Chapter 2

Reaction to the proposals

2.1 While the committee received a limited number of submissions to its inquiry, most contributors welcomed the introduction of the Child Dental Benefits Schedule (CDBS) and the broader dental reform package.

2.2 The Australian Dental Association (ADA) and the Australian Medical Association (AMA) both issued press releases following the government's announcement welcoming the policy and legislative proposals. The ADA stated:

> The re-direction of federal funding to Australia's children and adults on low incomes or in rural areas will prove to be a sound investment. We know that if dental care can be provided to children then their long-term dental health will be significantly improved. Early intervention and preventive treatments are a proven and well-established method to prevent poor dental health in later life...Currently about 65% of Australians receive regular dental care. The ADA believes the new program will provide assistance to many Australian families previously unable to access regular care, as a sure way of helping them to avoid a path where their dental health will deteriorate.[1]

2.3 The AMA concurred with the ADA:

> This is a huge improvement on the existing dental scheme…There is less bureaucracy and red tape, and the program is better targeted at those with the greatest need. While it is not a universal system, it will go a long way towards improving the dental health of the Australian community.[2]

2.4 The Consumers Health Forum of Australia (CHFA) described the reform announcement as a 'big win for the whole community', and commended the focus on preventative dental care for younger generations,[3] while the Australian Council of Social Service also applauded the reform announcement.[4]

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1 Dr F. Shane Fryer, Australian Dental Association Inc., 'Australia's dentists welcome targeted dental reform', Media Release, 29 August 2012, http://www.ada.org.au/newsroom/article,documentid,431928.aspx (accessed 25 September 2012).

2 Dr Steve Hambleton, Australian Medical Association, 'Dental care an important part of holistic primary health care', Media Release, 29 August 2012, http://ama.com.au/media/dental-care-important-part-holistic-primary-health-care (accessed 25 September 2012).

3 Carol Bennett, Consumers Health Forum of Australia, 'Dental spend a game changer for Australia's health', Media Release, 29 August 2012, https://www.chf.org.au/media-releases.php (accessed 25 September 2012).

4 Australian Council of Social Service, 'ACOSS applauds major reform to nationally coordinated dental care', Media Release, 29 August 2012, http://acoss.org.au/media/release/acoss_applauds_major_reform_to_nationally_coordinated_dental_care (accessed 25 September 2012).

2.5 In their submission the ADA also pointed to the evidence base that supports the investment in child oral health from both a health and a financial perspective:

> Investment in the oral health of children is a sound and sensible investment as it may result in a long-term monetary saving for government and the community by minimizing future deterioration in dental health. There is a substantial body of evidence indicating that early intervention and preventive treatments provided early in life are a proven and well-established method to prevent poor dental health in later life.[5]

2.6 The CHFA also cited evidence that child tooth decay is on the rise and expressed support for the proposals on that basis:

> According to statistics cited in the National Advisory Council on Dental Health's final report, the prevalence of child tooth decay and cavities and the average number of teeth affected by dental disease in children has increased since the late 1990s. Poor oral health in childhood is a strong predictor of poor oral health in adulthood. CHF therefore welcomes the emphasis on children's dental health, which has the potential to establish good oral health and reduce the likelihood of future problems.[6]

2.7 The Australian Healthcare and Hospitals Association (AHHA) were similarly supportive of the measures, stating in their submission that they accorded with current AHHA policies that include:

- the entitlement scheme for eligible children as it ensures that children and adolescents receive good quality care…;
- enhanced access to public dental services for people on low incomes…;
- ensuring people on low incomes can access treatment earlier…; and
- the creation of an expert group to oversee the implementation of the scheme…[7]

2.8 While there was broad consensus supporting the expansion and increased resourcing of public funded dentistry there were issues raised on the detail on the measures.

2.9 The main issues identified in both the submissions received by the committee and the oral evidence included:

- the commencement date of the CDBS;
- the details of the services that will be available under the scheme;
- the consultation with the profession;
- the funding arrangements for the proposed scheme;

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5 Australian Dental Association, *Submission 4*, p. 1.

6 Consumers Health Forum of Australia, *Submission 1*, p. 1.

7 Australia Healthcare and Hospitals Association, *Submission 3*, p. 1.

- the transitional arrangements for those patients currently being serviced under the Chronic Disease Dental Scheme (CDDS); and
- the eligibility criteria for the scheme.

Commencement date

2.10 In its 11th Alert Digest of 2012, the Senate Standing Committee for the Scrutiny of Bills (Scrutiny Committee) raised the issue of the Bill's delayed commencement date. The Scrutiny Committee noted:

> The bill will commence on 1 January 2014, the planned start date for the Child Dental Benefits Schedule. Although the explanatory memorandum does not expressly address the reason for delayed commencement, it does note that the caps applying to different groups and services that will be applicable under the Dental Benefit Rules (see item 17) will reflect the outcomes of consultations with dental professions in developing the schedule of services, which will occur after the passage of the Bill (see page 3).
>
> In the circumstances, the Committee leaves the question of whether the delayed commencement is appropriate to the Senate as a whole.[8]

2.11 In response to questions about the issue of the delayed commencement the ADA agreed that it was a period that would allow for 'appropriate consultation and development time'[9] in the design of the scheme.

Details to be determined in the Dental Benefits Rules

2.12 Significant details that will affect the operation of the CDBS have not been included in the Bill. The dental services which will be covered under the scheme, as well as the maximum entitlement eligible children under the scheme, having already been announced by the Minister, are not specified in the Bill. Rather, these details are proposed to be included in amendments to the Dental Benefits Rules.

2.13 The ADA discussed the schedule of services that should be available under the CDBS. The expressed the hope that all relevant preventative and therapeutic services should be included with flexibility built in to ensure long term oral health. They also suggested that 'hospital and day-stay procedures provided under general anaesthetic' be included in the scheme.[10]

2.14 The South Australian Government submitted that the schedule of dental services outlined in the *Report of the National Advisory Council on Dental Health* should form the basis for the services that should be provided under the CDBS.[11]

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8 Senate Standing Committee for the Scrutiny of Bills, *Alert Digest No. 11 of 2012,* 19 September 2012, p. 5.

9 Dr Shane Fryer, Australian Dental Association, *Proof Committee Hansard,* 23 October 2012, p. 22.

10 Australian Dental Association, *Submission 4,* p. 2.

11 Government of South Australian, SA Health, *Submission 7,* p. 2.

2.15 The AHHA and the ADA also recommended that this schedule of services be adopted but the AHHA pointed out that the list includes services for adults and children so 'requires further consideration and refining for application in the child and adolescent oral health arena'.[12] During the committee's hearing the AHHA expanded on their submission by saying that it is not only the services available that will need to be clearly defined but also the 'frequency of accessing [the program] …and the guidelines for operation'.[13]

2.16 In addition to the Schedule included in the *Report of the National Advisory Council on Dental Health* the ADA also suggested that there should be scope to treat exceptional cases:

> It has been said that the new scheme will include basic services and simple restorative work and simple check-ups and cleans. But in all clinical scenarios, as you would be aware, you are going to get individual variation and there should be provision put in place, through an exceptional case scenario shall we say, where if the clinician feels that the specific schedule of services does not cover that particular patient there is an avenue that is able to be pursued to provide the appropriate clinical treatment.[14]

2.17 The Department of Health and Ageing (DoHA) responded to questions on what progress had been made in devising an appropriate Child Dental Benefits Schedule by stating that they had not started working on it in any great detail yet but would do so after the legislation under consideration has passed.[15] Mr Maskell-Knight from DoHA also discussed the possibility of modelling the work on that of the Department of Veterans' Affairs who also run a dental benefits schedule:

> The Department of Veterans' Affairs actually run a dental benefits schedule at the moment, so they have dental advisers contracted to assist them. We piggyback off that, so we will be talking to them. We will sketch something out, and I imagine that we will then going to talk to our ADA friends, who gave evidence earlier, and consulting with them in some detail about what they believe should be in and out, what the conditions should be and so on…
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> Then we will need to talk to all the hygienists and the therapists. And we will need to talk to the states and territories, as they will clearly be significant.[16]

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12 Australia Healthcare and Hospitals Association, *Submission 3*, p. 2.

13 Dr Martin Dooland, Australian Healthcare and Hospitals Association, *Proof Committee Hansard,* 23 October 2012, p. 12.

14 Dr Shane Fryer, Australian Dental Association, *Proof Committee Hansard,* 23 October 2012, p. 18.

15 Mr Charles Maskell-Knight, Department of Health and Ageing, *Proof Committee Hansard,* 23 October 2012, p. 33.

16 Mr Charles Maskell-Knight, Department of Health and Ageing, *Proof Committee Hansard,* 23 October 2012, p. 34.

2.18 When asked about the provisions for exceptional cases and whether the department had considered how this would be administered Ms Kerry Flanagan from DoHA responded that for administrative reasons the responsibility for providing that care could lie with the states and territories:

> Administratively, the workload involved in that is very significant. One of the factors we took into account in striking the $1,000 over two years was that it allows an appropriate range of services. The other thing we took into account was that even though we are trying to have a clearer responsibility between the Commonwealth covering kids and the states covering low-income adults, it is still possible for the states to deliver services to children. So if there were exceptional circumstances—such as we described earlier on with kids with disabilities, for example—that might need a more complex range of services to be delivered, then we would see the states perhaps providing those.[17]

Consultation processes

2.19 One of the issues related to the services that will be provided was around the need for consultation with the sector during the development of the schedule of services. The ADA submitted that the administrative arrangements for the Chronic Disease Dental Scheme (CDDS) 'reflected a medical model of service' because '[t]he CDDS required the patient's medical practitioner to act as a gatekeeper for the provision of dental services'.[18] The ADA were strongly of the view that in this case the dental profession should be fully consulted to ensure that the scheme is administratively suitable for the their profession rather the medical profession:

> The ADA would also like to state that, before the implementation of any new scheme, there is a requirement for a number of factors to be met. There should be full consultation with the profession, to make it dentally effective—that is, it fits into dental practice and not medical practice.[19]

2.20 The ADA linked the need for full consultation with the need for education processes to combat the caution from the profession that may prevent dentists utilising the scheme:

> It is proven that the lack of education of the profession led directly to the high rate of administrative noncompliance in the initial years of the [CDDS] scheme, at least until early to mid-2011.[20]

> There will need to be reassurance from the association, and there will be caution. I do not think there is going to be a surge of dentists taking up any

17 Ms Kerry Flanagan, Department of Health and Ageing, *Proof Committee Hansard,* 23 October 2012, p. 34.

18 Australian Dental Association, *Submission 4,* p. 3.

19 Dr Shane Fryer, Australian Dental Association, *Proof Committee Hansard,* 23 October 2012, p. 18.

20 Australian Dental Association, *Submission 4,* p. 2.

> new scheme without a full and long lead-up time in the education process on how they need to function under the new program.[21]

2.21 According to the ADA the consultation process should allow time to ensure that these education processes could be carried out:

> …there should be the delivery of that information to the ADA for dissemination to the membership. We have magazines, journals, e-news, the web site and direct email communication—not with every dentist in the country but 90 per cent of them. We are able to get in contact with 90 per cent of dentists in the country.[22]

Funding arrangements for the Dental Reform Package

2.22 The Minister has announced that the Commonwealth will provide over $4.2 billion for its Dental Reform Package between 2014 and 2020. This comprises $2.7 billion in funding for the operation of the CDBS; $1.3 billion in funding for adults through state public dental services under a National Partnership Agreement; and $226.4 million for a flexible grants program for both private and public sectors for reforms in dental infrastructure and workforce initiatives.[23]

2.23 This funding is in addition to that allocated in the 2012-13 Budget to increase the capacity of the dental workforce ($158.6 million over four years); alleviate pressure on public dental waiting lists($345.9 million over three years); provide support for national oral health promotion activities ($10.5 million over three years); and pro bono dental services ($0.5 million over three years). [24] The package also involves the closure of the CDDS from 1 December 2012.

2.24 Most submitters agreed that the level of funding is a good first step. The AHHA were supportive of the Commonwealth funding for children's dental services as this will 'free up resources for the treatment of more low-income adults'.[25]

2.25 All submitters agreed that the success of the program in terms of delivering increased publicly funded dental services was dependent on the states and territories maintaining their investment in public dental services. The government expects the money currently provided by the states and territories to deliver services will be re-directed to providing services for adults from low-incomes or with other eligible needs.

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21 Dr Shane Fryer, Australian Dental Association, *Proof Committee Hansard*, 23 October 2012, p. 19.

22 Dr Shane Fryer, Australian Dental Association, *Proof Committee Hansard*, 23 October 2012, p. 23.

23 Department of Health and Ageing, *Submission 8*, p. 2.

24 Department of Health and Ageing, *Submission 8*, pp 2-3.

25 Ms Prue Power, Australian Healthcare and Hospitals Association, *Proof Committee Hansard*, 23 October 2012, p. 11.

2.26 DoHA said in evidence that they were in the process of developing a methodology that would make the flow of funds to the states and territories from the Commonwealth contingent on current investment levels in the states and territories:

> What we want to do is measure the level of output in 2011-12 and then use that as a baseline level of output and then tie funding under the National Partnership Agreement to increments in the throughput. We invented the notion of the DWAU—I had to get that on record in *Hansard*. All the states and territories collect information from the public service providers based on the ADA schedule, which is a three digit schedule, so the initial consultation is an item 11. It then goes up until you get into prosthodontics, interdontics and all sorts of other things. As long as we are able to collect the number of each DVA item or ADA items that the states carry out, we can use some sort of relativity to convert that down to a common unit of effort. We will then be able to monitor that over the life of the agreement. As I said, our aim is to link funding to increments in the level of output.[26]

The department expects an additional 1.4 million adults will be treated through the states and territories as a result of the package.[27]

2.27 Dr Dooland from AHHA suggested that while the funding may be at a similar level to that for the CDDS it will address more issues than that single program:

> With the additional funding that has been outlined in the government's reform agenda, I will point out that when we cost cash flow from year to year, for instance, in 2014-15, this is actually a billion dollars. So it is very much of the scale of the expenditure on the chronic disease dental program. However, it actually has the characteristics that Prue Power mentioned in terms of addressing the various aspects of public policy in dentistry that have to be addressed to make an ongoing, sustainable program.[28]

2.28 Dr Dooland added that the funding will increase the capacity of both public and private dentistry to meet demand:

> With the new funding that has been announced for the public dental sector—both that announced in the previous budget and in the national partnership agreement from 2014—the states and territories will build up their local infrastructure and local workforce capacity. They will be able to do that. Dentistry has already responded to the workforce shortage of the 2000s and dentists are coming through the training programs at required rates and overseas trained dentists are coming as well. But we will also contract a significant amount of dentistry to the private sector. There is capacity in the dental workforce to do that. It will not lead to price

26 Mr Charles Maskell-Knight, Department of Health and Ageing, *Proof Committee Hansard,* 23 October 2012, p. 31.

27 Ms Kerry Flanagan, Department of Health and Ageing, *Proof Committee Hansard,* 23 October 2012, p. 25.

28 Dr Martin Dooland, Australian Healthcare and Hospitals Association, *Proof Committee Hansard,* 23 October 2012, p. 13.

> problems. The scale is not such that it will lead to cost problems, pressure or inflation—that will not happen. [29]

2.29 The ADA welcomed the funding, saying it was a sound investment, but a 'limited investment'. Dr Fryer from the ADA also commented that the initial funding for the CDBS in 2013-14 could be as little as $57 per child depending on how many children are treated.[30]

2.30 DoHA explained that the funding of $194 million in the first year is structured to reflect their estimate that 80 per cent of the eligible population will take up the services on offer, and that they expect this to occur in the latter part of the year as this has been the situation under the teen dental health program that the CDBS is replacing:

> The estimates are based, I think, on an 80 per cent takeup in the eligible population…
>
> The experience under the Medicare Teen Dental Plan is that there is a very back-end-of-the-year skewing of when services happen. I think dentists and children all go on holiday in January, families are getting back to school in February and shortly after that you run into Easter. So the first half of the year is very light on. I think from memory it is about one-third to two-thirds, or something close to that, between the first six months and the second six months of the calendar year.[31]

2.31 Mr Maskell-Knight continued that the funding for the second year of the CDBS will be significantly higher and the department expects that this will equate to around $200 per child but that many children will have very low needs:

> Yes, $200-ish. I am doing it in my head. It will be around one-fifth of the maximum. That is actually for one year, as well. The $1,000 is for two years…
>
> The thing about dealing with average numbers is that we expect there will be a lot of children who will have very low needs. They will have a consultation, a scale and clean and will be sent home. At the other end there will be children that need lots more significant work done.[32]

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29 Dr Martin Dooland, Australian Healthcare and Hospitals Association, *Proof Committee Hansard,* 23 October 2012, p. 14.

30 Dr Shane Fryer, Australian Dental Association, *Proof Committee Hansard,* 23 October 2012, p. 18.

31 Mr Charles Maskell-Knight, Department of Health and Ageing, *Proof Committee Hansard,* 23 October 2012, p. 26.

32 Mr Charles Maskell-Knight, Department of Health and Ageing, *Proof Committee Hansard,* 23 October 2012, p. 27.

2.32 The AHHA stated that their research suggested that 81 per cent of children would have their needs met by the $1000 cap. The ADA also agreed that 'for the vast majority of children that will cover most of their dental needs'.[33]

2.33 Associate Professor Zoellner, Chairman of the Association for the Promotion of Oral Health (APOH) was the only contributor to disagree with the $1000 cap being appropriate:

> I think that the cap which is proposed of $1,000 spending per patient over a two-year period—and its focus, again, on basic care only—is misguided. First of all, very few children will actually require anything like that sort of amount of funding. Most children in Australia have very good dental health. Nonetheless, although there are only a handful of children, there are some children who will have particular problems, and they will require more advanced care. It seems to me that, especially in the light of the fact that such children will draw very little upon the public purse, it is particularly mean spirited to suggest that children who require more advanced care and more advanced dentistry should be denied access to that service. This is particularly in the light of the fact that there are some children with chronic disease who have benefited from the Medicare Chronic Disease Dental Scheme and that these children will be particularly disadvantaged by this focus suddenly upon basic dentistry only and this limitation to only $1,000, to be available over a two-year period.[34]

Committee View

2.34 The committee welcomes the investment generally and is of the view that the levels of funding are appropriate in the current financial climate. With specific regard to the $1000 cap for treatment over two years under the CDBS the committee believes this to be appropriate. However the committee would also support the establishment of an exceptional cases procedure whereby treatment can be provided under the CDBS, in accordance with strict clinical criteria, in cases where the $1000 cap would not be sufficient. The committee would envisage the provision of hospital-based dental treatment to be covered under such a procedure.

Closure of the Chronic Disease Dental Scheme

2.35 The APOH opposed the closure of the CDDS Scheme. Associate Professor Zoellner told the committee that while the scheme was not perfect it correctly targeted the cohort in most clinical need:

> …it does not really make clinical sense, because the real burden of dental disease in the Australian community is not in the child population. The real burden of dental disease is in the ageing group. Indeed, the Medicare Chronic Disease Dental Scheme particularly supported care which was medically required, medically indicated. So it really makes, to me, very

33 Dr Shane Fryer, Australian Dental Association, *Proof Committee Hansard,* 23 October 2012, p. 23.

34 Associate Professor Zoellner, Association for the Promotion of Oral Health, *Proof Committee Hansard,* 23 October 2012, p. 1.

> poor clinical sense to withdraw medically necessary dental services from the aged group and from, in fact, the population with the greatest clinical need for dental treatment and then to send these services somehow to another group in the population who generally require low levels of care. [35]

2.36 In contrast Dr Dooland from the AHHA expanded on his previous point by saying that the proposed Dental Reform Package addresses a much broader range of issues than the CDDS did:

> The program needs to clearly identify the target group with high needs. It needs to have a balance between short- and long-term focus—that is, a balance between the immediate needs of the high-need group and the long-term oral health outcomes of the community. The program needs to address the foundation issues, which are workforce and infrastructure development. And the program needs to do the most good for the greatest number of people. We believe the government program meets all of these characteristics much better than the CDDS does at the moment.[36]

2.37 While supporting the proposed reform package overall, and the closure of the Chronic Disease Dental Scheme (CDDS) the ADA expressed concern regarding the timeframe for the closure of the scheme, claiming that many patients will miss out on essential treatment as a result of the 30 November 2012 cut-off date:

> A 12-week period, to complete treatment, will mean that patients under the CDDS will not be able to finalise their treatment plans. Treatment of the chronically ill, for which this Scheme was designed, is often complex, requiring an extended period of time. Complex treatments are often staged to allow adequate healing… The ADA calls on the Australian Government to recognise that it is critical that arrangements are put in place to allow for treatment services to be completed even if this requires introducing a transition process for existing patients on a case by case basis.[37]

2.38 Dr Dooland questioned exactly how much impact the closure of the scheme would have, as he argued that many users of the scheme would generally not access public dental services outside the CDDS:

> The chronic disease dental program has been used by the state and territory dental services and we advise people about the program; some state and territory dental service more than others, and you can see that in the level of use. I also pointed out that from the example I am most familiar with in terms of data, in the second-highest user of the chronic disease dental program, South Australia, there has been no change in demand for the public dental services at all. That is because a substantial part of the users

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35 Associate Professor Zoellner, Association for the Promotion of Oral Health, *Proof Committee Hansard,* 23 October 2012, p. 1.

36 Dr Martin Dooland, Australian Healthcare and Hospitals Association, *Proof Committee Hansard,* 23 October 2012, p. 11.

37 Dr Shane Fryer, Australian Dental Association Inc., 'Australian Government must assist CDDS patients', Media Release, 20 September 2012, http://www.ada.org.au/newsroom/articles,category,Media.aspx (accessed 25 September 2012).

> of the chronic disease program are cardholders who would not otherwise use the public dental service. In that sense, the public dental services are somewhat insulated against a flow back of demand from the chronic disease closure. [38]

2.39 Primarily for the reasons above Dr Dooland also told the committee that in the short term the states and territories would have sufficient funding to cover the treatment costs of those transitioning from the CDDS:

> People often forget that funds have been put aside in the previous federal budget to provide additional funding to the state and territory dental services. Those funds start from December-January in this financial year. With the chronic disease program closing about the same time, there is not a gap in that situation. [39]

2.40 The department also told the committee that they believe there will be sufficient capacity through the states and territories to treat those patients who have not completed their treatment under the CDDS. The department stressed the importance of reaching an agreement with the states and territories by the end of November to cover transitional arrangements:

> **Senator Bushby**: …And the reason I just wanted to ask that is that in your evidence and the evidence of others today is that for those who have access to services under the CDDS, the answer for them in terms of their options for dental care is the increased money that you are putting in here. That needs to be delivered by the time the CDDS finishes for them to be able to access that—certainly, in the near term.
>
> **Ms Flanagan:** That is correct, and we are working very, very hard under the direction of government to ensure that we have an agreement signed, sealed and delivered by the end of November.

2.41 The committee noted that both state governments[40] that submitted to the inquiry supported the reform package.

Eligibility of the CDBS

2.42 The CDBS replaces the Medicare Teen Dental Plan that provided dental services to teenagers who met the following criteria:

- be aged between 12 and 17 years; and
- satisfy the means test for the program:
- the teenager must be receiving either Abstudy, Carer Payment, Disability Support Pension, Parenting Payment, Special Benefit, or Youth Allowance; or

38 Dr Martin Dooland, Australian Healthcare and Hospitals Association, *Proof Committee Hansard,* 23 October 2012, p. 16.

39 Dr Martin Dooland, Australian Healthcare and Hospitals Association, *Proof Committee Hansard,* 23 October 2012, p. 16.

40 The Governments of Tasmania and South Australia.

- the teenager's family/carer/guardian must be receiving either Family Tax Benefit Part A, Parenting Payment, or the Double Orphan Pension in respect of the teenager; or
- the teenager's partner must be receiving Family Tax Benefit Part A or Parenting Payment; or
- the teenager must be receiving financial assistance under the Veterans' Children Education Scheme (VCES) or the Military Rehabilitation and Compensation Act Education and Training Scheme (MRCAETS) and cannot be included as a dependent child for the purposes of Family Tax Benefit because they are 16 years or older.

2.43 The CDBS will have similar eligibility criteria except for extending the age range from 2-17 years, or as DoHA expressed in evidence, ' it is essentially based on the same architecture.'[41]

2.44 Associate Professor Zoellner from the APOH submitted that the eligibility criteria 'breaks three fundamental [principles] of Medicare. In that the new scheme is: Means Tested…; Limited with regard to age…; and Limited to basic service only.'[42]

2.45 The committee did not receive any other evidence in support in this view. As cited in paragraph 2.5 of this chapter the ADA welcomed the focus on the proposed age group by citing evidence suggesting that good dental health early in life has long-term benefits. In the committee's hearing the ADA further discussed the evidence that supports the focus on children:

> I will quote from a recent report from the Australian Research Centre for Population Oral Health that undertakes all the oral health research for the AIHW, the Australian Institute of Health and Welfare. Their report from 2011 indicates that in 2006 the proportion of children with caries in their baby teeth—the deciduous teeth—ranged from 40 per cent in four- to five-year-olds to up to 60 per cent in six- to eight-year-olds. Even in the permanent teeth in five-year-olds one per cent had evidence of decay while 58 per cent of 15-year-olds had evidence of decay in their permanent teeth. So we think that the problem is probably at the other end.[43]

2.46 Dr Fryer from the ADA also cited disadvantage as being a factor in poor oral health:

> …there is a differential depending on your socioeconomic status, with it being worse in the more disadvantaged families than in the wealthy.[44]

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41 Mr Charles Maskell-Knight, Department of Health and Ageing, *Proof Committee Hansard,* 23 October 2012, p. 30.

42 Association for the Promotion of Oral Health, *Submission 2,* p. 1.

43 Mrs Eithne Irving, Australian Dental Association, *Proof Committee Hansard,* 23 October 2012, p. 20.

44 Dr Shane Fryer, Australian Dental Association, *Proof Committee Hansard,* 23 October 2012, p. 22.

2.47 The AHHA also cited evidence that suggests that good oral health as a child is, at the very least, a good indicator of good oral health as a young adult:

> There is internationally published literature to show that children who get regular dental care have ongoing improved oral health up to the stage where that has been assessed well, which is into the teenage years.[45]

2.48 With regard to Associate Professor Zoellner's evidence that under the new scheme service will be 'restricted to basic service only',[46] the committee received no evidence to support this statement given that the schedule of services to be provided under the scheme has not yet been devised.

Committee View

2.49 The committee agrees with the majority of contributors that the scheme is targeted appropriately at children and will provide long-term health benefits for those that participate in the scheme. The committee also supports the means testing element of the scheme that while agreeing that universal public dental service provision is a long-term goal, adopting a scheme that as a first step attempts to tackle oral health inequality caused by socio-economic disadvantage is the correct strategy. As previously discussed the committee is hopeful that all services required to address children's dental needs will be available, and looks forward to the publication of the children's dental services schedule in the coming months.

2.50 The committee also looks forward to the outcome of the government's negotiations with the states and territories and hopes that the agreements will ensure that there will be no gaps in service provision for any clinically necessary treatment that commenced under the CDDS.

The role of other dental health professionals

2.51 The AHHA submitted that forthcoming discussions with all parties, including the states and territories, on the implementation of the scheme should include the expansion of the role of oral health therapists, dental therapists and dental hygienists.[47] The Government of South Australia also supported an increased role for other dental health professionals by supporting the award of MBS Provider Numbers to those professionals independent of dentists:

> The current Dental Benefits Rules 2009 only allow dental therapists, dental hygienists and oral health therapists to provide services under the existing Teen Dental Plan on behalf of dentists and dental specialists. One way of ensuring the dental workforce can be most efficient will be to award Medicare Provider Numbers to dental therapists, dental hygienists, and oral health therapists.[48]

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45 Dr Martin Dooland, Australian Healthcare and Hospitals Association, *Proof Committee Hansard,* 23 October 2012, p. 12.

46 Association for the Promotion of Oral Health, *Submission 2,* p. 1.

47 Australia Healthcare and Hospitals Association, *Submission 3,* p. 2.

48 Government of South Australia, SA Health, *Submission 7,* p. 2.

Committee View

2.52 The committee supports the extension of the role of dental therapists, dental hygienists, and oral health therapists within Medicare. The committee received evidence that described the typical services that will be required for children under the scheme and agrees with the Government of South Australia that allowing other dental professionals to administer services under Medicare would increase the efficiency of the scheme.

Recommendation 1

2.53 The committee recommends that the bill be passed.

Senator Claire Moore

Chair