
The Parliament of the Commonwealth of Australia

Bridging the Dental Gap

Report on the inquiry into adult dental services

House of Representatives
Standing Committee on Health and Ageing

June 2013
Canberra

© Commonwealth of Australia 2013

ISBN 978-1-74366-069-0 (Printed version)

ISBN 978-1-74366-070-6 (HTML version)

This work is licensed under the Creative Commons Attribution-NonCommercial-NoDerivs 3.0 Australia License.



The details of this licence are available on the Creative Commons website:
<http://creativecommons.org/licenses/by-nc-nd/3.0/au/>.

Cover design by Lucas Kuncewicz, Department of the House of Representatives
Printing and Publishing Office, Canberra.



Contents

Foreword	v
Membership of the Committee	vii
Terms of reference	ix
List of recommendations	xi
1 Introduction	1
Background	1
Referral and scope of the inquiry	3
Conduct of the inquiry	5
Committee comment	5
Structure of the report	6
2 Dental Services in Australia	7
Factors associated with poor dental and oral health.....	7
Responsibility for adult dental services.....	8
Overview of Commonwealth dental policy	10
Commonwealth support for dental services.....	12
Dental Reform Package.....	13
Committee comment	15
3 Priority areas for adult dental services.....	17
Priority populations	17
Low-income earners.....	18
The elderly	19
People with a disability.....	20

Indigenous Australians.....	21
Remote, rural and regional residents	23
People with chronic disease.....	26
Committee comment	28
Workforce distribution.....	30
Scope of practice	32
Public/private interface.....	35
Committee comment	36
Mix and coverage of services	39
Preventive services.....	40
Committee comment	41
4 Adult Dental Services National Partnership Agreement framework.....	43
Allocation of funding	43
Committee comment	44
Maintenance of effort.....	46
Committee comment	48
Accountability and reporting	49
Committee comment	53
Consistency across jurisdictions	54
Committee comment	56
Sustainable funding.....	57
Committee Comment	58
A coordinated approach.....	59
Committee comment	61
A strategic approach	62
Committee comment	65
Appendix A – List of submissions	69
Appendix B – List of public hearings and participants	73



Foreword

While advances in clinical practice and fluoridation of water have seen significant improvements, it is still the case that almost all Australians will experience an oral or dental health problem at some time in their lives. Currently, over 90 per cent of adults show signs of treated or untreated dental decay.

And yet, for many Australians the costs of accessing private dental services are prohibitive. Furthermore, with an estimated 400,000 adults on dental waiting lists across Australia, even those who qualify for public dental services frequently have to wait weeks or even months for treatment. What this points to, is a dental health system that is in need of significant reform.

In 2012 the Australian Government committed to a \$4.1 billion Dental Reform Package. Within the package, \$1.3 billion has been earmarked for the National Partnership Agreement (NPA) on Adult Dental Services, which is the focus of this inquiry. The NPA, to be delivered from 1 July 2014, will provide additional dental services in each of the states and territories to those adults who need it most.

During the inquiry the Committee considered how the NPA might be framed to optimise delivery of these additional public dental services. Importantly, with a history of dental health policy that is characterised by changing priorities and sporadic short-term funding, the Committee has also looked to the future. The Committee has recommended that the Australian Government continue to work with state and territory governments to achieve a coordinated, sustainable and strategic approach to dental policy.

Ultimately, the Committee would like to see a system that enables all Australians to access dental and oral health services – whoever they are, where ever they live and whenever they need them. I believe that implementation of the Dental Reform Package, including the Adult Dental Services NPA, represents significant progress toward achieving this worthy goal.

On behalf of the Committee, I would like to thank all those who participated in the inquiry by providing written submissions or attending the public hearings and roundtable discussions held in Canberra and Dubbo. I also thank Charles Sturt University for hosting the Committee's public hearing in Dubbo.

Ms Jill Hall MP
Chair



Membership of the Committee

Chair Ms Jill Hall MP

Deputy Chair Mr Steve Irons MP

Members Mr Mark Coulton MP

Ms Deborah O'Neill MP

Mr Steve Georganas MP

Mr Ken Wyatt MP

Mr Geoff Lyons MP

Committee Secretariat

Secretary Dr Alison Clegg

Inquiry Secretary Ms Renee Toy

Research Officers Ms Siobhán Leyne

Ms Emma White

Ms Belynda Zolotto

Administrative Officers Ms Fiona McCann

Ms Kathleen Blunden



Terms of reference

The National Partnership Agreement (NPA) for adult public dental services is a significant component of the Australian Government's Dental Care Reform Package. Under the NPA, from 1 July 2014, the Australian Government will provide funding to state and territory governments to expand services for adults in the public dental system.

To identify priorities and inform the NPA such that it can be framed to meet the particular and localised needs of each state and territory, the House of Representatives Standing Committee on Health and Ageing will inquire into and report on the provision of adult dental services.

Specifically, the Committee will consider:

- demand for dental services across Australia and issues associated with waiting lists;
- the mix and coverage of dental services supported by state and territory governments, and the Australian Government;
- availability and affordability of dental services for people with special dental health needs;
- availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations;
- the coordination of dental services between the two tiers of government and with privately funded dental services; and
- workforce issues relevant to the provision of dental services.



List of recommendations

3 Priority areas for adult dental services

Recommendation 1

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.

Recommendation 2

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

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.

Recommendation 4

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.

Recommendation 5

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.

4 Adult Dental Services National Partnership Agreement framework

Recommendation 6

The Australian Government, in negotiation with state and territory governments, develop a formula for the allocation of funding to state and territory governments under the Adult Dental Services National Partnership Agreement based on the size and distribution of priority population groups, including:

- concession card holder population;
- geographic spread of the population;
- the Indigenous population; and
- other priority population groups such as people with disabilities, people with chronic diseases, people on low incomes or people who are homeless.

Recommendation 7

The Australian Government include a 'maintenance of effort' clause in the Adult Dental Services National Partnership Agreement, similar to that included in the Dental Waiting List National Partnership Agreement. This clause should specify that state and territory governments must maintain public dental clinical activity for adults, so that additional funding provided under the Adult Dental Services National Partnership Agreement is used to increase current effort.

Recommendation 8

The Australian Government develop a performance and reporting framework for the Adult Dental Services National Partnership Agreement that will accurately and objectively assess progress towards achieving agreed benchmarks for service delivery and clinical outcomes.

In consultation with state and territory governments, and with private providers of dental services, consideration should be given to a range of key performance indicators that will allow for monitoring of:

- changes to the levels of clinical activity;
- preventive services as a proportion of all services delivered; and
- targeting of services to specific population groups.

In developing the performance and reporting framework, consideration must be given to making use of existing data collection and reporting systems to maximise administrative efficiency and minimise reporting burden.

Recommendation 9

The Australian Government include provision in the Adult Dental Services National Partnership Agreement that requires all signatories to commence negotiations for a new National Partnership Agreement (or alternative funding model) at least 12 months prior to its expiration.

Recommendation 10

The Department of Health and Ageing, in consultation with state and territory governments and other key stakeholders, examine the case to appoint a Commonwealth Chief Dental Officer or establish an independent advisory body to:

- improve coordination between the Australian Government, and state and territory governments;
- increase engagement with the private sector, particularly private providers of dental services; and
- provide independent policy advice on dental and oral health.

Recommendation 11

The Australian Government commit to a robust dental policy framework that guarantees the long-term sustainability of the public dental sector as a provider of dental services through ongoing funding support.

Recommendation 12

The Australian Government, in consultation with state and territory governments and other key stakeholders, establish and commit to an implementation strategy for the National Oral Health Plan 2014-2023.

Recommendation 13

The Australian Government adopt a strategic policy approach which supports deliberate and phased progress toward a universal access to dental services scheme for Australia.

Introduction

Background

- 1.1 The importance of good dental and oral health¹ to general health and wellbeing is well recognised. There are well established associations between poor dental and oral health, and acute or chronic health conditions such as heart disease and diabetes.² Furthermore, the pain associated with poor dental and oral health, coupled with social anxieties about appearance and avoidance of certain foods, can impact significantly on quality of life.
- 1.2 Although there have been substantial improvements in dental and oral health in Australia over the last century, the Australian Institute of Health and Welfare's (AIHW) publication *Australia's Health 2012* reports that almost everyone will experience an oral health problem at some time in the lives, and that over 90 per cent of adults show signs of treated or untreated dental decay.³
- 1.3 The same publication reports that dental and oral health tends to decline as people grow older. It also identifies inequalities in dental and oral health in some population groups, notably:
 - people on low incomes;

1 Dental and oral health is used as broad term to encompass both the health of teeth and gums.

2 Australian Institute of Health and Welfare (AIHW) 2012. *Chronic conditions and oral health*. Research report series no. 56. Cat. no. DEN 221. Canberra: AIHW, p. 1.

3 AIHW, *Australia's Health 2012*, p. 340.

- people with special care needs, including those with a disability and the elderly;
 - people living in rural and remote locations; and
 - Aboriginal and Torres Strait Islander people.
- 1.4 The reasons for the increased risk of oral disease in these populations are complex, but are generally associated with poor visiting patterns to dental and oral health services. For some this may be indicative of poor availability of dental services outside of metropolitan centres making access difficult. For others, a significant barrier may be the cost of accessing services.⁴ Public dental waiting lists also represent a barrier to care, with eligible patients often unable to afford to access services elsewhere.
- 1.5 In 2009-10 (the most recent year where data is available), total expenditure on dental services in Australia was \$7.7 billion. Around 62 per cent of this expenditure was borne by individuals through out-of-pocket payments, with another 14 per cent covered by private health insurance. Combining the out-of-pocket expenses with the private health insurance payments paid for by consumer premiums, around three quarters of the cost dental services is paid for by individuals. The remaining 24 per cent of expenditure is funded by Commonwealth or state/territory governments (16 per cent and 8 per cent respectively).⁵ This is in contrast to most other health services, where governments are responsible for around 70 per cent of expenditure.⁶
- 1.6 Dental services are available through the public and private sectors. State and territory governments provide the majority of public dental services and while eligibility requirements vary slightly between jurisdictions, generally access to public dental services for adults is restricted to concession card holders.⁷ Where public services are limited, some states

4 Harford JE, Ellershaw AC & Spencer AJ 2011. *Trends in access to dental care among Australian adults 1994–2008*. Dental statistics and research series no. 55. Cat. no. DEN 204. Canberra: AIHW, p. 44–55.

5 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. 38.

6 Australian Institute of Health and Welfare 2012. *Health expenditure Australia 2010–11*. Health and welfare expenditure series no. 47. Cat. no. HWE 56. Canberra: AIHW, p. 83.

7 Concession card holders are holders of a Pensioner Concession Card or Australian Health Care Card. Eligibility for these cards is determined by Commonwealth Government.

have a voucher system which enables concession card holders to access private dental services for emergency treatment.⁸

- 1.7 Treatments through the public system usually focus on providing emergency treatments, rather than preventive or restorative services. Even so, the demand for limited public dental services is such that there are significant waiting lists in all states and territories, with average waiting times of 27 months.⁹ For adults who are not eligible to access public dental services, treatment is only available through the private system.
- 1.8 For concession card holders and non-card holders alike, the AIHW found that a significant proportion of adults delayed or avoided seeking dental care due to the costs. The most recent data from 2008 indicates that around 46.7 per cent of card holders and 30.2 per cent of non-card holders had delayed seeking dental treatment in the previous 12 months due to the cost.¹⁰
- 1.9 Notwithstanding the evident importance of dental and oral health, the policy approach of successive governments has been piecemeal, and commitment to long-term strategies lacking. The 2012 announcement of the \$4.1 billion Dental Reform Package, which includes initiatives to expand public dental services for children and adults, and to invest in dental infrastructure and workforce, provides a robust framework to support a sustained approach to dental policy.¹¹ For dental and oral health to be integrated into promotional strategies to maintain and improve general health and well-being, significant reform encompassing a long-term, holistic approach to dental and oral health care will be needed.

Referral and scope of the inquiry

- 1.10 On 11 February 2013 the Minister for Health, The Hon Tanya Plibersek MP, referred the inquiry to the House of Representative Standing

8 See for example: Dental Health Services Victoria website, <www.dhsv.org.au/patient-information/vouchers/> viewed 29 May 2013.

9 Australian Dental Association (NSW Branch), *Submission 40*, p. 3. See also: *Report of the National Advisory Council on Dental Health*, February 2012, p. 50.

10 Harford JE, Ellershaw AC & Spencer AJ 2011. *Trends in access to dental care among Australian adults 1994–2008*. Dental statistics and research series no. 55. Cat. no. DEN 204. Canberra: AIHW, p. 47.

11 Department of Health and Ageing website, '*Dental Health: Dental Reform*', <www.health.gov.au/internet/main/publishing.nsf/Content/dentalreform> viewed 4 March 2013.

Committee on Health and Ageing (the Committee). The scope of the inquiry is set out in the terms of reference are at p. *ix*.

- 1.11 Specifically the Committee was asked to inquire into priorities for expanding adult dental services in the context of an Australian Government funding commitment to state and territory governments under a National Partnership Agreement (NPA).
- 1.12 NPAs are a key element of the federal financial relations framework with states and territories. They are supported under the Intergovernmental Agreement on Federal Financial Relations (the Intergovernmental Agreement), which:
- ... provides the overarching framework for the Commonwealth's financial relations with the States. It establishes a foundation for the Commonwealth and the States to collaborate on policy development and service delivery, and facilitate the implementation of economic and social reforms in areas of national importance.¹²
- 1.13 The Intergovernmental Agreement is intended to improve the quality and effectiveness of government services by reducing Commonwealth prescriptions on service delivery by the states and territories, providing them with increased flexibility in the way they deliver services.¹³
- 1.14 NPAs provide a mechanism to:
- support the delivery of specified outputs or projects;
 - facilitate reforms; or
 - reward those jurisdictions that deliver on nationally significant reforms.¹⁴
- 1.15 NPAs may also include Implementation Plans. Implementation Plans provide information on precisely how each signatory intends to achieve the NPA outcomes and outputs. Implementation Plans may be required

12 Ministerial Council for Federal Financial Relations website, <www.federalfinancialrelations.gov.au/Default.aspx>, viewed 29 April 2013.

13 Ministerial Council for Federal Financial Relations website, <www.federalfinancialrelations.gov.au/content/intergovernmental_agreements.aspx>, viewed 30 April 2013.

14 Ministerial Council for Federal Financial Relations website, 'National Partnerships', <www.federalfinancialrelations.gov.au/content/npa/default.aspx>, viewed 4 March 2013.

when there are contextual jurisdictional differences or when jurisdictional implementation approaches vary.¹⁵

Conduct of the inquiry

- 1.16 Following referral, the inquiry was publicised through a media release and via Twitter which directed interested parties to the relevant information on the Parliament of Australia website.¹⁶
- 1.17 Direct invitations to submit were sent to key stakeholders, including state and territory Ministers for Health, government health/human services departments, government dental services providers, peak bodies representing oral health professionals and consumer groups.
- 1.18 The inquiry received 46 submissions (Appendix A). The Committee held public hearings in Canberra and Dubbo (Appendix B).

Committee comment

- 1.19 The Committee acknowledges the context of the adult dental services inquiry and is aware of the principles that underpin the Intergovernmental Agreement and NPAs. In particular the Committee is aware of the Commonwealth Government's undertaking to be less prescriptive with regard to services and service delivery, and to allow greater flexibility for state and territory governments in this regard.
- 1.20 In this context, the Committee sees the inquiry as a means of progressing a process of consultation. The inquiry provides the opportunity for the Commonwealth, state and territory governments to give consideration to priorities for adult dental services before beginning formal negotiations for the NPA and associated Implementation Plans. It also provides the opportunity for other stakeholders to express their views on priority needs and suggest alternative or innovative approaches that might be used to achieve optimal outcomes.
- 1.21 On receiving the inquiry reference, significant efforts were made to engage with the relevant government portfolio agencies within each state and territory. Submissions were received from four of the eight state/territory

15 Ministerial Council for Federal Financial Relations website: 'Federal Finances Circular No 2011/04', <www.federalfinancialrelations.gov.au/content/guidelines_for_new_nps.aspx>, viewed 30 April 2013.

16 Parliament of Australia website, <www.aph.gov.au/dental>.

governments. State and territory government agencies that made submissions were also invited to participate at a public hearing. One state government accepted the invitation.¹⁷

- 1.22 The Committee has formulated its recommendations on the basis of the evidence received from a range of stakeholders. Although disappointed by the level of state and territory government engagement, the Committee anticipates that the outcomes of the inquiry will be used to inform development of the NPA and facilitate negotiation processes.

Structure of the report

- 1.23 Chapter 2 establishes the policy context for the inquiry. The Chapter presents a brief summary of Commonwealth Government involvement in funding of adult dental services. It considers the outcomes of recent policy reviews and agreements that provide the basis the current Dental Care Reform Package, which includes the NPA for adult dental services as a key component.
- 1.24 Chapter 3 examines in more detail the priorities that have been raised in evidence. In accordance with the terms of reference, consideration is given to the availability and access to services, particularly for special needs groups, workforce issues and the mix and coverage of services.
- 1.25 Chapter 4 examines a range of systemic issues associated with dental health services, and considers the general principles that might inform development of the NPA and dental health policy more generally.

17 Submissions were received from ACT Government; NSW Government and Tasmanian Government. A submission was also received from Dental Health Services Victoria (DHSV), a state government funded provider and purchaser of public dental services in Victoria. Representatives from the Tasmanian Government attended the public hearing in Canberra on 22 April 2013. A representative of DHSV also attended the public hearing in Canberra on 22 April 2013.

Dental Services in Australia

- 2.1 This chapter provides a brief overview of the factors associated with poor dental and oral health and the adult dental services framework in Australia. Detailed information on each of these issues is available from a number of authoritative sources. Rather than attempting to replicate this information, the intention is to highlight some key facts, and provide sufficient context to support consideration of issues arising in subsequent chapters.
- 2.2 The chapter also reviews developments in dental and oral health policy over time, concluding with a summary of the key initiatives being supported under the 2012 Dental Health Reform Package.

Factors associated with poor dental and oral health

- 2.3 The interaction of factors associated with poor dental and oral health is complex. As well as individual factors, there is a complex interplay of structural, social and economic factors. Factors associated with poor dental and oral health in adults include:
- Possession of a concession card: concession card holders are more likely to have poorer oral health compared to non-card holders. This is linked to unfavourable dental visiting patterns (i.e. do not visit the same dentist, do not visit yearly, seek treatment for a problem rather than for a check-up).¹
 - Access to public sector dental services: limited funding and workforce shortages within the public sector have been identified as contributing to the poorer oral health status of eligible patients.

1 *Report of the National Advisory Council on Dental Health*, February 2012, p. 9.

- Affordability of private care: in 2008, 46.7 per cent of concession card holders delayed dental treatment due to cost compared to 30.2 per cent of non-card holders.²
- Geography: remote, rural and regional residents have a higher rate of unfavourable visiting patterns at 38 per cent, which increases the risk of poor oral health, as compared to urban residents (27 per cent).³
- Workforce distribution: workforce is also predominantly centred around urban areas, with 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 practising in major cities.⁴
- Indigenous status: 40.2 per cent of Indigenous Australians have unfavourable visiting patterns as opposed to 28.2 per cent of non-Indigenous Australians.⁵
- Individual behaviour: diet and oral health behaviours contribute to oral health; for example, the consumption of bottled water may reduce the intake of fluoride (which provides a protective effect for teeth), and the consumption of sugary and acidic foods can lead to an increased risk of dental decay.⁶

2.4 The higher frequency of these factors in particular population groups means that some groups are more likely to have poor dental and oral health.⁷ The needs of these specific population groups are considered in more detail in Chapter 4.

Responsibility for adult dental services

2.5 The Australian health system is complex. Prior to 1946 the Commonwealth Government had limited responsibility for health services in Australia, this being confined to quarantine matters. However, following amendment to the Australian Constitution in 1946, the

2 Harford, JE, Ellershaw, AC and Spencer, AJ 2011. *Trends in access to dental care among Australian Adults 1994-2008*. Dental statistics and research series no. 55. Cat. no. DEN 204. Canberra: AIHW, p. 46.

3 *Report of the National Advisory Council on Dental Health*, February 2012, p. 44.

4 *Report of the National Advisory Council on Dental Health*, February 2012, p. 30-31.

5 *Report of the National Advisory Council on Dental Health*, February 2012, p. 44.

6 *Report of the National Advisory Council on Dental Health*, February 2012, p. 52.

7 Groups more likely to experience poor dental and oral health include: Concession card holders (e.g. aged pensioners, disability pensioners etc); remote, rural and regional residents; Indigenous Australians; frail and elderly people; low income workers; homeless people.

Commonwealth's powers were extended allow it to legislate with respect to:

The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances.⁸

- 2.6 As a result, responsibility for funding and provision of health services is now shared across all levels of government and the private sector. Generally, the Commonwealth sets national policy and contributes to health funding primarily through Medicare, the Pharmaceutical Benefits Scheme, Private Health Insurance rebates and direct payments to state and territory governments. States and territories (and to a lesser extent local governments) are responsible for funding and delivery of public health services. Private sector involvement through private health insurance and private sector service adds to the complexity of the system.
- 2.7 Unlike other health services, dental health services in Australia have not been generally covered by Medicare. The majority of dental services are paid for by individuals, with or without assistance from private health insurance. Public dental services are available in all states and territories. For adults, eligibility for these services is largely determined by eligibility for concession cards⁹, although type of concession cards and age eligibility vary across jurisdictions, as do co-payment requirements.¹⁰
- 2.8 Waiting times for public dental services are often long (between two and five years in some areas), with up to 400,000 adults on waiting lists across Australia. Treatment is often focused on emergency care rather than the provision of preventive or restorative services.¹¹ Public dental services also offer denture services to patients, but waiting times are long and patients may have to wait months for an appointment.¹² Those on waiting lists are generally lower-income individuals who often have no choice but to wait for care.

8 Section 51 xxiiiA of the Australian Constitution.

9 Over five million adults are concession card holders in Australia

10 *Report of the National Advisory Council on Dental Health*, February 2012, pp. 21, 94-96.

11 *Report of the National Advisory Council on Dental Health*, February 2012, pp. 16, 21, 50.

12 Dental Health Services Victoria (DHSV), *Submission 32*, p. 6.

Overview of Commonwealth dental policy

2.9 Australia's first national oral health plan was developed by the National Oral Health Advisory Committee and endorsed by AHMAC in 2004. The purpose of the plan was to 'improve health and well-being across the Australian population by improving oral health status and reducing the burden of disease'.¹³ The plan identified the following seven areas for action:

- promoting oral health across the population;
- children and adolescents;
- older people;
- low income and social disadvantage;
- people with special needs;
- Aboriginal and Torres Strait Islander peoples; and
- workforce development.¹⁴

2.10 An updated national oral health plan for 2014-23 is currently being developed by a subcommittee of the National Oral Health Plan Monitoring Group to be finalised by the end of 2013.¹⁵

2.11 Established in 2008 the National Health and Hospitals Reform Commission (NHHRC) was tasked with providing a long term health reform plan for Australia. In 2009, the NHHRC reported proposing a range of health measures across many health areas¹⁶. The outcomes included six recommendations for dental health, including Recommendation 83 which proposed:

We recommend that all Australians should have universal access to preventive and restorative dental care, and dentures, regardless of people's ability to pay. This should occur through the establishment of the 'Dentcare Australia' scheme. Under the 'Dentcare Australia' scheme, people will be able to select between private or public dental health plans. 'Dentcare Australia' would meet the costs in both cases. The additional costs of Dentcare

13 National Oral Health Advisory Committee 2004, *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2004-2013*, p. v.

14 National Oral Health Advisory Committee 2004, *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2004-2013*, p. 4.

15 Department of Health and Ageing (DoHA), *Submission 34*, p. 8.

16 National Health and Hospitals Reform Commission (NHHRC) 2009. *A Healthier Future For All Australians – Final Report, Recommendations* p. 26.

could be funded by an increase in the Medicare Levy of 0.75 per cent of taxable income.¹⁷

2.12 In its response to the NHHRC Final Report, the Government stated with regard to Recommendation 83:

The Government supports the recommendation's aim of increasing access to dental care. The Government is seeking to introduce better targeting of dental services to those Australians most in need through the closure of the existing Medicare chronic disease dental scheme, with saving redirected to the proposed Commonwealth Dental Health Program and Medicare Teen Dental Plan. However, the proposed legislative changes have been blocked by the Senate.¹⁸

2.13 In the 2011-12 Budget, funding was allocated for a National Advisory Council on Dental Health (NACDH) to:

... assist the Government through the development and provision of advice to the Minister for Health and Ageing on dental health, including prioritising areas for improvement.¹⁹

2.14 In September 2011, the NACDH was established to provide 'strategic, independent advice on dental health issues, as requested by the Minister for Health and Ageing, to the Government'. Its priority task was to provide advice on dental policy options and priorities for consideration in the 2012-13 Budget.²⁰

2.15 In its report, the NACDH considered:

- the scope of the problem, for both adults and children, by comparing oral health indicators across different income levels, private health insurance status, looking at effects on health and wellbeing linked to poor oral health, and the flow-on effects to the broader health system;
- the dental system, including funding arrangements and workforce issues;
- gaps in service provision and funding; and
- causes of poor oral health.

17 NHHRC 2009. *A Healthier Future For All Australians – Final Report*, Recommendations p. 26.

18 *A National Health and Hospitals Network for Australia's Future – Delivering better health and better hospitals*. Commonwealth of Australia 2010, Appendix C – *Response to the National Health and Hospitals Reform Commission Final Report*, p. 152.

19 Budget Paper No 2, 2011-12, p. 216.

20 *Report of the National Advisory Council on Dental Health*, February 2012, p. 87.

- 2.16 The NACDH provided its options for dental funding to the Minister for Health and Ageing, the Hon Tanya Plibersek MP, in February 2012. These included:
- Children
 - ⇒ A universal individual capped benefit entitlement for all children up to the age of 18, providing basic dental preventive services and general treatment through both the public and private dental sectors;
 - ⇒ Universal public dental access for children, providing basic dental preventive services and general treatment through the public sector. Concession card holder children would have no co-payments, where non-concession card holders may have limited co-payments;
 - Adults
 - ⇒ Means tested individual capped benefit entitlement for adults – concession card eligible only, providing basic dental preventive services and general treatment through both the public and private dental sectors;
 - ⇒ Means tested public dental access for adults – concession card eligible only, providing basic dental preventive services and general treatment;
 - Children and adults
 - ⇒ Integrated options could be developed using the above options.
- 2.17 Each option included methods of scaling the implementation based on different eligibilities (i.e. concession card holders, recipients of different Government payments) as well as including chronic disease patients.²¹

Commonwealth support for dental services

- 2.18 Successive governments have held different views of the Commonwealth's role in funding public dental services. As a result over the years there have been various policy approaches and programs which have affected funding and support of dental services by the Commonwealth.
- 2.19 The Commonwealth's first major involvement in supporting dental services came about in 1973 with the implementation of the Australian School Dental Program, which aimed to provide comprehensive dental treatment for all Australian school children up to the age of 15 years. By

21 *Report of the National Advisory Council on Dental Health*, February 2012, pp. 91–93.

- the early 1980s direct funding for this program from the Commonwealth had ceased.²²
- 2.20 In 1994 funding was provided for the Commonwealth Dental Health Program (CDHP) which aimed:
- ... to improve the dental health of financially disadvantaged adults, reduce barriers to dental care, ensure equitable access and improve prevention and early intervention.²³
- 2.21 The CDHP was discontinued in 1997 and although direct funding of dental services by the Commonwealth declined significantly at this time, indirect funding increased with the introduction of rebate incentives for private health insurance.
- 2.22 In 2004, the Chronic Disease Dental Scheme (CDDS) was implemented as part of the Allied Health and Dental Care Initiative (AHDCI). The CDDS provided limited Medicare benefits for dental services available to people whose chronic conditions were significantly exacerbated by dental problems.²⁴
- 2.23 In 2007 the newly elected Labor Government announced that it intended to close the CDDS and redirect the funds to a revived CDHP from July 2008. The Government also committed to a scheme to provide annual dental check-ups for eligible teenagers (12 to 17 years old) though the means tested Medicare Teen Dental Plan (MTDP). Although the MTDP was introduced in July 2008, closure to the CDDS was blocked by the Senate and the CDHP was not implemented.
- 2.24 In late 2012, after the announcement of a \$4.1 billion Dental Reform Package the CDDS was discontinued, closing to new patients on 8 September 2012 and with no further treatment available to exiting patients after 30 November 2012.

Dental Reform Package

- 2.25 In forming Government in 2010, the agreement between the Australian Greens Party and the Australian Labor Party stated in part (Clause 6.1 (b)):

22 Biggs, A 2008, *Overview of Commonwealth involvement in funding dental care*. Parliamentary Library, no. 1, ISSN 1834-9854.

23 D S Brennan, K D Carter, J F Stewart, A J Spencer, *Commonwealth Dental Health Program Evaluation Report 1994–1996*, AIHW, Dental Statistics and Research Unit, AIHW, Adelaide, 1997, p. 6.

24 Biggs, A 2008, *Overview of Commonwealth involvement in funding dental care*. Parliamentary Library, no. 1, ISSN 1834-9854.

That Australia needs further action on dental care and that proposals for improving the nation's investments in dental care should be considered in the context of the 2011 Budget.²⁵

2.26 The 2011-12 Budget identified that:

In line with the Government's agreement with the Australian Greens, the Government has committed that significant reforms to dental health will be a priority for the 2012-13 Budget.²⁶

2.27 In accordance with the Agreement with the Greens, and informed by the outcomes of the NACDH the 2012-13 Budget included funding measures for dental described as 'foundational activities'. These foundational activities include:

- \$345.9 million over three years to alleviate pressure on public dental waiting lists;
- \$158.6 million over four years to increase the capacity of the dental workforce (expanded over previously announced workforce measures);
- \$10.5 million for oral health promotion activities; and
- \$450,000 for *pro bono* dental service provision.

2.28 On 29 August 2012, the Minister for Health, the Hon Tanya Plibersek MP, announced a \$4.1 billion Dental Reform Package. The package which will replace the CDDS and the MTDP²⁷ includes:

- \$2.7 billion over six years for a Child Dental Benefits Schedule (CDBS) - *Grow Up Smiling* a child dental health program which will provide a capped benefit entitlement for basic dental services for eligible children aged 2 to 17 years. The CDBS will start on 1 January 2014 and replace the MTDP which will cease to operate on 31 December 2013;
- \$1.3 billion over four years for a National Partnership Agreement (NPA) to expand public dental services for around 1.4 million low income adults. The NPA will commence on 1 July 2014 and replaces the now discontinued CDDS;
- \$225 million over four years for a Flexible Grants Program for dental infrastructure in outer metropolitan, rural and regional areas to reduce barriers to accessing public dental services for people living in those areas; and

25 The Australian Greens and the Australian Labor Party Agreement, 1 September 2010.

26 Budget Paper No 2, 2011-12, p. 216.

27 The Hon Tanya Plibersek MP, Minister for Health, Media Hub, <www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-tp-tp074.htm?OpenDocument&yr=2012&mth=08> viewed 4 March 2013

- \$77.7 million for the Dental Relocation and Infrastructure Support Scheme to assist dentists to relocate into regional and remote communities.²⁸

Committee comment

- 2.29 As noted in Chapter 1, the scope of the inquiry as defined by the terms of reference is confined to consideration of the Commonwealth's \$1.3 billion commitment to a NPA to expand public dental services for adults (adult dental services NPA). However, the Committee understands that an adult dental services NPA has to be considered in a context which acknowledges the effects of the wider package of dental reform.
- 2.30 The implications of foundational activities are also key considerations. Of particular relevance to the current inquiry is the \$345.9 million for a NPA (Dental Waiting List NPA) to alleviate pressure on public dental waiting lists. In addition, consideration will be given to a number of general policy issues associated with the implementation of the Dental Reform Package. This will include consideration of the need for a better coordinated and strategic approach to dental health policy and delivery of dental services.

28 DoHA website, '*Dental Health: Dental Reform*', <health.gov.au/internet/main/publishing.nsf/Content/dentalreform> viewed 4 March 2013; DoHA, *Submission 34*, p. 5.

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:

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:

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.

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

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:

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

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.

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 Health 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).

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 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

- 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 voucher⁶¹ 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 Dr 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.

Adult Dental Services National Partnership Agreement framework

4.1 This chapter considers structural aspects of the Adult Dental Services National Partnership Agreement framework. In considering this the Committee has identified a number of key principles which it believes should form the foundation for negotiations between the Commonwealth, and states and territories. The chapter also examines the broader policy context and the importance of a coordinated and strategic approach to public dental health policy and service delivery.

Allocation of funding

4.2 The Commonwealth Government has committed \$1.3 billion to state and territory governments to support additional dental services for adults. This funding will be provided through a National Partnership Agreement for adult dental services (the Adult Dental Services NPA). As noted earlier in the report, the Intergovernmental Agreement on Federal Financial Relations sets out a framework 'which will provide a robust foundation for collaboration on policy development and service delivery and facilitate the implementation of economic and social reforms in areas of national importance'.¹ The Adult Dental Services NPA, which will provide funds to the states and territories to provide public dental services based on mutually agreed outcomes, will sit under this framework.

4.3 Although the total funding for the Adult Dental Services NPA has been announced, the allocation of funding to individual states and territories is yet to be determined. It is anticipated that the allocation of funds will be

1 Intergovernmental Agreement on Federal Financial Relations, pp. 1-2.

determined on the basis of a formula that takes into account a number of factors.

- 4.4 An example of how funding allocation is determined is provided by the current Dental Waiting List NPA. The Dental Waiting List NPA provides Commonwealth Government funding to the states and territories based on the number of health care and pensioner concession card holders in each jurisdiction. In essence, this provides states and territories with a share of funding based on the population of people eligible for public dental services in each jurisdiction (concession card holders). An additional loading is provided to Tasmania, the ACT and the NT to account for their smaller populations.²
- 4.5 While basing funding on the concession card holder population is comparatively straightforward, evidence suggests that the cost of delivering services varies depending on location (based on the Australian Statistical Geography Standard (ASGS)), Indigenous status and individual needs.³
- 4.6 For example, the submission from the National Oral Health Steering Group observes:
- The cost and complexity of provision of care in rural and remote locations is far greater than in metropolitan areas. This should be reflected in any funding model.⁴
- 4.7 The Australian Healthcare and Hospitals Association (AHHA) have also advocated for the NPA to acknowledge the additional costs of providing treatment to patients in rural and remote locations and for a proportion of funding to be quarantined for services to Aboriginal and Torres Strait Islander people.⁵ The National Aboriginal Community Controlled Health Organisation (NACCHO) estimates that a weighting of 30 per cent for Indigenous Australians is necessary to appropriately provide services to this group.⁶

Committee comment

- 4.8 Allocation of funding based on the total eligible population numbers in each jurisdiction ensures that the Commonwealth Government is

2 Department of Health and Ageing (DoHA), *Submission 34*, p. 2. See also: Ms Flanagan, *Official Committee Hansard*, Canberra, 12 March 2013, p. 10.

3 National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 29*, p. 2.

4 National Oral Health Promotion Steering Group, *Submission 22*, p. 2.

5 Ms Prue Power, Australian Healthcare and Hospitals Association (AHHA), Canberra, 22 April 2013, *Official Committee Hansard*, p. 7.

6 Ms Lisa Briggs, NACCHO, Canberra, 22 April 2013, *Official Committee Hansard*, p. 15.

providing equal funding for each eligible individual. While being easy to manage administratively this may not represent the fairest way to allocate funds. Providing funding to states and territories in this way may unintentionally impose restrictions on providing services, as it does not take into account variations in state and territory priority groups that may require funding above average levels to receive appropriate dental treatment.

- 4.9 The Committee agrees that there is a need for further consideration of the formula used to allocate the proportion of funding to the states and territories under the Adult Dental Services NPA. While not necessarily an exhaustive list of factors that might be taken into account, the funding formula could include loadings to reflect differences in the size and distribution of priority population groups, including:
- concession card holder population;
 - geographic spread of the population;
 - the Indigenous population; and
 - other priority population groups such as people with disabilities, people with chronic diseases, people on low incomes or people who are homeless.
- 4.10 As with the Dental Waiting List NPA, an additional loading for states and territories with smaller populations may also be appropriate.

Recommendation 6

The Australian Government, in negotiation with state and territory governments, develop a formula for the allocation of funding to state and territory governments under the Adult Dental Services National Partnership Agreement based on the size and distribution of priority population groups, including:

- concession card holder population;
- geographic spread of the population;
- the Indigenous population; and
- other priority population groups such as people with disabilities, people with chronic diseases, people on low incomes or people who are homeless.

Maintenance of effort

4.11 A key principle for the Adult Dental Services NPA is that it provides funding to state and territory governments to support additional adult dental services. The importance of maintaining current services in the lead up to implementing the Adult Dental Services NPA was emphasised by the Public Health Association of Australia (PHAA) which submitted:

[The NPA] must require states and territories to maintain their current effort or the potential gains will be minimised by cost shifting.⁷

4.12 However, concern was raised that state and territory governments were scaling back efforts to support public dental services in anticipation of receiving additional Commonwealth support through the NPA. For example, the NSW Oral Health Alliance stated:

Over the past five years, NSW governments' anticipation of Commonwealth oral health reform has in effect frozen state-level investment in public dental services.⁸

4.13 While maintenance of funding provides a simple measure to determine ongoing state and territory financial commitment to dental health services, it does not necessarily provide the most meaningful measure. This was

7 Public Health Association of Australia (PHAA), *Submission 12*, p. 5.

8 NSW Oral Health Alliance, *Submission 36*, p. 8. See also: Australian Dental Association (ADA) (NSW Branch), *Submission 40*, p. 9; Ms Julie Barker, Australian Dental and Oral Health Therapists' Association (ADOHTA), *Official Committee Hansard*, Canberra, 23 April 2013, p. 10.

explained further in the following testimony by a representative of the Department of Health and Ageing (DoHA), who observed:

If [state and territory governments] are able to maintain their baseline activity and do the additional activity we want while spending less of their own money, then that is an efficiency saving, and that is probably a good thing.⁹

- 4.14 Adding to consideration of this issue, representatives of DoHA advised that Clause 5 of the Dental Waiting List NPA specifies that in order to achieve agreed outcomes states and territories must maintain existing efforts:¹⁰

... for this agreement to have the desired impact on public dental services it is essential that the States' clinical activity related to public dental services, child, adult and special needs patients, is maintained and not withdrawn and redirected away from dental services, and that investments under this agreement are additional to such effort.¹¹

- 4.15 DoHA explained that 'effort' under the Dental Waiting List NPA is measured in terms of notional units of clinical activity known as Dental Weighted Activity Units (DWAUs). Assessment of DWAUs supplied to the Commonwealth prior to state and territory governments signing the NPA provides a baseline measure. Additional effort is assessed against this baseline.

- 4.16 Application of this assessment system to the Dental Waiting List NPA was described by DoHA in more detail as follows:

The [Dental Waiting List] NPA is framed to allow an initial up-front payment of \$69.2 million to assist the states and territories in building capacity for dental infrastructure and workforce. From June 2013 until 2015, the remaining funds of \$274.8 million will be tied to performance targets measured against the 2011-12 baseline. States will need to achieve at least 65% of their target to receive a proportion of the total funds available for that period.

All targets will be expressed in terms of Dental Weighted Activity Units (DWAU), calculated using the Australian Dental Association three digit item codes, and a weighting included as a Schedule to the Agreement. The performance indicators will measure the clinical activity of the states and territories to ensure that they use

9 Mr Charles Maskell-Knight, DoHA, *Official Committee Hansard*, Canberra, 12 March 2013, p. 6.

10 Mr Charles Maskell-Knight, DoHA, *Official Committee Hansard*, Canberra, 12 March 2013, p. 3.

11 Ms Kerry Flanagan, DoHA, *Official Committee Hansard*, Canberra, 23 April 2013, p. 49.

the Commonwealth funds to provide services beyond their current levels.¹²

Committee comment

- 4.17 Funding provided under the Adult Dental Services NPA is intended to supplement existing state and territory effort. In providing this additional funding the aim is to increase access to public dental services for those who need it most.
- 4.18 To ensure that funding provided through the Adult Dental Services NPA is used to provide additional dental services the Committee believes that a baseline assessment of current effort is essential. Establishing agreed benchmarks for expansion of dental services and processes for monitoring progress thereafter is clearly critical to assessing whether additional services are in fact being provided.
- 4.19 The Committee believes that the Adult Dental Services NPA should include a 'maintenance of effort' clause, similar to the clause included in the Dental Waiting List NPA, that measures increased effort in terms of higher levels of dental activity and improved clinical outcomes against an established baseline.

Recommendation 7

The Australian Government include a 'maintenance of effort' clause in the Adult Dental Services National Partnership Agreement, similar to that included in the Dental Waiting List National Partnership Agreement. This clause should specify that state and territory governments must maintain public dental clinical activity for adults, so that additional funding provided under the Adult Dental Services National Partnership Agreement is used to increase current effort.

- 4.20 While acknowledging concerns expressed that state and territory governments might reduce their own expenditure on dental services, the Committee notes that equating effort to level of expenditure only will provide an overly simplistic representation of the public dental system. A more meaningful assessment of effort should take into account levels of service provision and clinical outcomes. As long as agreed service delivery and clinical activity benchmarks are being met, expenditure decreases may reflect efficiencies in service delivery.

12 DoHA, *Submission 34*, p. 3.

- 4.21 Accountability and reporting requirements are considered in more detail below. Further consideration will be given to DWAUs and how these units might be used to assess changes to the levels of clinical activity and types of dental services provided by states and territories.

Accountability and reporting

- 4.22 State and territory governments, and those responsible for delivery of adult dental services, have indicated that the NPA should not include ‘onerous and difficult reporting’¹³ and that there ‘be a reduction in administrative burden’.¹⁴ In relation to this, Ms Prue Power, Chief Executive, AHHA, stated:
- It is critical that the data collection and reporting of activity levels required by the Commonwealth are not excessive. That is a key principle of the National Health Reform Agreement – to reduce the burdens of administration.¹⁵
- 4.23 However, given the nature of the NPA framework and the financial requirements related to it, agreed benchmarks and key performance indicators (KPIs) are needed to measure progress and outcomes.
- 4.24 For example, performance and monitoring under the Dental Waiting List NPA requires states and territories to report on the following KPIs:
- Number of patients receiving dental services;
 - Number of patients on dental waiting lists;
 - Waiting time for patients on public dental waiting lists;
 - Number of children and adults receiving specialist or general anaesthetic services;
 - Number of dental occasions of service provided; and
 - The number of additional Dental Weighted Activity Units (DWAUs).¹⁶
- 4.25 Clearly, specific benchmarks and KPIs for the Adult Dental Services NPA will need to be developed and negotiated. However, evidence to this

13 Dental Health Services Victoria (DHSV), *Submission 32*, p. 17.

14 ACT Health, *Submission 30*, p. 1.

15 Ms Prue Power, AHHA, *Official Committee Hansard*, Canberra, 22 April 2013, p. 8.

16 Ms Janet Anderson, DoHA, *Official Committee Hansard*, 22 April 2013, Canberra, p. 49.

inquiry has questioned the validity of one of the commonly used measures of dental need; that is, the number of patients on dental waiting lists.¹⁷

4.26 For example, the submission from Dental Health Services Victoria states:

Public dental waiting lists in Victoria do not reflect the true or potential demand for care by the eligible population. Across Australia, waiting lists have been used as demand management tools and have assisted to suppress the true need for dental care of the eligible population.¹⁸

4.27 As explained further in the submission made by the NSW Ministry of Health:

Waiting lists are poor measures of unmet demand for dental services as they do not include adults who for various reasons are not seeking access to dental care even when they need it. In NSW this includes adults with poor dental health, who are not eligible for public dental services and cannot afford private dental care.¹⁹

4.28 Additionally, the Loddon Mallee Region Oral Health Network states:

The public dental waiting lists potentially do not account for those people who [are] unaware of the importance of dental care or their eligibility for public dental services or those that experience access barriers such as lack of public and private transport options, mobility issues, cultural reasons etc.²⁰

4.29 Services for Rural and Remote Allied Health (SARRAH) provides the following perspective on dental waiting lists:

SARRAH believes it is time that political parties of all persuasions realise that waiting lists are a political measure, not a measure of access to dental care. Waiting list times and lengths can be manipulable to suit political ends. For example, methods of creating a short waiting list may include instructing dental practitioners:

- not to do full oral examinations and provide a very limited range of dental services;
- not to inform patients that there is a waiting list;
- to inform patients who become aware of a waiting list that it is many years long;

17 ADA, *Submission 37*, p. 4. See also: Australian and New Zealand Academy of Special Needs Dentistry (ANZSND) and the Australian Society of Special Care in Dentistry (ASSCD), *Submission 21*, p. 2; NSW Oral Health Alliance, *Submission 36*, p. 5.

18 DHSV, *Submission 32*, p. 6.

19 NSW Ministry of Health, *Submission 24*, p. 3.

20 Loddon Mallee Region Oral Health Network, *Submission 20*, p. 1.

- to audit the waiting list by contacting patients and removing those who do not respond within a short period of time from the list; and
 - to redefine the waiting list into a number of lists such as placing those who have had treatment in the last year on a recall list, not a waiting list.²¹
- 4.30 An additional concern in relation to the use of waiting lists as a measure of demand is that those treated in the public dental system includes those individuals in need of emergency treatment.²² These patients are generally triaged and provided an appointment in a short space of time.²³ These patients usually do not appear on waiting lists. Furthermore, triaging and responding to emergency cases also has effects on waiting times for those already on public dental waiting lists.²⁴
- 4.31 However, and as illustrated by the Dental Waiting List NPA, it is usual practice to have a range of KPIs, rather than a single measure to assess outcomes.
- 4.32 The submission from Queensland's Minister for Health, Hon Lawrence Springborg MP, advocates for:
- ... performance benchmarks based on improvements in service outcomes, not just increases in service activity for example, questioning if waiting times for routine dental care are reducing, or if access to emergency care has improved.²⁵
- 4.33 The Consumer Health Forum (CHF) has proposed that a range of KPIs be developed for the Adult Dental Services NPA under the following items:
- community-wide oral health promotion and community education;
 - planning for and provision of dental services for high-risk consumers according to need, including provision of general services, emergency care and more complex treatments;
 - dental health service infrastructure and programs for hard to reach populations;
 - water fluoridation, particularly in centres with populations of 1000 or above;

21 Services for Rural and Remote Allied Health (SARRAH), *Submission 3*; p. 4, ADA, *Submission 37*, p. 4.

22 ADA, *Submission 40*, p. 4; Mr Andrew McAuliffe, AHHA, *Official Committee Hansard*, Canberra, 22 April 2013, p. 8.

23 Ms Emma Bridge, Oral Health Services Tasmania, *Official Committee Hansard*, Canberra, 22 April 2013, p. 33; Ms Jennifer Floyd, Western NSW Local Health District, *Proof Transcript of Evidence*, Dubbo, 17 May, 2013, p. 10.

24 DHSV, *Submission 32*, p. 6.

25 Hon Lawrence Springborg MP, *Submission 43*, p. 2.

- the elimination of co-payments for pensioner and Health Care Card holders; and
 - reducing the number of emergency presentations by pensioner and health care card holders and increasing the percentage of card holders receiving regular check-ups and preventive care.²⁶
- 4.34 Whatever the agreed benchmarks and KPIs, collection of dental data and statistics remains a fundamental challenge. As noted by DoHA:
- There are currently gaps in existing dental and oral health data sources. Specifically, there is a lack of data about adults accessing publicly-funded dental services and visits to private dental services.²⁷
- 4.35 To address some of the concerns associated with dental waiting list data specifically, DoHA noted that the Australian Institute of Health and Welfare (AIHW) has developed the Public Dental Waiting Times National Minimum Data Set (PDWT NMDS). The PDWT NMDS will ‘collect information on waiting times for people placed on public dental service waiting lists in all states and territories, measuring the time between placement on the list and the date an offer of care is made, or care received.’ The PDWT NMDS will be implemented from 1 July 2013.²⁸
- 4.36 Also, as noted earlier in this chapter, the Dental Waiting List NPA includes a KPI which measures progress toward clinical activity benchmarks in terms of DWAUs. Evidence suggests that the use of DWAUs as a measure to more accurately assess clinical activity and outcomes is subject to ongoing development:
- ... we are still looking at the data set which is going to best inform the Commonwealth, as essentially funder or purchaser of services under the expanded package. This is the first time we have actually engaged with states and territories on this notional unit called DWAU. It would be fair to say that we are all learning how to use it and how it can be best applied to a monitoring regime. ... That is something we are being very open about in our discussions with states and territories – that we are feeling our way into this space and look to do so collaboratively.²⁹

26 Consumer Health Forum of Australia (CHF), *Submission 15*, p. 10.

27 DoHA, *Submission 34*, p. 8.

28 DoHA, *Submission 34*, p. 8.

29 Ms Janet Anderson, DoHA, *Official Committee Hansard*, Canberra, 22 April 2013, p. 50.

- 4.37 In order to maximise reporting efficiency, it was proposed that consideration be given to the use of existing data collection and reporting systems.³⁰

Committee comment

- 4.38 To support the principle of accountability the Commonwealth Government must have appropriate oversight of the NPA and the services delivered under it. The Committee understands that this is achieved by placing reporting requirements on jurisdictions to monitor progress towards agreed outcomes. At the same time, the Committee is also aware of the need to ensure that reporting is not unnecessarily onerous.
- 4.39 With regard to the Dental Waiting List NPA, the Committee notes that the current KPIs are not solely based on public dental waiting list numbers. Given the concerns expressed in relation to limitations of this KPI as a measure of unmet demand for services, inclusion of a wider suite of KPIs would seem justified. The Committee is optimistic that work being undertaken by the AIHW to establish a PDWT NMDS will alleviate these concerns.
- 4.40 As the Dental Waiting List NPA and the Adult Dental Services NPA will overlap by 12 months, it will be important to ensure that any reporting requirements over this period are managed appropriately. In particular, consideration should be given to making use of dental data and statistics already collected by states and territories to streamline reporting for the two NPAs, maximising administrative efficiency and minimising reporting burden.
- 4.41 Establishing benchmarks and KPIs for the Adult Dental Services NPA will need to be negotiated between the Commonwealth and the states and territories. The Committee also recognises that to be effective, KPIs must be clearly defined, measurable and based on outcomes that are achievable.
- 4.42 While the KPIs used for the Dental Waiting List NPA could provide a starting point for negotiations, development of an altered or expanded range of KPIs that address the unique objectives of the Adult Dental Services NPA will be essential. In addition to assessing increases in clinical activity over baselines, the Committee would like to see the inclusion of KPIs that have the capacity to monitor agreed outcomes, including shifts in the type of service being delivered (e.g. from emergency to preventive) and delivery of services to specific population groups.
- 4.43 To monitor shifts in the type of services delivered or targeting of services it may be possible to adapt DWAs by applying weighting to agreed

30 Hon Lawrence Springborg MP, *Submission 43*, p. 2.

priority outcomes. The Committee notes that work on the use of DWAUs as a tool to monitor clinical activity is still in progress. The Committee also supports the collaborative approach that has been adopted to progress this.

Recommendation 8

The Australian Government develop a performance and reporting framework for the Adult Dental Services National Partnership Agreement that will accurately and objectively assess progress towards achieving agreed benchmarks for service delivery and clinical outcomes.

In consultation with state and territory governments, and with private providers of dental services, consideration should be given to a range of key performance indicators that will allow for monitoring of:

- **changes to the levels of clinical activity;**
- **preventive services as a proportion of all services delivered;**
and
- **targeting of services to specific population groups.**

In developing the performance and reporting framework, consideration must be given to making use of existing data collection and reporting systems to maximise administrative efficiency and minimise reporting burden.

Consistency across jurisdictions

4.44 A number of submissions have observed that the type of dental services, eligibility requirements for access, and co-payments for services differ between states and territories. As noted by SARRAH:

There is also limited coordination of dental services between State and Territory Governments. The State and Territory Governments have different rules and systems for supplying dental care. A meeting between these government oral health administrators is needed to develop a consistent set of rules for supplying public dental care across Australia.³¹

4.45 The submission from the Australian Dental Association (ADA) observes:

31 SARRAH, *Submission 3*, p. 8. See also: Dental Hygienists Association of Australia (DHAA), *Submission 2*; Mr Thomas Higgins, *Submission No 31*.

There is no consistency in the eligibility criteria for those entitled to treatment in the public sectors. Some offer dental care to all children, some only to a subset of children. All state and territories provide dental care to those that hold a form of concession card. In some states/territories, patients are required to make a co-payment for services while in others there is no additional charge to the patient.³²

4.46 Also noting that co-payment practices vary considerably between states and territories, a representative of DoHA provided the following testimony:

Queensland do not have any co-payments – that might be why they have the longest waiting lists; New South Wales have co-payments for some specialist dental services and some dentures; Victoria has a range from \$25 for emergency, \$100 for general course of care, up to \$120 for dentures; Tasmania hits everybody for \$25 up to maximum of \$366 for course of care ... [t]he Northern Territory does not have any; WA has a sliding scale; ACT has an annual maximum ...³³

4.47 Differences between states and territories in relation to scope of practice limitations that apply particularly to dental and oral therapists were also raised. Inconsistency in scope of practice restrictions means workforce limitations are more significant in some jurisdictions than in others. As submitted by the Australian Dental and Oral Health Therapists' Association (ADOHTA):

Currently, limits are placed on dental and oral health therapists based upon the level of tertiary training in the state they work in. In Victoria a dental therapist is allowed to treat patients up to the age of 25, whereas dental and oral health therapists in Queensland are restricted to working on patients from between four and 18 years of age.³⁴

4.48 While there was general support for greater cross-jurisdictional consistency, the context of the Dental Reform Package as part of the Federal Financial Relations Framework provides flexibility for state and territory governments to determine priorities for services and service delivery. In relation to this, DoHA provides the following advice:

32 ADA, *Submission 37*, p. 5.

33 Mr Charles Maskell-Knight, DoHA, *Official Committee Hansard*, Canberra, 12 March 2013, p. 10.

34 ADOHTA, *Submission 19*, p. 3.

The [adult dental services] NPA's deliverables will be customised for each state and territory depending on the demonstrated local needs and progress under the 2012-13 Dental Waiting List NPA.³⁵

- 4.49 Similarly the submission from ACT Health emphasises that in order to comply with the principles of the Intergovernmental Agreement on Federal Financial Relations, the Commonwealth Government should focus more on agreed outcomes and be less prescriptive in relation to service delivery, stating:

The ACT Health Directorate expects the Commonwealth uphold its commitment to move away from prescriptions on service delivery in the form of financial or other input controls, which inhibit state service delivery and priority setting, and instead, focus on the achievement of mutually agreed outcomes, providing the states and territories with increased flexibility in the way services are delivered.³⁶

Committee comment

- 4.50 While acknowledging that variations to the type of dental services, eligibility requirements for access, and co-payments between jurisdictions exist, the Committee believes that the most important consideration is to increase availability and access to public dental services for those who need it most. Although national consistency would ensure that all Australians have access to the same public dental services wherever they are and whatever their age, the Adult Dental Services NPA is being developed in a framework which aims to provide states and territories with maximum flexibility for delivering services.
- 4.51 In the context of this framework, the Committee understands that there is some scope, albeit rather limited, for the Adult Dental Services NPA to promote a degree of national consistency for adult dental services. For example, this may be achieved through an NPA which includes benchmarks and KPIs to promote the delivery of particular service types or prioritises access for particular population groups. However, the benefits of national consistency need to be offset against the basic principle that supports the rights and responsibilities for states and territories to prioritise and shape services to meet particular and localised needs.

35 Department of Health and Ageing website, 'Dental Health: Dental Reform', <www.health.gov.au/internet/main/publishing.nsf/Content/dentalreform> viewed 8 May 2013.

36 ACT Health, *Submission 30*, p. 1.

Sustainable funding

4.52 Although the Dental Waiting List NPA and the Adult Dental Services NPA provide substantial additional funding to extend state and territory public dental services, concerns have been raised about the sustainability of the funding. This is particularly significant given that NPAs have defined end-dates, while the dental and oral health needs of the population will be ongoing.³⁷

4.53 With regard to this issue, the NSW Ministry for Health observed:

... a long term sustainable funding mechanism needs to be put in place to ensure that those who cannot afford private health insurance have access to basic preventive and treatment dental services.

Unfortunately National Partnership Agreements may not provide a secure funding mechanism. The current arrangement is time limited and like the Commonwealth Chronic Disease Dental Scheme (CDDS), creates a situation where service activity is increased with no certainty of that capacity being able to be sustained.³⁸

4.54 Similarly, the Tasmanian Department of Health and Human Services emphasised the importance of sustained funding, explaining:

In terms of structure of future programs, states and territories always have problems with national partnership agreements basically because they are there for limited terms, probably three years, and especially where your investment is going to be in recurrent expenditure. If you are going to employ more dental staff, what happens at the end of three years if the funding ceases?

... National partnership agreement: while we commend the investment, in the longer term it actually needs to move into something like a national agreement so that there is ongoing commitment of funding.³⁹

4.55 The ADA (NSW Branch) expressed concern about longer-term funding, saying:

Furthermore, the funding that has been announced under the National Partnership Agreement for adult public dental services is

37 See for example: NSW Ministry of Health, *Submission 24*, p. 6; ACT Health, *Submission 30*, p. 2; DHSV, *Submission 32*, p. 16.

38 NSW Ministry of Health, *Submission 24*, p. 6.

39 Mr Paul Geeves, Department of Health and Human Services Tasmania, *Official Committee Hansard*, Canberra, 22 April 2013, p. 34.

only committed up to the end of 2017-18. As noted, there is already a level of uncertainty around this funding given the impending election later this year. This uncertainty makes it very difficult for state and territory public dental services to efficiently and effectively plan dental programs around this funding, particularly in the medium to long term.⁴⁰

4.56 Also acknowledging the time and expense involved in establishing public dental services, the submission from Mr Lawrence Springborg MP states:

... an NPA that does not provide certainty of funding, both within and beyond the NPA period, risks the development of short-term, temporary 'band-aid' strategies, that ultimately do not address the oral health needs of adults requiring public dental services in Queensland.⁴¹

4.57 To address this concern Mr Springborg MP suggests:

The [Adult Dental Services] NPA should have provisions for State and Federal Governments, and private dental providers, to discuss ongoing funding for dental services at least 12 months prior to the expiry of the NPA.⁴²

Committee Comment

4.58 The issue of funding sustainability is clearly an important one and is likely to affect all states and territories, particularly when undertaking infrastructure or workforce planning. The Committee recognises that in order to build on improvements in dental and oral health arising from the Dental Waiting List NPA and the Adult Dental Services NPA, an approach that supports a commitment to ongoing funding is necessary.

4.59 To alleviate concerns about sustained funding, and assist state and territory governments and private sector partners to make longer-term planning decisions, the Committee recommends the inclusion of a provision in the Adult Dental Services NPA which requires negotiations about continued funding for adult dental services to commence at least 12 months prior to the NPA's expiration.

40 ADA (NSW Branch), *Submission 40*, p. 9.

41 Hon Lawrence Springborg MP, *Submission 43*, p. 2.

42 Hon Lawrence Springborg MP, *Submission 43*, p. 2.

Recommendation 9

The Australian Government include provision in the Adult Dental Services National Partnership Agreement that requires all signatories to commence negotiations for a new National Partnership Agreement (or alternative funding model) at least 12 months prior to its expiration.

- 4.60 The Committee comments further on the need for sustainability in the context of a strategic approach to dental and oral health policy.

A coordinated approach

- 4.61 As outlined in Chapter 2, responsibility for dental services is shared by Commonwealth, state and territory governments, and the private sector. Funding for dental services is also shared, with the majority of services being paid for by individuals with or without assistance from private health insurance. However, evidence to the inquiry suggests that coordination is a significant area of weakness.
- 4.62 Several submissions indicate that coordination between the two tiers of government in relation to dental policy and service delivery is inadequate. Some have noted in particular that a lack of clarity around roles and responsibilities has resulted in 'buck passing' between the Commonwealth, and states and territories. Furthermore, evidence indicates that inadequate coordination extends to government engagement with private dental services.⁴³
- 4.63 As noted in the submission from the Tasmanian Department of Health and Human Services:
- Dental services funded or provided by state/territory governments, the Australian Government and by the private sector tend to operate independently from each other with no linkages to an overall national dental care strategy. Given that fund holders for dental services are both tiers of government, individuals through out-of-pocket expenses and private health insurance companies, it is not surprising that there is very little coordination of services. Improved coordination of dental services may lead to more cost effective dental programs and better

43 See for example: DHAA, *Submission 2*; Association for the Promotion of Oral Health (APOH), *Submission 4*, pp.11-12.

targeting of government funded services to people who would most benefit from dental treatment.⁴⁴

4.64 The NSW Oral Health Alliance observed:

[t]he Alliance is concerned about on-going fragmented policy and funding responsibility for dental services between the two tiers of government, and the scope and coverage of services funded under the package.

The Alliance is concerned about the lack of a clear, comprehensive national framework for oral health policy and funding. The current shared approach between the states and the Commonwealth is piecemeal and fragmented. Blurred responsibilities between the two tiers of government in the absence of a comprehensive framework leave the system exposed to gaming and perverse incentives.⁴⁵

4.65 The AHHA also expressed concern about inefficiencies and the potential for duplication, observing:

After many years of minimal involvement in the funding of dental programs by the Australian Government there are now a myriad of programs being administered by a range of Departments and Agencies. There is a significant risk of inefficiency, duplication and waste as a result of an uncoordinated approach to the planning and implementation of new initiatives and integration with existing programs.

4.66 Some contributors to the inquiry have recommended appointing a Commonwealth Chief Dental Officer or an independent oral health advisory body to improve coordination across the two tiers of government, increase engagement with the private providers of dental services and to provide independent policy advice.⁴⁶

4.67 DoHA already has a Chief Medical Officer, a Chief Nursing Officer and, as noted by the AHHA, has recently appointed a Chief Allied Health Officer.⁴⁷ The AHHA also notes that DoHA currently has independent advisory bodies to cover areas such as mental health, aged care funding, influenza, suicide prevention, dementia, pathology, pharmaceuticals, preventive health and marketing of infant formula.⁴⁸

4.68 Responding to these proposals, DoHA commented:

44 Tasmanian Department of Health and Human Services, *Submission 26*, p 3.

45 NSW Oral Health Alliance, *Submission 36*, p. 8.

46 APOH, *Submission 4*, p. 12; AHHA, *Submission 5*, p. 7; ADA (NSW Branch), *Submission 40*, p.11.

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

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

I suppose for me it would be about what value [a Commonwealth Chief Dental Officer] might add. There is already a lot of engagement with the industry that occurs anyway. You do not necessarily need a specialist in the Department of Health and Ageing – you can get advice from many sources, as we do. For example, on dental issues, the Department of Veterans' Affairs runs a dental scheme for veterans, and they have a panel of dental experts that we use. We think that is probably a cheaper and more efficient way of accessing expertise. Also, I am sure that the Australian Dental Association, if we asked them, would be more than happy to give us advice for free. So it would be up to government to decide whether it wanted to do something like that. We have quite a lot in place already which allows us to get expert advice on dental policy.⁴⁹

Committee comment

- 4.69 The Committee understands concerns regarding a lack of coordination between the two tiers of government, and the private sector, in relation to dental health policy and services. The Committee has commented elsewhere in this report on the importance of increasing engagement with the providers of private dental services, particularly in areas where public services are not available or are oversubscribed.
- 4.70 With regard to improving coordination, the Committee considers that the Adult Dental Services NPA provides an opportunity for significant progress. Clearly defining roles and responsibilities for the Commonwealth, and for states and territories, is a fundamental element of any NPA, and as such will be integral to dialogue and negotiations.
- 4.71 While acknowledging the views expressed by DoHA, there is precedence for appointments such as a Chief Dental Officer or an independent advisory body to improve coordination across the tiers of government and the private sector, and to provide policy advice. On this basis, the Committee believes that suggestions to appoint a Commonwealth Chief Dental Officer or an independent advisory body for oral health warrant further consideration.

49 Ms Kerry Flanagan, DoHA, *Official Committee Hansard*, Canberra, 22 April 2013, p. 51.

Recommendation 10

The Department of Health and Ageing, in consultation with state and territory governments and other key stakeholders, examine the case to appoint a Commonwealth Chief Dental Officer or establish an independent advisory body to:

- improve coordination between the Australian Government, and state and territory governments;
- increase engagement with the private sector, particularly private providers of dental services; and
- provide independent policy advice on dental and oral health.

A strategic approach

4.72 Evidence notes inconsistent government approaches over the years to dental policy and to responsibility for funding and provision of dental services. This has resulted in a history of dental policy and services characterised by changing priorities and sporadic, short-term funding.⁵⁰

4.73 History has shown that there is a need for a national strategic approach to dental health service provision.

4.74 In the following testimony Dental Health Services Victoria outlined the effect of the changing policy frameworks on waiting lists for public dental services:

The Government needs to consider long term sustainability. Oral Health has suffered over the years with on-off funding. Over a decade ago the Commonwealth Dental Health Program was axed resulting in a number of people unable to access care. This has been repeated with the closure of the Chronic Dental Disease scheme. Both of these events resulted in significant increases in waiting lists as the resultant increase in demand through the success of these Commonwealth schemes led to additional eligible people, who might not previously had accessed public dental care, now demanding care with no other options than already lengthy public dental waiting lists.⁵¹

4.75 Commenting on the consequences of closing the CDDS, Dr Kerrilee Punshon of the Australian Society of Special Care in Dentistry and the

50 See for example: CHF, *Submission 15*, p. 5.

51 DHSV, *Submission 32*, p. 16. See also: NSW Oral Health Alliance, *Submission 36*.

Australian and New Zealand Academy of Special Needs Dentistry described the implications on continuing of care for dental patients:

... I have a pool of patients at the moment that have just finished the Chronic Disease Dental Scheme. Some of them had come to me with very poor oral health several years ago. We have cleaned them up and got them tidied up. We now have a lot of them under control and they are ticking along nicely, but there is a lack of continuity. Some of them are staying on in the practice but I do not know how long for, even though their costs are less now because they are coming in more for check-up and cleaning rather than comprehensive work, because that was done. Others are going back to the private sector and others are saying it is all too hard and they have just given up. What concerns me is that you have spent this basket of money on getting these people's oral health better and sorting out the backlog of problems they had, and now we have just dropped them and things are just going to break down again for a lot of them.⁵²

4.76 The implications for individual patients is also illustrated in personal testimony from a patient with long-term and ongoing dental care issues:

My name is Sally and I received the dental health plan when it was up and running and now am in desperate need of this again. I have suffered from anorexia for the past 28 years and never anticipated that it would result in my losing most of my teeth which now leaves me five up top. I am in need of having two of them pulled and a denture so that I can at least feel more normal. It is difficult trying to emotionally cope with the loss of my teeth and not being able to afford private dental care. I am in chronic pain because of my teeth and am on a two year waiting list for public dental care but by that stage I don't know what will happen.⁵³

4.77 With regard to strategic planning for dental and oral health, DoHA advised that the process of developing an updated National Oral Health Plan has started. The National Oral Health Plan 2014-2023 will replace the National Oral Health Plan 2004-2013. The updated plan is expected to be finalised by the by the end of 2013.

52 Dr Kerrilee Punshon, ANZSND and ASSCD, *Official Committee Hansard*, Canberra, 23 April 2013, p. 20.

53 Ms Sally Stamm, *Submission 41*, p. [1].

4.78 While evidence was generally supportive of updating the National Oral Health Plan, CHF expressed concern that implementation of the first plan had been poor, observing:

The patchiness of funding, coupled with the lack of coordination, has contributed to the lack of progress under the National Oral Health Plan 2004-2013. The document was ratified by the Australian Health Ministers' Advisory Council in 2004, and in the decade since, minimal progress has been made under several of its key indicators.⁵⁴

4.79 A longer-term strategy that was strongly supported in evidence was for implementation of a universal dental care scheme funded by Medicare.⁵⁵

4.80 For example, Dr Thomas Higgins, a Tasmanian-based periodontist, suggested:

The answer to ensuring better access [for] all adult Australians to better dental health is to transfer the provision of general dental services to the private sector insisting upon quality guidelines, standards and practice accreditation. The financing of these services would be via taxation arrangements and an increase in the Medicare levy by a realistic percentage, with built-in 3 year reviews.⁵⁶

4.81 Testimony indicated that a universal dental care system would make best use of services available through the private sector and public system. As explained by the Association for the Promotion of Oral Health (APOH):

Were Medicare to fund dental treatment in a similar way to medical service, then most people currently unable to access timely treatment in the public dental service could receive near immediate treatment by private dentists. This would greatly reduce demand for public dental services, and provide opportunity for the public dental service to improve the quality of treatment delivered.⁵⁷

4.82 Several submissions noted that the issue of universal dental care has been gaining momentum recently, referring to the National Health and Hospitals Reform Commission (NHHRC), which put forward an option of

54 CHF, *Submission 15*, p. 6.

55 See for example: SARRAH, *Submission 3*, p. 5, APOH, *Submission 4*, p. 4, AHHA, *Submission 5*, p. 3, Combined Pensioners and Superannuants Association of New South Wales, *Submission 6*, p. 3, Public Health Association of Australia, *Submission 12*, p. 4, Australian Research Centre for Population Oral Health, *Submission 18*, p. 4, NSW Oral Health Alliance, *Submission 36*, p. 8.

56 Mr Thomas Higgins, *Submission 31*, p. 9.

57 APOH, *Submission 4*, p. 6. See also: SARRAH, *Submission 3*, p. 5.

a universal dental scheme 'Denticare', in its 2009 report to Government.⁵⁸ In responding to the NHHRC's recommendation for 'Denticare', the Government advised only that it was committed to the aim of increasing access to dental services by proving a package of dental reforms to better target services to those Australian most in need.⁵⁹

- 4.83 Recognising the financial implications of introducing a universal dental care scheme, the majority of proponents supported a phased approach to implementation. The Dental Reform Package and the Commonwealth Government's commitment to fund an extension to adult dental services under the NPA were viewed as an opportunity to progress toward the goal of a universal dental care scheme.⁶⁰

Committee comment

- 4.84 It is clear that the approach of successive governments to dental policy has been inconsistent. This has resulted in a changeable policy environment that has not been compatible with a sustained commitment to improving the dental and oral health for all Australians.
- 4.85 The Committee notes evidence relating to the CDHP and the CDDS which illustrates the impact of the 'stop-start' funding on patients. Patients impacted by closure of these schemes have had few options available to them. While some who can afford to do so have sought treatment through the private system, others have had to join lengthy waiting lists to access public dental services. Some patients, unable to afford private treatment and discouraged by lengthy waiting times to access public services, have discontinued treatment altogether. For governments responsible for the provision of public dental services, the changeable policy environment compromises their ability to plan services and support the necessary workforce to deliver services in the longer term.
- 4.86 Notwithstanding the policy decisions to close these schemes, there are some key lessons to be learned which should inform the development of future policy. The Committee believes that many of these issues could have been avoided if both tiers of governments adopted a longer-term strategic approach to dental policy and funding of dental care.
- 4.87 To achieve the best possible outcome and level of commitment necessary, the Committee recognises the need for the Commonwealth to work closely with state and territory governments and other key stakeholders to

58 *National Health and Hospitals Reform Commission Final Report*, June 2009, p. 26.

59 *A National Health and Hospitals Network for Australia's Future 2010*, p. 152.

60 See for example: AHHA, *Submission 5*, p. 2.

develop a strategic plan to underpin longer-term dental policy endeavours.

- 4.88 Although the Committee is encouraged to note that develop of the updated National Oral Health Plan for 2014-2023 has involved stakeholder consultation, it also notes evidence which suggests that implementation of the National Oral Health Plan 2004-2013 was disappointing. Therefore, to complement development of the National Oral Health Plan for 2014-2023, the Committee recommends a process of negotiation with state and territory governments and other key stakeholders, to establish and commit to an implementation strategy.

Recommendation 11

The Australian Government commit to a robust dental policy framework that guarantees the long-term sustainability of the public dental sector as a provider of dental services through ongoing funding support.

Recommendation 12

The Australian Government, in consultation with state and territory governments and other key stakeholders, establish and commit to an implementation strategy for the National Oral Health Plan 2014-2023.

- 4.89 In considering the evidence, the Committee notes the general enthusiasm for the introduction of a universal dental scheme delivered through a combination of public and private dental services. While a universal dental scheme is a worthy goal to work toward in the longer-term, the Committee understands the substantial cost that a universal scheme would present.
- 4.90 The current public dental system provides important and necessary services to the eligible population, and its contribution to the oral health of Australians should not be undervalued. However, there are evidently issues in providing access to the eligible population as illustrated to some degree by long waiting lists and delays in accessing public dental services.
- 4.91 In the shorter-term, the Committee agrees that effort should be focussed on how to prioritise access to publicly funded dental services to ensure that those most in need are able to access care. However, in the longer-

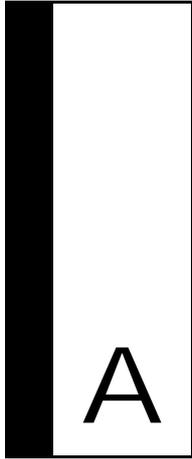
term the Committee is keen to support a strategic policy approach for phased implementation of a universal dental care scheme.

Recommendation 13

The Australian Government adopt a strategic policy approach which supports deliberate and phased progress toward a universal access to dental services scheme for Australia.

**Ms Jill Hall MP
Chair**

4 June 2013

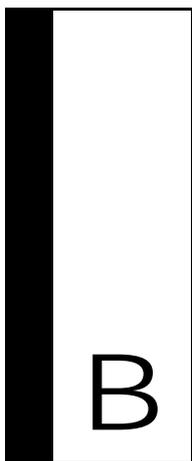


Appendix A – List of submissions

- 001 Australian Rural Health Education Network
- 002 The Dental Hygienists' Association of Australia Inc
- 003 Services for Australian Rural and Remote Allied Health
- 004 Association for the Promotion of Oral Health
- 005 Australian Healthcare and Hospitals Association
- 005.1 Australian Healthcare and Hospitals Association
- 006 Combined Pensioners and Superannuants Association of NSW Inc
- 007 University of Tasmania – Department of Rural Health
- 008 Australian Dental Association (Queensland Branch)
- 009 Grampians Region Oral Health Network
- 010 Mr Peter Muller
- 011 Royal Flying Doctor Service
- 012 Public Health Association of Australia
- 013 Mr Clarrie Griffiths
- 014 Western Region Health Centre
- 015 Consumers Health Forum of Australia
- 015.1 Consumers Health Forum of Australia
- 016 DEXCL
- 017 Westfund Health Limited
- 018 Australian Research Centre for Population Oral Health

-
- 019 Australian Dental and Oral Health Therapists' Association Inc
 - 020 Loddon Mallee Oral Health Network
 - 021 Australian and New Zealand Academy of Special Needs Dentistry
and Australian Society for Special Care in Dentistry
 - 022 National Oral Health Promotion Steering Group
 - 023 Dr Peter Foltyn
 - 024 NSW Ministry of Health
 - 025 National Aboriginal Community Controlled Health Organisation
 - 026 Department of Health and Human Services, Tasmanian
Government
 - 027 Australian Dental Prosthetists Association Limited
 - 028 Professor Frederick Clive Wright
 - 029 Aboriginal Medical Services Alliance Northern Territory
 - 030 ACT Health
 - 031 Dr Tom Higgins
 - 032 Dental Health Services Victoria
 - 033 Western NSW Local Health District
 - 034 Department of Health and Ageing
 - 034.1 Department of Health and Ageing
 - 035 Lake Cargelligo Multi-Purpose Health Service Advisory
Committee
 - 036 NSW Oral Health Alliance
 - 037 Australian Dental Association
 - 037.1 Australian Dental Association
 - 038 National Seniors Australia
 - 039 Ms Anya (no surname provided)
 - 040 Australian Dental Association (NSW Branch) Limited
 - 041 Ms Sally Stamm
 - 042 Ms Lynne Ford

- 043 Queensland Government
- 044 Bila Muuji Aboriginal Health Services Inc
- 045 Charles Sturt University
- 046 Walgett Aboriginal Medical Service Cooperative Limited



Appendix B – List of public hearings and participants

Tuesday, 12 March 2013 - Canberra

Australian Government Department of Health and Ageing

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Ms Kerry Flanagan, Deputy Secretary

Mr Charles Maskell-Knight, Principal Adviser, Acute Care Division

Monday, 22 April 2013 - Canberra

Australian Healthcare and Hospitals Association

Mr Andrew McAuliffe, Senior Director, Policy and Networks

Ms Prudence Power, Chief Executive

Consumers Health Forum of Australia

Ms Maiy Azize, Policy Manager

Ms Carol Bennett, Chief Executive Officer

Dental Health Services Victoria

Ms Deborah Cole, Chief Executive Officer

Australian Government Department of Health and Ageing

Ms Janet Anderson, First Assistant Secretary, Acute Care Division

Ms Kerry Flanagan, Deputy Secretary

Ms Kate McCauley, Assistant Secretary, Health Workforce Division

Department of Health and Human Services, Tasmanian Government

Mr Paul Geeves, Principal Consultant, Government Relations and Strategic Policy

National Aboriginal Community Controlled Health Organisation

Ms Elizabeth Adams, Board Member

Ms Lisa Briggs, Chief Executive Officer

Dr Alex Thomas

Oral Health Services Tasmania

Ms Emma Bridge, General Manager

Services for Australian Rural and Remote Allied Health

Dr Leonard Crocombe, Member

Mr Rod Wellington, Chief Executive Officer

Westfund Health Limited

Mr Grahame Danaher, Managing Director

Tuesday, 23 April 2013 - Canberra

Australian Dental and Oral Health Therapists' Association

Ms Julie Barker, President

Mrs Lynn Keyworth, Councillor

Australian Dental Association

Dr Karin Alexander, President

Mr Robert Boyd-Boland, Chief Executive Officer

Australian Dental Prosthetists Association

Mr Terry McHugh, Director

Australian Society of Special Care in Dentistry

Dr Kerrilee Punshon, President

Dental Hygienists Association of Australia

Ms Clare McNally, Member, Aged Care Committee

Ms Margaret Steffens, Member and Chairperson, SA Branch Aged Care Team

Friday, 17 May 2013 - Dubbo**Private Capacity**

Mr Peter Muller, Dental Prosthetist

Australian Dental and Oral Health Therapists' Association

Mrs Helen Tane

Bila Muuji Inc and Walgett Aboriginal Medical Service

Dr Sandra Meihubers, Dental Consultant

Charles Sturt University

Professor David Wilson, Head of School, Dentistry and Health Sciences

Orange Aboriginal Medical Service

Mr James Newman, Chief Executive Officer

Royal Flying Doctor Service

Ms Linda Cutler, General Manager, Health Services, South-East Section

Mr Greg Rochford, National Chief Executive Officer

Walgett Aboriginal Medical Service Cooperative Limited

Ms Jessie Richardson, Clinic Manager

Western NSW Local Health District

Ms Jennifer Floyd, Director, Oral Health Services