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Inquiry into adult dental services in Australia

March 2013

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Dental Health Services Victoria is the State's leading public oral health agency, promoting oral health, purchasing services and providing care to Victorians.

22 March 2013

Clerk Assistant (Committees)
House of Representatives
PO Box 6021
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CANBERRA ACT 2600

email: committee.reps@aph.gov.au

Dear Sir/Madam,

Inquiry into Adult Dental Services in Australia

The following is Dental Health Services Victoria's (DHSV) submission for your consideration responding to the Terms of Reference of the Inquiry into Adult Dental Services in Australia.

DHSV is the leading public oral health agency in Victoria. DHSV provides dental services through The Royal Dental Hospital of Melbourne (RDHM) and purchases dental services for public patients from 58 community health agencies throughout Victoria. DHSV also delivers oral health promotion programs across Victoria to improve oral health in the community and reduce demand on public dental services. It also has a significant role in oral health research and supporting education and training for Victoria's current and future oral health professionals. DHSV is classified as a metropolitan health service under the Health Services Act.

DHSV is passionate about improving Victoria's oral health and ensuring greater levels of access, higher quality service and sustainable practice for oral health and the wider health care sector.

Oral health is fundamental to overall health and wellbeing and DHSV looks forward to working with the Committee and other parties to assist in delivering quality health outcomes, improved access and more responsive health care.

We welcome the opportunity to discuss our submission further with you and the Committee and look forward to reviewing the recommendations of the Committee when they are concluded.

Yours faithfully,

Deborah Cole
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Inquiry into Adult Dental Services in Australia

Dental Health Services Victoria
Introduction - Context

The following is Dental Health Services Victoria (DHSV) submission to the House of Representative Standing Committee on Health and Ageing inquiry into Adult Dental Services in Australia. This submission is for the Committee's consideration and responds to the Terms of Reference.

DHSV is the leading public oral health agency in Victoria. DHSV provides dental services through the Royal Dental Hospital of Melbourne (RDHM) and purchases dental services for public patients from 57 community health agencies throughout Victoria. DHSV also delivers oral health promotion programs across Victoria to improve oral health in the community and reduce demand on public dental services. It also has a significant role in applied oral health research and supporting education and training for Victoria's current and future oral health professionals.

DHSV is passionate about improving Victoria's oral health by ensuring greater levels of access, high quality service and developing models of care involving oral health and the wider health care sector professionals to ensure sustainable oral health for all members of the community.

Oral health is fundamental to overall health and wellbeing.

The House of Representatives Standing Committee on Health and Ageing has noted:

"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 Terms of Reference that the Committee will consider are:

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

Key Points

- 30% of the Australian population are eligible for care, approximately 14% of the eligible Victorian population access services through State funded public dental services.

- There is a gap in oral health status between adults with favourable and unfavourable patterns of dental attendance. As the number of adults with unfavourable attendance is a sizeable proportion of the adult population, a significant challenge remains for the dental health system in Australia to close this gap.[1]

- Almost all adults have experienced tooth decay. Dental caries is the second most costly diet-related disease in Australia, with an economic impact comparable with that of heart disease and diabetes. Approximately $6.1 billion was spent on dental services in 2007-08, representing 6.2% of total health expenditure.

- The disadvantaged are more likely to have more untreated disease, have more extractions or have no teeth.

- Services provided are not always accessible to the disadvantaged. Many public clinics were in historically disadvantaged areas but with gentrification are now not the most disadvantaged.

- The factors that increase the likelihood of dental disease are socioeconomic factors, cultural and linguistic diversity, ATSI status, homelessness, living in rural, regional and remote areas, living in non-fluoridated communities and living a long distance from a dental clinic.

- Oral diseases are a key marker of social disparity.

- Poor oral health is significantly associated with major chronic diseases like cardiovascular diseases, diabetes, respiratory infections, strokes and adverse pregnancy outcomes.

- Oral health diseases and major diseases share common risk factors.

- Poor oral health causes disability.

- Many people are unable to eat or socialise without pain due to oral health issues.

- There are waiting times in Victoria of up to 40 months for those on the public waiting list. Waiting lists do not reflect the true demand for care let alone the need for care.

- Some at-risk population groups (e.g. ATSI communities, refugees, homeless, etc) have higher disease rates than the general population and poorer access to services.

- Almost one third of Australians avoid dental visits due to cost. A recent on-line survey commissioned by DHSV reported a higher figure of around 40%.

- A large number of families are not eligible and cannot afford care – this is a significant gap in the safety net.

[1] 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. DEN204. Canberra AIHW.

- Commonwealth concession cardholders have poorer oral health status than the general population. Within this population group are people who are most at risk.

Demand for dental services across Australia and issues associated with waiting lists

- 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.

- We know that in 2011/12 1.34 million adults were eligible for State publicly funded care in Victoria, of which just over 180,000 adults were able to access services in the public sector. This is 13.6% of the eligible adult population accessing care.

- At the end of 2011/12 within the Victoria there were just under 120,000 people on dental waiting lists. Of these, almost 12,000 were on the denture waiting lists and about 101,000 were waiting for general dental care. Almost another 7,000 were waiting for specialist care.

- Waiting times were on average 18.9 months for dentures and 16 months for general dental care. The range of waiting times differed significantly between clinics and was usually due to a lack of ability to recruit dental practitioners.

- Public dental waiting lists numbers represent a small proportion of the eligible population and also of those seen in public clinics. In 2011/12, over 50% of adults accessing care in the public sector were not on a waiting list. The majority came for emergency care.

- Less than 40% of Australian dentate adults have a pattern of visiting for dental care that is seen as favourable, that is seen at least once a year and usually for a check-up. Almost 30% of adults have an unfavourable pattern of visiting where they visit less than once a year and usually for a problem.[2]

- Additional funding from the NPA will allow a significant increase in the number of eligible adults that demand and receive more timely dental services.

- We know from other research that many people eligible for public care access the private sector. The type of care they receive can often be suboptimal as decisions about the type of care they choose are made based on what they can afford.

- Specialist waiting lists are only available in the RDHM and as a result very few of the people on the lists are from outside of Melbourne. In addition, the specialist waiting lists only contain names of people that are classified as having high priority clinical needs. Most people in rural locations are unable to access specialist services in the public sector due to the inability to make multiple trips to Melbourne.

- Since the closure of Chronic Dental Disease Scheme there has been a 6% increase in the waiting list additions over previous time periods.

[2] http://www.arcpoh.adelaide.edu.au/resources/policy/Improving%20oral%20health%20&%20dental%20care%20for%20Aust.pdf

- Dental problems consume substantial Medicare resources as patients access subsidised consultations from non-dentally trained health professionals, such as medical practitioners, often without the problem being resolved.

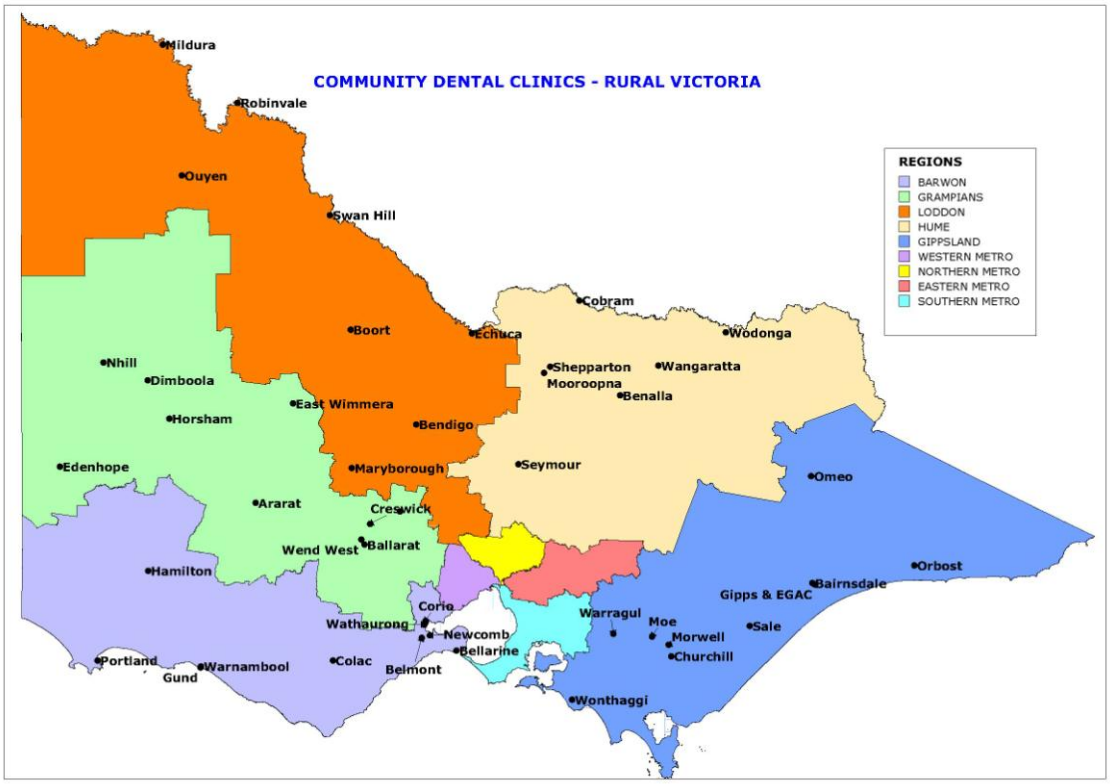
Waiting lists do not reflect the true community demand. The ability to measure the number of eligible people accessing appropriate care is key to measuring success of a public dental scheme.

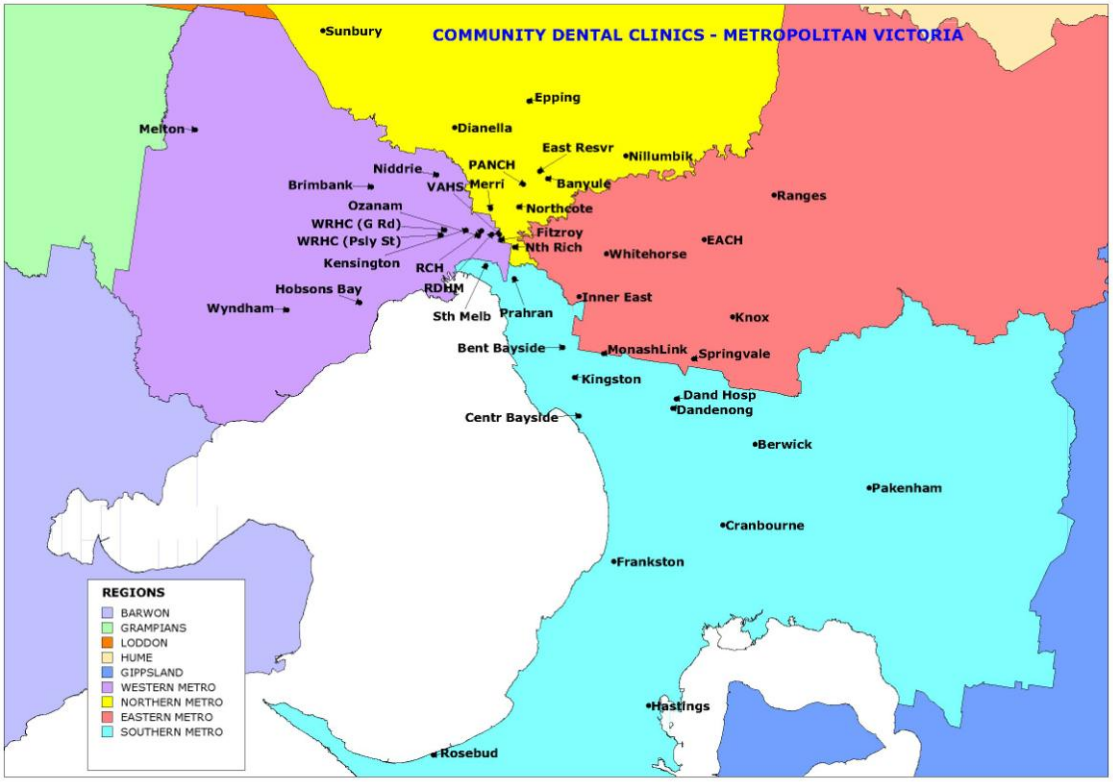
The mix and coverage of dental services supported by state and territory governments and the Australian Government

- The Royal Dental Hospital of Melbourne (RDHM) and 57 Victorian community agencies provide the full range of general dental services across the State. Most specialist services are provided at the RDHM.

- Additional funding from the NPA will allow a move towards more preventive services, recall appointments and provide access to specialist services in more geographically isolated areas of Victoria.

- Within the State of Victoria, there are 57 community agencies throughout the State and the RDHM that provide public dental services. The following maps provide an indication of the spread of community agencies. The location of clinics is historical with many of the new growth areas having limited access to dental services in close proximity.





- In addition there are services provided through the acute sector in the form of admissions for trauma, pathology and special needs patients requiring high dependency support. The majority of admissions are preventable but also predominantly children. There are also many attendances in General Medical Practices and Emergency Departments for dental related issues. While there has been limited documentation on this issue, the anecdotal advice is that people attend these practices as they will not have any out of pocket expenses.

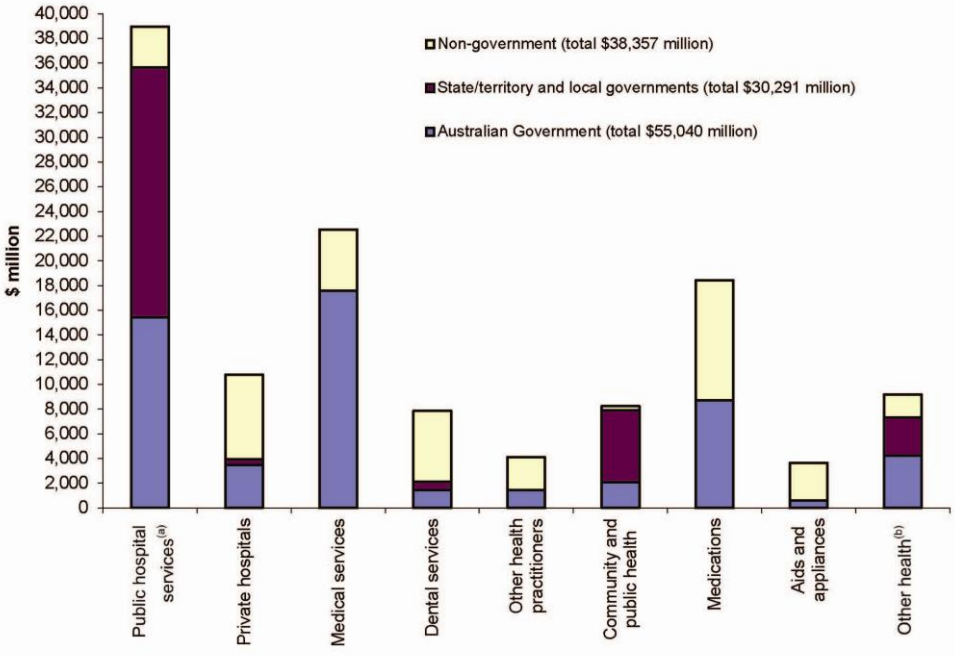
- The mix of services in publicly funded Victorian clinics provides the full range of dental services that are available on the ADA schedule of item numbers. As the RDHM and a number of community clinics are teaching institutions, they provide a wide range of dental services. Specialist services are limited and traditionally were established to support a post graduate teaching environment. They tend to be offered to those with the highest clinical priority.

- Most community agencies will use private practitioners to provide a proportion of services through a State based voucher schemes. About 8% of services to adults are provided through the private sector using State funded vouchers. This is often used to manage timely access to care.

- The State Government also provides funding through the Transport Accident Commission and WorkSafe.

- The Commonwealth Government provides funding for dental services through the Teen Dental Scheme, Department of Veterans' Affairs and previously the bulk was through the now closed Chronic Dental Disease Scheme.

- Many eligible people access the private sector for care resulting in significant out of pocket expenses. Some use the private sector because of long established relationships with their private dental provider, others because they are unaware of public service availability and others because that is the most accessible option. This issue is they often choose suboptimal care due to affordability.



(a) Public hospital services exclude certain services undertaken in hospitals. Can include services provided off–site, such as hospital in the home and dialysis (see Box 4.1).

(b) Other health comprises patient transport services, administration and research.

Source: Table A3.

Figure 3.2: Recurrent health expenditure, by area of expenditure and source of funds, current prices, 2010–11

- Dental services are usually self funded or by a third party insurer. The graph above states the proportion of Government funding that makes up the expenditure on dental services.[3]

- Particular population groups do not access services at the same rate as the rest of the eligible population. This can be a result of poor oral health literacy and/or poor literacy due to cultural, socioeconomic reasons, disabilities, etc.

State publicly funded services are offered across the State of Victoria. Certain populations have less access to dental services than others with social determinants being a major determinant in this mal-distribution.

[3] Australian Institute of Health and Welfare 2011, Health Expenditure Australia 2009-10, Health and Welfare Expenditure Series, No. 46, Cat No. HWE55, Canberra, AIHW, P25

Availability and affordability of dental services for people with special dental health needs

- Cost is a major factor for people accessing care and disadvantaged people often choose suboptimal care – resulting in poorer oral health outcomes.
- There are significant barriers to access dental services due to language issues, poor literacy and a lack of knowledge of service availability.
- Favourable visiting patterns to a dental practitioner are poor in the general population and anecdotally significantly poorer in these special needs groups.
- The number of people in the community affected by disability and chronic disease continue to rise. These community groups often require significantly more resources than the general community and would benefit significantly from intensive preventive programs.
- The links between poor oral health and poor general health are increasingly linked. The programs need to be integrated into other health services in the general health sector.
- The Chronic Dental Disease Scheme attempted to develop those links. The closure of the scheme poses some risks that those developing referral/partnership relationships between dental and other health practitioners will be lost.
- Oral health is integral to overall health.4
- The Victorian Government has prioritised some adults within the already disadvantaged eligible population. The following community groups are priority groups and therefore do not have to go on the waiting lists but receive the next available appointment
    - Eligible Aboriginals and Torres Strait Islanders (ATSI)
    - Eligible homeless people and people at risk of homelessness
    - Eligible pregnant women
    - Refugees
    - Asylum seekers
    - Eligible registered clients of mental health and disability services.
- Copayments are waived for ATSI, homeless and refugee and asylum seekers.
- There are significant numbers of the eligible populations that are unable to access services due to poor referral pathways and limited access to complex treatment options. They include;
    - people with disabilities that require special needs dentistry
    - Older people both in aged care facilities and their own homes

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

- People from culturally and linguistically diverse backgrounds
- ATSI
- Refugees & asylum seekers
- Homeless

Any programs need to recognise the need to address the preventive programs that would be needed and the affirmative programs that may be needed to address or counteract some of the social determinants that result in poor oral health. These groups often have significant backlogs of care because of poor access to services.

Support needs to be given to people with chronic diseases in both the dental environment but also in other settings, both health and non-health.

Availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations

- Australians who live in rural and remote areas face significant challenges in accessing dental education and treatment, and generally have much poorer oral health than those living in metropolitan locations. The Victorian Government's Improving Victoria's oral health plan of 2007 states that 'internationally, WHO (2006) ranks Australia 17 among OECD countries for adult dental caries…' and that 'Poor oral health in this country is most evident among Aboriginal and Torres Strait Islander people, people on low incomes, rural and remote populations…".

- 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.

- These disparities can be attributed to many factors, including lower socio-economic status and limited access to dental treatment and education, which are generally more pronounced in non-capital city locations.

- Ambulatory care sensitive conditions hospital admissions are higher for rural people than those in metro regions, in some areas the rates are over double (although this predominately relates to children).

- There are significant disparities in geographical access for many Victorians. In rural, regional and remote areas, this is often exacerbated by difficulties in recruiting the dental workforce.

- Metropolitan services are reasonably accessible by public transport but Victorians do not tend to use public transport in large numbers. 80% of all trips are made by car, 10% use public transport and about the same percentage walk. Hence geographical accessibility by car is very important.

- There are a number of growth areas within metropolitan Melbourne that do not have dental clinics within easy access.

- Regional areas have reasonable access to clinical facilities but often have issues recruiting workforce to provide services.

- Rural and remote services are disparate. Some have good access, others have very limited access. Innovative programs are being developed to improve that access.

- Research exists that indicates that people that live further than 50km from a dental service have poorer oral health.

Case Study: The Oral Health Status Of A Remote Victorian Community

The Northern Mallee region of Victoria has been chosen as a case study to emphasise the current oral health conditions in rural and remote Victoria, due to:

- Significantly higher than the state average hospital admissions for dental conditions.
- A proportionately large indigenous population and very poor socio-economic conditions.
- A shortage of dental providers.
- No evidence of structured and targeted health promotion and prevention programs

The Ambulatory Care Sensitive Conditions hospital admission rate for Dental Conditions for the Northern Mallee region are significantly higher than the Victorian average, as shown below:

Geographical Area	Northern Mallee PCP
ACSC	Dental conditions

ACSC Standardised Admission rate (Dental Conditions) Trend for Victoria and selected sub group (Northern Mallee)

Year	**State per 1,000 Persons**	State (Lower Level 95% CI)	State (Upper Level 95% CI)	**Northern Mallee per 1,000 Persons**	Northern Mallee (Lower Level 95% CI)	Northern Mallee (Upper Level 95% CI)
2006-07	**2.72**	2.68	2.77	**6.13**	5.48	6.79
2007-08	**3.02**	2.97	3.06	**5.99**	5.33	6.65
2008-09	**3.05**	3.00	3.09	**5.31**	4.69	5.92
2009-10	**3.03**	2.99	3.08	**4.60**	4.04	5.16

https://hns.dhs.vic.gov.au/3netapps/vhisspublicsite/ViewContent.aspx?TopicID=1

It is likely the high number of admissions for dental conditions is due to the remoteness of the community and the significant portion of the population who identify as Aboriginal or Torres Strait Islander.

It ranks in the 2nd lowest decile which is the twelve lowest percent of all SLAs in Australia, according to ABS 2006 reports. Socio-economic disadvantage and low health outcomes have been proven to be linked, and this is exacerbated when combined with less access to appropriate services, such as in rural and remote communities.

Many people living in this area face challenges with transport, making it extremely difficult to access services located in neighbouring towns.

A lack of accessible services, low socio-economic status and large population who are at high risk of suffering oral health issues have deemed Robinvale and the Northern Mallee region as being an appropriate area for the trial program.

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.

The coordination of dental services between the two tiers of government and with privately funded dental services

- Funding models drive the types of services delivered. Fee for service models can lead to over-servicing. Capitation and course of care models can lead to under-servicing. In a public health model the latter is preferable with strong incentives to prevent re-attendance and to promote health. This may involve more intensive programs for high risk individuals but would involve population health decision making. There is a need to support Minimal Intervention Dentistry philosophies.

- The NPA needs to carefully consider the funding model as the current NPA is based on a fee-for-service model and has no incentives to improve oral health. Funding needs to be available to support non-dental professionals that may be undertaking dental screening or oral health promotion.

- 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.

- The National Oral Health Plan is being developed that ideally should be supported through the Council of Australian Governments (COAG). This gives an opportunity for all levels of Government to support the issue of improving oral health. In addition the National Oral Health Plan would be supported by the National Oral Health Promotion Plan and the Health Workforce Australia Health Workforce 2025 – Oral Health.

- DHSV has long had a private voucher scheme that allows private practitioners to provide services for public patients. It has predominantly been for dentures and emergency services but some general dental care is provided. Similar schemes are available in other States.

- Commonwealth schemes have been accessed by DHSV in recent years through the Teen Dental, Chronic Dental Disease Scheme and Department of Veteran Affairs. The Medicare based schemes present issues for public dental practitioners as many needed to have rights of private practice to enable them to bill Medicare. This has presented a number of barriers to service provision. It is important that the Commonwealth make any possible Medicare like system simple to enable public clinicians to bill Medicare. These clinicians earn significantly less than their private colleagues and thus are more risk averse and less likely to sign up into these schemes.

- NPAs should always reflect the intent of the Government announcement and should ensure that in the negotiation, the community is not denied services due to components/interpretation of the agreement.
- NPA needs to avoid onerous and difficult reporting.

The Commonwealth funding presents a significant opportunity to provide additional targeted services to many disadvantaged people in our community. The NPA process should ensure the agreement allows all parties to participate easily so that the community is not disadvantaged.

Workforce issues relevant to the provision of dental services

- The public sector has long had issues with recruiting a workforce, particularly in regional and rural areas and to work with significantly disadvantaged and challenging individuals.
- The workforce model has predominantly been dentist based with little opportunity to change the model of care.
- Work undertaken in DHSV has expanded the scope of Oral Health Therapists and Dental Therapists to allow them to work on adults within the clinical scope of practice that they apply to children. This provides significant opportunities for future expansion into service provision in settings that currently do not receive care. The NPA funding could support this expansion of scope.
- In addition, Dental assistants can provide oral health promotion services and fluoride application under instruction from a dental practitioner. These opportunities allow a dentist to undertake the more complex tasks and work as part of a multidisciplinary team to treat a population.
- Public dental organisations across Australia use overseas trained dentists as part of their workforce. Approximately 60% of DHSV dentists are overseas trained clinicians.
- Recent proposals to remove the automatic registration of UK and Ireland trained clinicians present a significant impost to public dental organisations where, as is the case in Victoria, almost a quarter of their full time workforce are trained in UK or Ireland. In addition, there are other Universities that have excellent quality graduates that are denied access because of the significant hurdles required to become accredited in the Australian environment.
- There are a number of programs that will be beneficial to enhance the Victoria public sector workforce
    - Victorian State funded Rural Incentive Scheme for Dental Practitioners
    - Victorian State funded Graduate Program
    - Victorian State funded International Dental Graduate Scheme
    - Victorian State funded Mentoring Program for staff
    - Victorian State funded Continuing professional Development program including roll-out programs of Clinical Practice Guidelines
    - Commonwealth funded Graduate Program (Dentists)
    - Commonwealth funded Rural Incentive Program (Not for profit sector only)
    - Commonwealth funded Graduate Program (Oral Health Therapists)

Factors limiting the supply and distribution of dental health services in rural areas include:

- Funding: The geographical spread of people living in rural communities provides challenges in developing models of care which are financially viable in small populations.

- Responding to need: the needs of people living in regional towns can be different to people in the cities, and often a major challenge can be encouraging people to proactively engage with a service.

- Changing population numbers and demographics: as the job market, affordable housing and immigration numbers change, so do the service requirements of regional towns. The cost of infrastructure and service establishment makes it difficult to constantly review and adapt static services in an attempt to remain appropriate and effective.

- Access to fluoridated water supplies is a key ingredient in prevention of oral disease. Many regional areas in Victoria do not have access to fluoridated water - dental activities are more effective when there are preventive measures already existing in a community.

- Many dentists in regional areas have little opportunity to acquire new skills through their clinical practice, such as treating very young children. As a result some patients need to be referred to larger centres for specialist treatment.

- Oral Health professionals who work in isolation are unlikely to create sustained long term improvements in the oral health of the community, as time restrictions can mean the clinical focus is on treatment of issues rather than preventive measures or health promotion.

Challenges in recruiting and retaining good quality healthcare dental professionals include.

- Professionally trained people often have a range of choices of where to practice, and rural and remote locations can be viewed negatively due to poor access to fresh food, reduced employment opportunities for their family members, limited training and professional development opportunities, housing shortages, and an overall lack of services which are readily available in urban settings

- It can often be the case that attracting people to work in regional locations is not as difficult as keeping them there. It is widely accepted that if an organisation can support a new employee such that they stay in a small town for 2 years, it is very likely that they will stay longer. Unfortunately a significant majority of people do not make it to the 2 year mark.

- The remuneration gap between the private and public sector is a major threat to sustainability of the public sector workforce. New graduates enter the public sector workforce for mentoring and support but usually leave within a few years. Very few dentists remain in the public sector except for professional and/or philosophical reasons.

- The service mix provided in a public health environment can be limited in the clinical professional sense. It can also result in deskilling of the professionals

when they are not able to undertake their full scope of practice that their training allows.

- Career progression can be more difficult and slow in regional areas due to a lack of ongoing training opportunities and a readily available variety of CPD programs.
- Professional support is often lacking for dental practitioners operating in isolated small and/or rural clinics due to lack of suitable mentors.

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. Other health professionals and carers can contribute to improving oral health.

Dental practitioners in the public sector need professional development to support their public health decision making and to have employment conditions that attract and retain them in the public sector.

Support mechanisms need to be put in place to support dental practitioners in rural, regional and remote settings.

Summary

- Waiting lists do not reflect the true community demand. The ability to measure the number of eligible people accessing appropriate care is key to measuring success of a public dental scheme.
- State publically funded services are offered across the State of Victoria. Certain populations have less access to dental services than others with social determinants being a major determinant in this mal-distribution.
- Any programs need to recognise the need to address the preventive programs that would be needed and the affirmative programs that may be needed to address or counteract some of the social determinants that result in poor oral health. These groups often have significant backlogs of care because of poor access to services.
- Support needs to be given to people with chronic diseases in both the dental environment but also in other settings, both health and non-health.
- 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.
- The Commonwealth funding presents a significant opportunity to provide additional targeted services to many disadvantaged people in our community. The NPA process should ensure the agreement allows all parties to participate easily so that the community is not disadvantaged.
- 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. Other health professionals and carers can contribute to improving oral health.
- Dental practitioners in the public sector need professional development to support their public health decision making and to have employment conditions that attract and retain them in the public sector.
- Support mechanisms need to be put in place to support dental practitioners in rural, regional and remote settings.

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