CHAPTER 3

COMMONWEALTH DENTAL HEALTH PROGRAM

3.1 This Chapter reviews the operations of the Commonwealth Dental Health Program (CDHP). The Chapter discusses the benefits and deficiencies of the Program and reviews the impact the CDHP has had since its abolition on the main beneficiaries of the Program, including aged people and other socially and economically disadvantaged groups in the community.

Background to the operation of the CDHP

3.2 The CDHP, based on the recommendations of the 1991 National Health Strategy, was introduced in January 1994. The National Health Strategy documented in a Background Paper titled *Improving Dental Health in Australia* social inequalities in oral health status and access to dental care among Australian adults. The CDHP had the overall objective of improving the dental health of financially disadvantaged people in Australia. The specific aims of the Program were:

- to reduce barriers, including economic, geographical and attitudinal barriers, to dental care for eligible adults;
- to ensure equitable access of eligible persons to appropriate dental services;
- to improve the availability of effective and efficient dental interventions for eligible persons, with an emphasis on prevention and early management of dental problems; and
- to achieve high standards of program management, service delivery, monitoring, evaluation and accountability.[1]

3.3 The principal objectives of the Program were to direct the dental care received by adult Health Card holders from emergency to general dental care; extraction to restoration; and treatment to prevention.[2]

3.4 States signed Agreements with the Commonwealth Government for the years 1993-94 to 1996-97. The Western Australian Agreement operated from 1994-95 to 1996-97. The Agreements specified the aims and structure of the Program, Commonwealth and State/Territory responsibilities, as well as financial, data collection and evaluation arrangements that governed the grant of funds. The conditions set out the basis under which the States agreed to provide a specified number of services to eligible persons. The conditions also specified that States had to

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1 AIHW Dental Statistics and Research Unit, *Commonwealth Dental Health Program Evaluation Report 1994-96*, AIHW, 1997, pp.5-6.

2 AIHW study , p.1.

maintain their baseline level of recurrent funding to adult dental services under the Program.[3]

3.5 The CDHP funding was allocated to two separate components – the Emergency Dental Scheme (EDS) and the General Dental Scheme (GDS). The EDS was implemented to broaden the possible range of treatment options for patients making emergency or problem visits. Specifically it was aimed at increasing the retention of teeth through treatment of disease with fillings rather than extractions. The GDS was implemented to draw people receiving public-funded care into routine general dental care.[4]

3.6 A total of $245 million was provided by the Commonwealth under the Program over the four years from 1993-94 to 1996-97 inclusive. This comprised payments to the States of $240 million for service provision and State administration costs and a further $4.6 million for national projects and evaluation purposes.[5] The Commonwealth ceased funding the CDHP on 31 December 1996, following which the States resumed full responsibility for public dentistry.

Eligibility

3.7 Holders of Health Cards and their dependants aged 18 years or more were eligible for services under the CDHP. From 1 July 1994, eligibility was broadened to include holders of the new Commonwealth Seniors' Health Card. At the commencement of the Program there were some 4.12 million Health Card holders Australia wide who were eligible for services under the Program. In December 1994 the number of eligible clients was 4.46 million. The later figure included adult dependants and approximately 30 000 Commonwealth Seniors' Health Card holders. School age children of Health Card holders were not covered under the Program. All States provided access to dental care for students who were dependants of Health Card holders through the School Dental Service or the Adult/General Dental Services.[6]

Service exclusions

3.8 The CDHP provided for basic levels of dental care. Full and partial dentures were specifically excluded from the Program (as programs for these services already existed in most States), as were other specialist services such as crowns, bridges and orthodontics. The expensive nature of these services was such that their inclusion under the Program would have necessarily meant that fewer people would have been able to access basic levels of care.[7]

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3 Submission No.121, p.2.

4 AIHW study, p.72.

5 Submission No.121, p.3.

6 Submission No.121, p.1.

7 Submission No.121, p.2.

Target numbers

3.9 In accordance with the Agreements with the States throughput measures were agreed annually, as initially it was difficult to be precise about how many people would be treated under the Program. Under the Program a total of 1.5 million services were provided to eligible adults.[8]

Benefits provided by the CDHP

3.10 Evidence to the Committee suggested that the Program had been generally successful in terms of providing access to services for low income groups, reduction in waiting lists and in the shift in treatment options away from extractions and towards restorative treatments.[9]

3.11 The Australian Council of Social Service (ACOSS) stated that 'there is significant evidence that the Commonwealth Dental Health Program was very successful and that its abolition has had an immediate and very damaging impact on the ability of low income people and other disadvantaged Australians to receive the oral health care they need'.[10] The Victorian Healthcare Association also argued that the Program enabled greater access to dental services for 'high need groups' such as the homeless, indigenous Australians, people living in rural and remote areas, new migrants and people with disabilities.[11]

3.12 The views expressed to the Committee in relation to the general success of the Program were supported by evaluation studies conducted by the Australian Institute of Health and Welfare (AIHW) Dental Statistics and Research Unit. The Unit conducted a series of surveys designed to assess the Program's effectiveness in changing the profile of oral health and access to dental care of the eligible Card holder population relative to the broader community.[12]

3.13 The AIHW evaluation of the Program concluded that:

> The CDHP increased the number of eligible card-holders who received public-funded dental care in any year, reduced their waiting time, increased their satisfaction with care, and moved the provision of services in the direction of less extractions and more fillings. However, during the 24

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8 Submission No.121, p.2. DHFS stated that the 1.5 million figure strictly relates to occasions of service, rather than to individuals as a number of clients received more than one service under the Program. See *Committee Hansard,* 6.3.98, p.16.

9 Submissions No.120, p.6; No.61, p.7; No.38, p.4; No.53, p.4; No.85, p.7; No.107, p.5; No.63, p.3. See also *Committee Hansard,* 6.3.98, p.18.

10 Submission No.120, p.6.

11 Submission No.63, p.3.

12 These surveys included information from the wider community via annual national telephone interview surveys with an associated postal survey of satisfaction with care received; from eligible card holders who received publicly funded care; and about publicly funded services provided to card holders. See AIHW study, p.1.

> months since implementation, a substantial shift from emergency to general dental care was not achieved, which will have limited the movement away from extractions and added to provider dissatisfaction. Despite improved public-funded dental care for more card-holders, card-holders are still disadvantaged in terms of their oral health and access to dental care.[13]

3.14 The AIHW found that eligible card-holders benefited from the Program with 200 000 additional persons receiving public-funded dental care in any year (under the full funding in 1995-96). Some 616 000 persons who had received public funded dental care prior to the CDHP, also benefited from shifts in the mix of services with the additional resources available under the Program.[14]

Waiting times

3.15 Evidence to the Committee suggested that the CDHP lead to a significant reduction in waiting times for dental treatment.[15] The AIHW in its evaluation report stated that in the two years following the introduction of the Program the proportion of card holders waiting less than one month for a check-up increased from 47.5 per cent to 61.5 per cent, and those waiting for 12 months or more decreased from 21.1 to 11.3 per cent.[16] Dental Health Services Victoria (DHSV) stated that prior to the introduction of the Program waiting lists of up to 5 years applied for general dental care. Under the CDHP waiting lists for general treatment decreased to about 6 months on average.[17]

3.16 Dr Robert Butler, Executive Director of the Australian Dental Association (ADA), argued that the introduction of the Program:

> …produced an incredibly beneficial effect on its waiting lists. In a very, very short time these waiting lists that I have referred to as being about two years in the dental hospitals were down to below six months. That was a very, very rapid reduction. Not only was it a reversal of the numbers of people on the waiting list, but it was a growing figure before and it became a declining figure. So it had a tremendous effect on access.[18]

Treatment profiles

3.17 The preventative focus of the CDHP was emphasised, as evidence indicated that the Program led to fewer extractions and more fillings being received by recipients. The ADA stated that as a result of the Program 'dental health status was

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13 AIHW study, p.4.

14 AIHW study, pp.1-2, 73.

15 See Submissions No.63, p.3; No.77, p.2; No.120, p.6.

16 AIHW study, p.2.

17 Submission No.67, p.14. See also Submission No.51, p.5.

18 *Committee Hansard,* 6.3.98, p.18.

improved and fewer teeth were being lost as a result of dental diseases'.[19] The Health Department of Western Australia similarly noted an effect of the Program was to move people from emergency care to the restorative focus of the Program as people were encouraged to try to retain teeth and maintain their dentition.[20] The NT Government also referred to this positive change in attitude towards dental health.[21]

3.18 The AIHW study found that in the two years following the introduction of the Program, Card holders received fewer extractions (especially among those last visiting for a problem, 43.8 to 36.5 per cent) and more fillings (among those last visiting for a check-up, 21.7 to 53.5 per cent). The study also found that here was a decreased perceived need for extractions or fillings among card holders and an increase perceived need for check-ups.[22]

More frequent dental visits

3.19 Under the Program there was also a pattern of more frequent visits for dental care. The AIHW study found that the proportion of card holders who made a dental visit in the previous 12 months increased from 58.6 to 67.4 per cent.[23] The ADA noted that the Program enabled card holders 'many who had previously resigned themselves to episodic emergency care only were able to enjoy the benefits of access to dental treatment resources'.[24]

Other benefits

3.20 The AIHW identified a number of secondary benefits under the CHDP. These included the development of a dental policy focus in the Commonwealth Department of Health and Family Services (DHFS), the support of management information systems in the States and Territories (which required annual dental plans) and participation in the monitoring and evaluation of adult access to dental care (conducted by the AIHW Dental Statistics and Research Unit). AIHW stated that as a result 'a better informed environment emerged which could sustain more detailed dental health policy analysis, leading to improved service and oral health'.[25]

3.21 Further, the AIHW noted that a number of smaller ancillary activities were supported such as the Remote and Aboriginal Dental Care Demonstration Projects and

19 Submission No.51, p.5.

20 Submission No.130, p.3.

21 Submission No.133, p.6.

22 AIHW study, p.2.

23 AIHW study, p.2.

24 Submission No.51, p.5.

25 AIHW study, p.84.

Rural Dental Projects under the National Oral Health Advisory Committee and the Quality Assurance Program which was being developed.[26]

3.22 In 1995 the National Oral Health Advisory Committee approved several projects aimed at improving access and equity in rural and remote areas, particularly for Aboriginal and Torres Strait Islander communities. A total of $677 312 was provided for twelve months, ending in June 1996, for five remote areas demonstration projects. These included funding for the Durri Aboriginal Medical Service (AMS), based in Kempsey NSW, for a new mobile dental clinic to serve additional communities and the Western District of Central Australia, based in Alice Springs, to expand the dental team and permit more time to be spent in remote communities.[27]

3.23 In addition, $1.9 million was approved in February 1996 under the National Oral Health Advisory Committee rural initiatives program, for 12 months funding of initiatives in rural areas to provide mobile dental teams for priority areas identified by the States as lacking services or with long waiting times.[28] AIHW stated that these demonstration projects were ‘important public dental health initiatives and rare instances of a national focus on oral health and dental care in Australia’.[29] DHFS also noted that the demonstration projects piloted effective methods of reaching rural and remote communities, including the training of local Aboriginal Health Workers.[30]

Deficiencies of the CDHP

3.24 Notwithstanding the many positive features of the CDHP identified in evidence to the Committee a number of criticisms were made of the Program. These criticisms largely related to features of the Program, which would have been addressed by a more comprehensive oral health program and were aimed particularly at enhancing the delivery of services under the CDHP.

3.25 One deficiency noted by the ADA and AIHW was the restricted range of services offered for the treatment of patients.[31] The ADA stated that in many cases this encouraged removal of teeth, which could have been saved. The Association argued that comprehensive dental treatment options must be available to all patients.[32] The ADA noted, however, that while there were initially ‘some deficiencies in obvious preventive treatments that were offered under the program…we did get some change early in the program as a result of our lobbying on that’.[33]

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26 AIHW study, p.3.

27 Submission No.121, p.4.

28 Submission No.121, pp.4-5.

29 AIHW study, p.84.

30 Submission No.121, p.6.

31 AIHW study, p.3.

32 Submission No.51, p.10.

33 *Committee Hansard,* 6.3.98, p.22.

3.26 Another problem identified by the ADA, AIHW and Public Health Association of Australia (PHA) was that the relatively low level of fees for referrals to private practice meant that there was not sufficient incentive to encourage widespread practitioner participation in the Program.[34] The ADA noted that in many cases, these fees ‘did not even cover costs and it was difficult to persuade many practitioners to undertake treatment for public patients under these circumstances’.[35] The ADA further noted, however, that many of the serious anomalies in the Government fee scale have recently been addressed so that this potential barrier to the profession’s participation in future programs would not occur.[36]

3.27 The ADA stated that the Association ‘collectively and nationally – supported by states – supported the principle of the Commonwealth dental health program’.[37] The ADA noted that while there were ‘pockets of resistance’ to participation in the CDHP, especially from sections of the profession in NSW, generally around the country participation by the profession was ‘quite good’.[38] The AIHW also indicated that the majority of dentists, when offered the opportunity, participated in providing services under the Program.[39]

3.28 Another problem raised by the ADA concerned certain administrative problems with the CDHP such as the separation of emergency and general dental care and the nature of some referrals, for instance for items not covered under the Program. The ADA noted, however, that these problems were ‘fairly minor’.[40] The AIHW noted that most of the concerns raised in relation to the Program could be addressed by policy changes leading to restrictions on emergency care and an emphasis on a more comprehensive, but highly targeted dental care program.[41]

3.29 The AIHW also noted that despite the intention of the CDHP of moving away from emergency dental care towards general dental care, there was only a small shift in public funded care away from problem and emergency care. The AIHW noted that emergency dental care is associated with higher rates of tooth extraction and lower rates of fillings for decayed teeth.[42]

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34 Submissions No.51, p.10; and No.73, p.3; AIHW study, p.3.

35 Submission No.51, p.10.

36 Submission No.51, p.10.

37 *Committee Hansard,* 6.3.98, p.22.

38 *Committee Hansard,* 6.3.98, pp.22-23.

39 AIHW study, p.3.

40 *Committee Hansard,* 6.3.98, p.22.

41 AIHW study, p.3.

42 AIHW study, p.2.

Impact since cessation of the CDHP

3.30 The abolition of the CDHP has had significant effects on the dental care needs of low income and disadvantaged people. The major impacts have been on public dental waiting lists and waiting times, and an overall deterioration in the oral health status of low income and disadvantaged groups in the community.

3.31 The ADA, commenting on the social impact on people since the termination of the Program, stated that:

> Preventable disease has not been addressed and irreparable damage and loss of teeth has resulted. State dental health budgets have been severely attenuated with this loss of funding and the States have not generally been able to make up this shortfall... In most areas of Australia, a waiting time for a simple filling now involves a period of some two years at least and tooth extraction rates are again increasing.[43]

3.32 The PHA, commenting on the adverse effects of the cessation of the Program, stated that:

> The axing of the program in January 1996, just as it was showing positive oral health and access outcomes was a major blow to the provision of publicly funded oral health care. Its demise has left a large gap in access to oral health services for those who traditionally received inadequate oral health care. In addition, the loss of the CHDP has effectively generated a large demand for oral services which is now largely unmet.[44]

Waiting lists and waiting times

3.33 Evidence received by the Committee indicated that since the abolition of the CDHP waiting lists and waiting times for treatment have increased dramatically.[45] At the time of the cessation of the Program in December 1996 there were approximately 380 000 Health Card holders on public waiting lists across Australia, representing an average waiting time of 6 months for non-emergency dental treatment. Currently there are some 500 000 people nationally on waiting lists, representing waiting times ranging from 8 months to 5 years (see the table below).[46]

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43 Submission No.51, p.5.

44 Submission No.73, p.3.

45 Submissions No.51, p.5; No.67, p.15; No.120, p.6; No.103, p.5; No.125, p.7.

46 Submission No.67, p.15.

Table 1: Waiting Lists for Publicly Funded Dental Care with the Loss of the CDHP

	Number of people-mid 1996	Number of people-mid 1997	Estimated average waiting time
NSW	78 000	140 000	Up to 58 months
SA	53 800	78 000	22 months
ACT	1 400	3 600	15 to 30 months
TAS	Not available	13 400	30 months
VIC	101 000	143 000	16 months
QLD	Not available	69 000	10 months
WA	Not available	11 000	8 months

Source: Submission No.67 (Dental Health Services Victoria), p.15.

3.34 The ADA also noted that since the termination of the Program 'waiting lists have blown out and there are now over half a million people on waiting lists for general dental care throughout Australia. This number represents only those Health Care Card Holders who have placed their names on the lists and there are many more who have simply given up due to the waiting times involved'.[47]

3.35 ACOSS also remarked that in the short time since the abolition of the Program waiting lists 'have grown by 20 per cent and now stand at half a million. One hundred thousand people have joined the queue for services in the past twelve months as a result of this short-sighted expenditure cut'.[48]

3.36 The Committee notes that the House of Representatives Standing Committee on Family and Community Affairs commented in an October 1997 report that since the cessation of the CDHP 'there is now some evidence that waiting times for public dental treatment are increasing'. The House of Representatives Committee recommended 'that the Commonwealth Government conduct an annual review of waiting periods for public dental treatment, with a view to ensuring waiting periods do not revert to those experienced prior to the introduction of the Commonwealth Dental Health Program'.[49]

3.37 Information provided from State and Territory Governments and dental services has confirmed the significant increase in the numbers of people on waiting lists and in waiting times for public dental services since the cessation of the Program.

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47 Submission No.51, p.5.

48 Submission No.120, p.6.

49 House of Representatives Standing Committee on Family and Community Affairs, *Concessions – WhoBenefits? Report on Concession Card Availability and Eligibility for Concessions*, October 1997, p.79.

3.38 In New South Wales waiting lists have increased from 92 066 in 1995-96 to 118 504 in 1996-97, with waiting times increasing in some areas to 58 months.[50] At the United Dental Hospital (UDH) of Sydney, which serves residents of Central and South Eastern Sydney, the waiting time for general adult dental care was 4 months in June 1996 when the CDHP was in full operation. After the abolition of the Program, the waiting time increased to 16 months in June 1997 and 20 months in December 1997.[51]

3.39 In Victoria waiting times increased between June 1996 and June 1997 from 12 months to an average of 18 months for general dental care. In the same period the number of people waiting for dental care increased from 101 000 to 139 000.[52] In South Australia waiting lists increased from 41 000 in May 1996 to 77 000 in November 1997 and waiting times from 12 months in August 1996 to 23 months by the end of November 1997.[53] Other States/Territories reported similar increases in waiting times for dental services.[54]

Change from general care to emergency care

3.40 Evidence indicated that since the cessation of the CDHP there has been a shift in the type of care provided by public dental services towards emergency care.[55] Dr Butler of the ADA stated that:

> What is happening now is that the patients who do get access to the public facilities are more often than not very heavily restricted to emergency care only. …in some major hospitals, patients are coming back every five or six months with another crisis – having another tooth extracted or something. That is the sort of dentistry that we had hoped had gone out years ago.[56]

3.41 The Council of Social Service of NSW (NCOSS) also noted that:

> Long waiting times will also mean that the public system becomes increasingly focused on emergency care. Disadvantaged people who are discouraged from seeking care by extremely long waiting lists are much more likely to access services when an emergency situation occurs.[57]

3.42 Analysis of services provided in public dental clinics also indicates that the rate at which teeth are extracted has increased since the abolition of the Program. In

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50 Submission No.131, p.11.

51 Submission No.91, p.6.

52 Submission No.127, p.10.

53 Submission No.86, pp.11-14.

54 Submissions No.41, p.2; No.77, p.3; No.130, p.3.

55 Submissions No.86, p.14; No.91, pp.6-8; No.120, p.6.

56 *Committee Hansard,* 6.3.98, p.19.

57 Submission No.53, p.3.

Victoria the number of extractions increased 10 per cent between July 1996 and October 1997.[58] A similar trend was seen in South Australia, although the increased extraction rate was 6 per cent over the same period.[59] The UDH in Sydney also reported a higher proportion of persons presenting for emergency care who received extractions in 1997 (40 per cent) than in 1996 (31 per cent).[60]

3.43 DHSV stated that the increasing extraction of teeth is a particular concern because extractions are a major cause of functional problems of a dental origin (eating, speaking, and socialising) and is the major inequality in oral health suffered by low income earners.[61]

Community expectations

3.44 Some evidence suggested that the CDHP raised awareness of dental care among the eligible adults and encouraged people to expect a certain standard of dental care, which is now not generally available.[62] Dr Dell Kingsford Smith of the UDH in Sydney asserted that:

> The level of dental awareness and of the rights that people had during that window of opportunity of the Commonwealth dental health program… was so great that people now have an enormous expectation that that is the level of care they ought to be getting.[63]

3.45 The Northern Territory Government also argued that the CDHP had 'influenced a positive change to dental health' for clients in both remote and urban locations. Their submission stated that:

> Until the inception of the CDHP, demand for dental programs was relatively low for reasons including low priority of dental health within the general sphere of health, lack of knowledge about the impact of poor dental health…and acceptance of pain. With the advent of preventive programs established under CDHP, many clients chose to keep their teeth rather than resort to extractions because of delayed access to treatment.[64]

Effect on individuals

3.46 The Committee received anecdotal evidence from numerous pensioners and other people on low incomes which expressed their concern at growing waiting lists for dental services and the personal pain and anguish they are experiencing as a result

58 Submission No.127, p.10.

59 Submission No.86, p.15.

60 Submission No.91, p.8.

61 Submission No.67, p.16.

62 Submissions No.130, p.3; No.131, p.8; No.133, p.6.

63 *Committee Hansard,* 6.3.98, p.44.

64 Submission No.133, p.6.

of the abolition of the Program. One 70-year old pensioner stated that she could ‘no longer afford dental treatment’.[65] Another elderly pensioner wrote saying that he required ‘urgent treatment to save the teeth I have left’.[66] Another pensioner stated that measures were needed to ‘help us poor pensioners to regain what should be a right in a rich country so that we can at least preserve our physical dignity’.[67]

3.47 Welfare groups similarly emphasised the deleterious effect of the abolition of the Program on individual pensioners and beneficiaries.[68] The Council on the Ageing (COTA) reported that its Seniors Information Service in NSW received over 100 calls between July and November 1997 on dental care issues following the abolition of the CDHP. The majority of the calls were from older people wanting information as to where they might obtain dental care sooner than relying on the public system.[69] A survey conducted in South Australia in 1997 of low income clients of financial counselling agencies found that 51 per cent of respondents reported needing urgent dental attention and 60 percent had experienced toothache in the last twelve months necessitating immediate action.[70]

3.48 DHSV stated that State dental programs now are only able to treat the immediate problem causing the dental emergency and place the person’s name on a waiting list. As the waiting lists generally exceed two years the person’s oral condition deteriorates further before a course of care is available; the person often suffers repeat episodes of pain and emergency treatment while on the waiting list; and treatment is more complex and costly as a result of the time interval taken to treat the condition.[71]

Effect on State/Territory funding

3.49 The Committee received evidence that since the cessation of the CDHP most State and Territory governments have been unable to make up the expenditure shortfall as a result of the withdrawal of Commonwealth funding, and therefore have a reduced capacity to respond to the oral health needs of the most disadvantaged groups in the community. The Queensland Government indicated that it has maintained full replacement funding for dental services in that State following the cessation of the Program.[72]

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65 Submission No.14, p.1.

66 Submission No.27, p.1.

67 Submission No.26, p.1.

68 Submissions No.120, p.6; No.85, pp.3-5; No.53, p.3.

69 Submission No.97, p.8.

70 Submission No.105, pp.1-5. See also Submission No.107, pp.4 -6.

71 Submission No.67, p.18.

72 Submission No.128, pp.2, 5-6.

3.50 The New South Wales Government submission noted that the abolition of the CDHP has resulted in a $34 million reduction in Commonwealth funding for NSW for general oral health care. The New South Wales Government stated that:

> This has had profound effects on the oral health of the NSW population and the ability of the Area Dental Services to provide oral health care. The loss of the Commonwealth Dental Health Program resulted in a 47 per cent reduction of funding for adult oral health care annually resulting in approximately 230 000 pensioners and other Social Security beneficiaries no longer being able to access oral health care.[73]

3.51 The New South Wales Government further stated that while the Commonwealth has ceased funding the CDHP, NSW increased its funding for general dental services by $2 million to $69 million in 1997-98.[74]

3.52 In evidence to the Committee, the South Australian Dental Service stated that:

> The loss of the Commonwealth Dental Health Program funding has had significant implications for the financial capacity of the South Australian Government through the South Australian Dental Service, in being able to realistically meet the current, let alone the future dental care needs of low income earners and other disadvantaged groups in this State.[75]

3.53 Other States and Territories expressed similar concerns. In the ACT the Territory dental service indicated that funding was reduced by almost 50 per cent of its adult dental care budget with the abolition of the CDHP.[76] The Northern Territory Government stated that funding constraints have led to a reduction in the number of dental teams in certain areas. The submission noted that CDHP funding cuts will impact 'disproportionately' on rural dental services in the Territory.[77] The Western Australian Department of Health stated that the Western Australian Government does not have sufficient resources to meet the increased demand for dental services following the withdrawal of the CDHP and that without the involvement of the Commonwealth Government 'there will not be an adequately resourced basic dental health program for adults in Australia'.[78]

Reduced access to dental services

3.54 The cessation of the CDHP has led to a diminished capacity of most States and Territories to respond to the oral health needs of the eligible population. In New South Wales, the Government stated that the loss of the Program has resulted in a

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73 Submission No.131, p.11.

74 Submission No.131, p.9.

75 Submission No.86, p.8.

76 Submission No.77, p.3; *Committee Hansard,* 6.3.98, pp.83-85.

77 Submission No.133, p.6.

78 Submission No.130, p.4.

47 per cent reduction of funding for adult oral health care annually resulting in approximately 230 000 pensioners and other social security beneficiaries no longer being able to access oral health care.[79] The Victorian Government stated that in 1995-96 some 211 600 people received public dental services, whereas in 1996-97 only 172 000 accessed care.[80] In Queensland, the State Government noted that without the decision of that Government to provide full replacement funding following the abolition of the Program services to eligible adults would have had to be reduced by some 120 000 treatments annually.[81]

3.55 The Committee received evidence that the abolition of the CDHP has had a severe impact on the ability of the aged and other low income and disadvantaged groups to receive an appropriate level of oral health care.[82] As noted in Chapter 2, these groups suffer particular disadvantage in accessing dental services and generally have poorer oral health than other people in the community. The effect of the cessation of the Program on these groups is discussed below.

Aged people

3.56 Several organisations, including COTA, Aged Care Australia (ACA) and the National Seniors Association (NSA) stated that the withdrawal of the CDHP has significantly reduced access by older people to public dental health services.[83] COTA emphasised that dental health care is a ‘core health issue’ for older people because of its implications for their quality of life.[84]

3.57 ACA stated that for older people:

> Extremely long waiting lists severely restrict access with the result that timely access to dental health care for prevention and maintenance is unavailable. Because of the inability of many older people to afford private dental health care services, many are denied access to any dental health care.[85]

3.58 Evidence also indicated that access to dental health services is a particular problem for older people in nursing homes and residential care facilities.[86] ACA stated that the demise of the CDHP saw the cessation of mobile dental health units to older people in residential care in some metropolitan areas. Dental health services are not included in the residential care prescribed services and thus residents must pay for

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79 Submission No.131, p.13.

80 Submission No.127, p.10.

81 Submission No.128, p.5.

82 Submissions No.120, p.6; No.53, p.3; No.97, pp.7-8.

83 Submissions No.97, pp.7-9; No.49, p.2; No.83, p.3. See also *Committee Hansard,* 23.3.98, pp.112-18.

84 *Committee Hansard,* 23.3.98, p.112.

85 Submission No.49, p.2.

86 Submission No.59, pp.5-6 and Submission No.97, p.7.

these services themselves. For many older people the cost of private dental health care is prohibitive.[87]

People in rural and remote areas

3.59 Organisations representing people living in rural and remote areas stated that with the abolition of the CDHP many people in these areas would be without ready access to dental care. The organisations stated that the Program provided many areas in rural Australia with access to public dental care services for the first time.[88] The National Rural Health Alliance (NRHA) stated that the Program 'was clearly meeting a need for people on low incomes, including many in rural and remote areas.'[89] In Western Australia the Program was available to some 100 000 people in rural and remote areas of the State, but since its termination the number of people in country areas eligible for subsidised services has fallen to 65 000.[90]

3.60 Health Consumers of Rural and Remote Australia (HCRRA) noted that increasing waiting times will adversely affect many rural families with many families now only able to visit a dentist in crisis situations. HCRRA also noted that the limited transport available means that families must travel substantial distances for often long awaited appointments and must incur the additional accommodation and out-of-pocket expenses.[91]

Aboriginals and Torres Strait Islanders

3.61 The Committee received evidence that Aboriginal and Torres Strait Islander (ATSI) communities have been adversely affected by the abolition of the Program.[92]

3.62 The National Aboriginal Community Controlled Health Organisation (NACCHO) argued that some regions have been 'hit particularly hard' by the cessation of the CDHP. In NSW several Aboriginal Community Controlled Health Services (ACCHSs) have had their dental positions cut – 'a similar fate has befallen ACCHSs across the country'.[93] The Northern Territory Government indicated that dental service teams operating from Darwin, Alice Springs, Katherine and Gove had been reduced or had their services modified following the cessation of CDHP funding.[94]

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87 Submission No.49, p.2.

88 Submission No.40, p.1 and Submission No.129, p.6. See also *Committee Hansard,* 6.3.98, pp.56-65.

89 *Committee Hansard,* 6.3.98, p.58.

90 *Committee Hansard,* 6.3.98, p.58.

91 Submission No.40, p.1.

92 Submissions No.78, pp.5-7 and No.23, pp.7-11. See also *Committee Hansard,* 6.3.98, pp.66-78.

93 Submission No.78, p.6.

94 Submission No.133, pp.5-6.

3.63 The impact of the cessation of the Program on local Aboriginal communities was illustrated in the case of the Durri Aboriginal Medical Service (AMS). The Durri AMS stated that since July 1997 it has been unable to provide dental health services to the local Aboriginal community of the North Eastern region of NSW after providing the service successfully for 18 months prior to the abolition of the CDHP.[95] The AMS stated that the service 'was well received by the community members and provided an essential service that has been overlooked for many years'.[96]

3.64 NACCHO stated that in other States such as Tasmania, the abolition of the CDHP would mean ACCHSs would be forced to make fee-for-service payments to dentists in private practice to keep pace with the demand for dental services. [97]

Medically compromised patients

3.65 Evidence indicated that medically compromised patients have had reduced access to public dental services as a result of the cessation of the Program.[98] Dr Peter Foltyn, a Consultant Dentist at St Vincent's Hospital, Sydney, in evidence to the Committee, outlined the problems faced by these patients, including long waiting lists for public treatment in hospitals in the larger cities, and the often inadequate provision of public dental facilities in rural and remote areas.[99]

3.66 Dr Foltyn stated that many patients requiring dental treatment as part of their medical management before undergoing a surgical or medical procedure have been 'unable to access the appropriate treatment in the public sector'.[100] Dr Foltyn added that the abolition of the Program 'has denied many patients ready access to a treatment adjuvant to their primary medical condition'.[101]

Other disadvantaged groups

3.67 The Council for Homeless Persons noted that the CDHP was important in providing access to dental care for homeless people. The Council noted that, for example, the Program enabled the Gill Dental Health Clinic at the Salvation Army in Melbourne to treat over 1 000 homeless people in the nine months to August 1996. Prior to the establishment of the Program the Clinic could only offer a rudimentary service to homeless people.[102] The Council stated that 'people who are homeless were

95 Submission No.23, p.10.

96 Submission No.23, p.9.

97 Submission No.78, p.6.

98 Submission No.91, pp.4, 9; *Committee Hansard,* 6.3.98, pp.34-38.

99 Submission No.59, p.3.

100 Submission No.59, p.3.

101 Submission No.59, p.6.

102 Submission No.48, p.5.

able, often for the first time, to pursue dental treatment that was both accessible and affordable'.[103]

3.68 Organisations representing people with intellectual disabilities also argued that the abolition of the Program was causing problems of access to dental care. The Intellectual Disability Services Council stated that 'almost without exception people with intellectual disability are poor, and rely upon a number of public services for their well being'.[104] The organisations noted that increasing waiting lists are causing pain and discomfort for people with disabilities unable to access dental services and additional worry and concern for their carers.[105]

3.69 Organisations representing people with HIV/AIDS stated that people with AIDS have been disadvantaged as a result of the cessation of the Program which has reduced access to dental services for AIDS sufferers, particularly those who are already financially disadvantaged.[106] The Australian Federation of AIDS Organisations (AFAO) stated that the abolition of the CDHP has 'caused financial pressure and increased difficulties for positive people – a community with a much greater need for dental services than the general population'.[107]

Conclusions

3.70 Evidence to the Committee indicates that the CDHP was successful in meeting its aims, especially in terms of providing greater access to dental services for low income and other disadvantaged groups in the community. Since the cessation of the Program access to dental care has been reduced with increasing public dental waiting lists. There are now over half a million people on waiting lists for general dental care throughout Australia. The Committee believes that it is unacceptable that this situation should occur contributing as it does to social inequalities in the community and affecting the most vulnerable and disadvantaged groups in society.

3.71 Evidence to the inquiry also indicates that there has been an overall deterioration in the oral health status of persons previously utilising services under the CDHP and a shift in the type of care provided from general dental care to emergency care. Evidence presented to the Committee also showed that since the abolition of the Program most State and Territory Governments have been unable to make up the expenditure shortfall caused by the withdrawal of Commonwealth funding which is affecting the ability of most State and Territory Governments to respond to the needs of the most disadvantaged groups in the community.

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103 Submission No.48, p.4.

104 Submission No.45, p.1.

105 Submission No.45, p.1 and Submission No.11, pp.1-2.

106 Submission No.124, pp.1-5 and Submission No.119, pp.1-6. See also *Committee Hansard,* 6.3.98, pp.37-38.

107 Submission No.124, p.1.