Australian Government

Department of Health and Ageing

DEPUTY SECRETARY

Dr Alison Clegg
Committee Secretary
House of Representatives Standing Committee on Health and Ageing
PO Box 6021
Parliament House
CANBERRA ACT 2600

Dear Dr Clegg

Please find attached the Department of Health and Ageing's responses to the Questions on Notice that arose from the Public Hearing on the Inquiry into Adult Dental Services in Australia on 22 April 2013.

If you require any more information, please contact Ms Margaret Noris, Director, Dental Programs Section on (02) 6289 9270 or margaret.noris@health.gov.au

Yours sincerely

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Deputy Secretary

17 May 2013

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Questions on Notice

from the April 22 Public Hearing on the

Inquiry into Adult Dental Services in Australia

Question on Notice 1 (page 46):

CHAIR: Okay. That is really good news. The next question I want to ask is: in the big picture scheme of comparing Australia to other countries, how do our dental health and the affordability and accessibility of dental health for Australians compare? If you want to, you can put it into categories, such as people with more disadvantage and the general Australian population.

Ms Flanagan: Thank you for that question. Can I take it on notice, please.

CHAIR: Yes. It is something I have been thinking about all day, and I thought I would direct it towards you guys. We heard that $7.7 billion is spent on dental services in Australia, and I wondered how we compare on the affordability and accessibility of dental services for Australians and also the state of our overall dental health. Do we have poor dental health? As a nation, where do we fit on the scale?

Ms Flanagan: I will have to take that on notice. More broadly, in a funding sense, Australia is relatively unique in the world in having these universal systems of care, particularly around health. I am not as familiar with how dental sits in that. For example, in the USA there are a lot fewer people on low incomes who are covered by health care, and I would not be surprised to find that it would be the same with dental care. We can look into that and get back to you.

Mr LYONS: Recently a woman talked to me about health care. She said she had a healthcare plan: it was 'do not get sick'. Her whole family had the same plan.

Mr GEORGANAS: Earlier we heard that our dental care in Australia is equivalent to that in the Third World. When I queried they were quite adamant that that was the case. What would your views be on that?

Ms Flanagan: Again, I would like to get the facts together. I find that hard to believe.

International Comparisons

Adult Oral Health

Recent oral health data comparing Australian adults to the rest of the world is sparse. It is often quoted that Australia ranks in the bottom third of OECD countries in terms of adult oral health. However, the data used to make this assertion is now 25 years old (Spencer, 2001 - see page 18[1]).

A World Health Organisation 2003 report stated that Australia, Japan, Canada and much of Europe experienced high levels of tooth caries in adults aged 35 to 44 (WHO, 2003[2]). In comparison, America had moderate levels of tooth caries. However, it is unclear which data sources were used in this international comparison and therefore care should be taken in interpreting its results.

The Department is not aware of any other more recent international comparisons of adult oral health.

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[1] http://www.adelaide.edu.au/arcpoh/downloads/publications/reports/miscellaneous/spencer-options-paper.pdf

[2] http://www.who.int/oral_health/media/en/orh_report03_en.pdf

In measuring adult oral health, it should be noted that levels of dental caries decreases markedly between each successive generation of adult Australians. The National Survey of Adult Oral Health 2004-06[3] showed that the pre-1930 generation had an average of 24.3 of Decayed, Missing and Filled Teeth (DMFT) compared with 14.4 teeth for the 1950-69 generation and 4.5 for the 1970-90 generation. The difference in generations reflects the effect of age on oral health as well as different exposure to risk factors and protective factors, such as fluoride, across the generations.

As the Report of the National Advisory Council of Dental Health outlines, the relationship between income and dental caries is not strong (page 8) – that is, low income adults have only slightly higher levels of DFMT when compared with high income adults. However, 39.8 per cent of adults from low income households had untreated dental decay compared with 17.3 per cent of adults from high income households.

Affordability and Accessibility of Dental Care

The OECD measures access to dental care by examining the average number of per capita dental consultations and patient's out-of-pocket costs (OECD, 2009). High levels of access to dental care would be measured as a high levels of dental consultations per capita and low levels of out-of-pocket costs.

In terms of the number of dental consultations per capita, Australia recorded 1.4 which was slightly above the OECD average of 1.3.

In terms of out-of-pocket costs, 60.9 per cent of dental expenditure in Australia was attributed to out-of-pocket costs. The OECD average was 54.2 per cent.

Further information on this OECD indicator, including graphs ranking various countries, can be found at the OECD website[4].

Question on Notice 2 (pages 47 and 51):

Mr COULTON: Could a local council in a country town apply for that grant for the infrastructure to set up a clinic in an effort to attract a dentist to their community?

Ms McCauley: That level of detail I would need to take on notice, and I will need to refer to the guidelines around that. This particular program is due to commence in the next financial year, and the invitation to apply for the administrator and program developer only closed on Friday. The department is currently considering those. But I am not familiar enough with the guidelines to know whether a local council can make an application. I would need to take that on notice and provide you with an answer.

Dental Relocation and Infrastructure Support Scheme (DRISS)

The council would not be considered an eligible applicant as DRISS has been designed as an encouragement for relocating dentists. However, a dentist who relocates to work in a council owned practice may be eligible to apply for the relocation and infrastructure grant.

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[3] http://www.aihw.gov.au/publication-detail/?id=6442467953

[4] http://www.oecd-ilibrary.org/sites/health_glance-2011-en/06/06/index.html?contentType=/ns/StatisticalPublication,/ns/Chapter&itemId=/content/chapter/health_glance-2011-57-en&containerItemId=/content/serial/19991312&accessItemIds=&mimeType=text/html

Question on Notice 3 (pages 47 and 48)

Mr LYONS: I have noticed that, in some of the allied health, the universities in the big island, the mainland, actually have attachments to particular hospitals in Tasmania. You may not know, but do those schools have attachments to practices in remote areas? Does the Commonwealth have some say in that?

Ms Flanagan: I think with dental there is much less placement, as there is with medical students, for example. I think a lot of it is done, in effect—

Mr LYONS: During their university training.

Ms Flanagan: within universities. But again we can check on that. This was one of the reasons—there were many reasons, but this was one of the reasons—why we were interested in looking at a voluntary intern year for dentists, to actually give them some practical on-the-ground experience, because they can go and hang their shingle up as soon as they have graduated.

Mr LYONS: They do appear to do a lot of practical during their course. I have come across them. I do not know how much time they put in.

Ms Flanagan: Yes. What we might do is look to the Dental Board of Australia, which might have set up a standard about how much practical experience they need to have as an undergraduate.

University Undergraduate Courses

Based on the university websites, all courses provide clinical experiences from Year 1 or Year 2 of the undergraduate degree and this increases to full-time clinical involvement in the last year or two of the course. Below are details of all currently accredited courses, along with details of clinical components. All of these courses involve clinical placements in a combination of local public dental hospitals, community health facilities and university-based public dental health clinics, as well as private dental services.

	Degree	Years	Clinical content
Adelaide	Bachelor of Dental Surgery	5	From Year 2. Years 3 and 4 supervised practice. Year 5 clinical placements in dental hospital, community and private practice.
CSU	Bachelor of Dental Science	5	From Year 2. Years 3,4 and 5 are clinically focussed.
Griffith	Bachelor of Oral Health in Dental Science/Graduate Diploma in Dentistry	5	From year 2. Years 4 and 5 are clinically focussed.
JCU	Bachelor of Dental Surgery	5	First intake 2014. Years 3,4 and 5 are clinically focussed.
La Trobe	Bachelor of Health Sciences in Dentistry/Master of Dentistry	5	Years 4 and 5 are clinically focussed.
Melbourne	Bachelor of Dental Science	5	From year 1. Years 4 and 5 are clinically focussed.
Queensland	Bachelor of Dental Science	5	From year 1. Years 4 and 5 are clinically focussed.
Sydney	Bachelor of Dentistry	4	Last intake 2011.
Sydney	Doctor of Dental Medicine	4	First intake 2012. Graduate entry. From Year 1. Year 4 is clinically focussed.
UWA	Bachelor of Dental Science	5	Last intake 2012.
UWA	Doctor of Dental Medicine	4	Graduate entry. First intake 2013. From year 1. Year 4 is clinically focussed.

As part of the National Registration and Accreditation Scheme, the Australian Dental Council (ADC) undertakes a number of functions including developing accreditation standards, policies and procedures for dental practitioner programs of study, including clinical placements. The ADC is an independent accreditation authority for the Australian dental profession. Both the registration and accreditation processes under the National Registration and Accreditation Scheme are industry led with administrative support from the Australian Health Practitioner Regulation Agency but are independent of Commonwealth, state and territory governments.

Voluntary Dental Graduate Year Program

As part of the 2011-12 Budget, the Australian Government announced funding of $52.6 million over 4 years for the Voluntary Dental Graduate Year Program (VDGYP) to support 50 graduate placements per year from 2013. The VDGYP provides dental graduates with a structured program for enhanced practice experience and professional development opportunities, whilst increasing the dental workforce capacity, particularly in the public sector. A further $35.7 million over 3 years was announced in the 2012-13 Budget. This funding will provide 50 placements in both 2013 and 2014, increasing to 75 in 2015 and 100 from 2016. Where possible, graduate placements have been directed towards the public sector and areas of need. The first group of 50 graduates commenced participation in the VDGYP on 21 January 2013. Graduates for 2013 have been distributed nationally with 27 graduate placements in metropolitan areas, 18 placements in regional areas and 5 placements in remote areas.