principles that you have, which include prevention and population health, and including people outside of dentistry as part of the model. Then you get right down to the detail of the

73 Dr Greg Rochford, Royal Flying Doctor Service, *Proof Transcript of Evidence,* Dubbo, 17 May 2013, p. 20.

74 Lake Cargelligo Multi-Purpose Health Services Advisory Committee, *Submission 35*.

75 See for example: SARRAH, *Submission 3*; University of Tasmania Department of Rural Health, *Submission 7*; DEXCL, *Submission 16;* Westfund Ltd, *Submission* 17; ADOHTA, *Submission 19*; NACCHO, *Submission 25*; Professor Fredrick Clive Wright, *Submission 28*;

76 Andrew McAuliffe, AHHA, *Official Committee Hansard,* Canberra, 22 April 2013, p. 9.

77 University of Tasmania Department of Rural Health, *Submission 7*, p. 4.

78 SARRAH, *Submission 3*, p. 6.

> types of care you will provide, the clinical pathways and clinical guidelines you will have and the types of care, which would include minimal intervention dentistry. If you were doing the same model of care in a private setting, running a cosmetic clinic you would obviously have a very different model of care, but we are talking about a pure public health type model of care. It is important that it is documented and articulated and then you start the process.[79]

Committee comment

3.104 These issues are linked in part to the maldistribution of the dental workforce across Australia, both geographically and between the public and private dental sectors, and the scope of practice issues raised earlier.

3.105 The Committee acknowledges capacity constraints in terms the ability of the public dental system to deliver preventive services, but anticipates that these issues will start to be resolved with the implementation of the Dental Waiting List NPA.

3.106 The delivery of public dental services in rural, regional and remote areas has been identified as a gap, and steps need to be taken to ensure that eligible people living in those areas are able to access public dental services (or private services through a voucher system).

Recommendation 4

3.107 **The Australian Government include principles in the Adult Dental Services National Partnership Agreement which require state and territory governments to develop improved linkages with private providers of dental services and not-for-profit organisations so that patients living in areas where public dental services are not available or are oversubscribed have better access to care.**

3.108 Submissions raised a number of worthwhile considerations regarding the need for publicly funded dental care to be based on a comprehensive, preventative, model of care.

3.109 Service provider Westfund submitted that its policy approach is to remunerate preventive and non-invasive treatment with an aim to reduce

79 Deborah Cole, DHSV, *Official Committee Hansard,* Canberra, 22 April 2013, p. 44.

acute treatment, particularly in regional areas where treatment can be compromised by delays caused by lack of access and affordability.[80]

3.110 Similarly, a greater focus on regular preventative oral health care for low-income earners, Indigenous people and people with a disability may reduce the need for later extensive, painful and expensive dental treatment.

Recommendation 5

3.111 **The Australian Government include incentives in the Adult Dental Services National Partnership Agreement to encourage state and territory governments to improve the focus on preventive dental services as a component of addressing overall dental and oral health.**

80 Westfund Health Ltd, *Submission 17*, pp. 2–3.