AUSTRALIAN DENTAL ASSOCIATION

Select Committee into the Provision of and Access to Dental Services in Australia

Australian Dental Association

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Executive summary

Dental caries (also known as tooth decay or dental cavities) is the *most common noncommunicable disease worldwide*, and *Australia's most prevalent health problem*.

This condition was associated with spending of $4.5 billion in Australia in 2019-20.[1] Overall, $11.1 billion was spent on dental services in 2020–21 ($432 per capita).[2]

Dental problems are largely preventable. By practicing preventive measures and seeking timely dental care, individuals can significantly reduce the incidence of dental problems and the demand for services would subsequently be reduced.

Failure to prevent dental problems can result in significant personal and societal costs – including pain, discomfort, and decreased quality of life for individuals – and economic burdens such as lost productivity, and increased healthcare expenses for society.

The ADA's Australian Dental Health Plan (enclosed) provides a blueprint for the Australian Government's involvement in the delivery and funding of dental care in Australia. We encourage the Committee to consider this document along with our submission, and we will be most happy to supply further advice.

Specific opportunities we would like to emphasise to the Committee include:

- Establishing targeted and staged schemes to improve access to oral care for Australians, initially aimed at demographics more susceptible to oral disease such as those in aged care, or those with a disability.
- Introducing a health levy on sugary drinks to incentivise reduced consumption and potentially provide funding for additional programs.
- Utilising the extensive private clinic infrastructure to provide public dental services via voucher schemes.
- Extending availability of preventive services available under the Child Dental Benefits Schedule, including eligibility for custom-made mouthguards and in-hospital services provided under general anaesthesia.
- Considering effective methods to educate Australians about the importance of oral health, and what they can do to support their own oral health and that of their families.
- Supporting state and local governments to extend access to fluoridated water to more Australian communities with reticulated water supplies.

1 Disease expenditure in Australia 2019–20, Summary - Australian Institute of Health and Welfare. Retrieved 22 May 2023, from https://www aihw.gov.au/reports/health-welfare-expenditure/disease-expenditure-in-australia-2019-20/contents/summary

2 Oral health and dental care in Australia, Costs - Australian Institute of Health and Welfare. Retrieved 25 May 2023, from https://www.aihw gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/costs

About us

The Australian Dental Association (ADA) is the peak representative body for dentists in Australia. Our 17,000-plus members operate more than 7,500 small businesses across Australia. They include highly trained professionals who work across the public and private sectors, in general dental practice, or in one of 13 areas of dental specialisation, in education and research roles, as well as dentistry students currently completing their entry-to-practice qualification.

The primary objectives of the ADA are to encourage the improvement of the oral and general health of the public, promote the ethics, art and science of dentistry and support members to provide safe, high-quality professional oral care.

Dentists are vital contributors to Australian public health. The importance lies in their ability to treat and prevent oral diseases and enhance overall well-being. By providing essential care and services, dentists help their patients maintain healthy teeth and gums, empowering them to eat, speak, and smile with confidence. They are crucial in diagnosing and treating oral diseases, which, if left untreated, can lead to more severe health issues and increase the burden on Australia's hospital system. Dentists also contribute to aesthetics by enhancing smiles and boosting self-esteem.

The ADA is an active member of the FDI World Dental Federation, underscoring our commitment to global oral health. As a representative of the dental profession in Australia, the ADA collaborates with the FDI to advocate for optimal oral care standards, promote oral health policies, and advance dental education and research on an international level. This partnership strengthens the ADA's role as a key influencer in shaping dental practices, policies, and public health strategies.

The experience of children and adults in accessing and affording dental and related services

Overview

Experiences in accessing and affording dental and related services will vary widely across the country, subject to factors including geographical location, whether emergency treatment in a hospital is needed, whether a patient receives publicly funded treatment, holds a relevant insurance policy, or funds their treatment themselves, and the complexity of their oral health needs.

In Australia approximately one-third of people have indicated they do not access oral health care in a timely manner because of cost. This can reflect both the price sensitivity toward oral health services and priorities given by individuals with their discretionary spending.

Experience of children

Australia has public dental programs that aim to provide basic dental care for children. In certain states free or subsidised dental care is available up to the age of 12. Additionally, around 3 million children have access to the Child Dental Benefits Schedule (CDBS), with uptake rates approaching 40% of those eligible. The CDBS is discussed further below.

Many families hold private health insurance (PHI) policies for their children which, in return for their payment of premiums, can subsidise the cost of dental treatment, in full or part, up to pre-agreed annual limits. They may need to privately fund gap payments for their child's dental treatments.

Almost 81% of Australian children had visited a dental provider within the last 12 months at the time of the National Child Oral Health Study 2012-14[3] – a rate far higher than adults. But for some children and families there remain challenges to overcome. Financial barriers can hinder access for low or middle-income families who may not qualify for treatment under public programs, who may not hold PHI policies for their children, or who might struggle to afford to privately fund their child's treatment. Geographical challenges also exist, particularly in remote areas, where access to paediatric dentists can be limited.

More complex cases requiring conscious sedation or general anaesthetic for pre-cooperative aged children can be challenging to accommodate. Access to specialist care is often limited, partly due to the reduction of access to hospital facilities for dental providers.

Children – oral health statistics

- 42% of 5–10-year-olds have had decay in their baby teeth.[4]
- 24% of 6–14-year-olds have decay in their permanent teeth.[5]
- The proportion of children aged 10–14 years who experienced toothache in the previous 12 months increased from 4.3% in 2013 to 13% in 2017–18.[6]

3 Do LG, Spencer AJ, eds. (2016), Oral health of Australian children: The National Child Oral Health Study 2012-14, Adelaide: University of Adelaide Press, Retrieved 31 May 2023, p.172, from https://healthinfonet.ecu.edu.au/uploads/resources/32797_32797.pdf

4 Australian Institute of Health and Welfare. (2023). Retrieved 2 June 2023, from https://www aihw.gov.au/getmedia/b44000d6-52c7-4f1d-a7fe-7938e104184f/Oral-health-and-dental-care-in-Australia.pdf aspx?inline=true

5 Ibid

6 National Oral Health Plan 2015–2024: performance monitoring report (2020). Retrieved 2 June 2023, from https://www.aihw gov.au/getmedia/b8ab9d5f-598b-412c-8c22-d774423f58da/National-Oral-Health-Plan-2015-2024-performance-monitoring-report.pdf.aspx?inline=true

Experience of adults

Only 44% of adult Australians display a favourable dental visiting pattern – being once or more per year. Australia has public dental programs that aim to provide basic dental care for eligible adults. However, public programs are oversubscribed, and rationing through queuing occurs, with long wait-times for general care common for those individuals who do not benefit from 'priority access'.

There is historical evidence that outsourcing to the private sector has reduced waiting lists significantly in the past. Issuing publicly funded vouchers for use at private dental clinics and enabling dentists to recommend a treatment plan under a voucher system, are measures that might be expected to reduce wait times and enhance treatment outcomes. To have the greatest impact, public funds are far better spent on oral health treatment rather than infrastructure, as the set-up costs of a dental surgery are considerable (over $100,000 per operatory).

A key issue with previous and some existing voucher schemes is that they are generally focused on emergency patients and may only allow care defined as emergency care. Therefore, the patient experiences disempowerment, such as where a treating private practitioner may identify other issues with their oral health during emergency treatment, but the patient is prevented from electing to address these issues with that private practitioner via further publicly subsidised care and must instead return to a public general care waitlist. This delay increases the severity of oral disease and consequent burden on the healthcare system.

Many adults hold PHI policies which, in return for their payment of premiums, can subsidise the cost of dental treatment, in full or part, up to pre-agreed annual limits. They may need to privately fund gap payments for their own dental treatments.

Adults – oral health statistics

- Australian adults aged 15 years and over had an average of 11.2 decayed, missing and filled teeth in 2017–18.[7]
- The average number of teeth affected by dental caries per person in Australia increased with age, from an average of 4.1 in 15–34 year olds to 10.3 in 35–54 year olds, 19.4 in 55–74 year olds and 24.4 in people aged 75 and older in 2017–18.[8]
- The proportion of adults with untreated tooth decay increased between 2004–06 and 2017–18.[9]
- The proportion of adults with at least one tooth with untreated decay has increased over time. In 2017–18, around 1 in 3 (33%) adults aged 15–64 years and around 1 in 4 (27%) adults aged 65 years and over had at least one tooth with untreated decay compared to 1 in 4 (26%) and 1 in 5 (22%) in 2004–06.[10]
- In 2017–18, around one-third (30%) of adults aged 15 years and over had moderate or severe periodontitis, an increase from around one-quarter (23%) in 2004–06.[11]

7 Australian Institute of Health and Welfare. (2023). Oral health and dental care in Australia: Healthy teeth. Retrieved 22 May 2023 from https://www aihw gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/healthy-teeth

8 Ibid

9 National Oral Health Plan 2015–2024: performance monitoring report, About - Australian Institute of Health and Welfare. (2020). Retrieved 2 June 2023, from https //www.aihw.gov au/reports/dental-oral-health/national-oral-health-plan-2015-2024/contents/about

10 National Oral Health Plan 2015–2024: performance monitoring report, Untreated caries prevalence - Australian Institute of Health and Welfare. (2020). Retrieved 2 June 2023, from https://www.aihw.gov.au/reports/dental-oral-health/national-oral-health-plan-2015-2024/contents/our-oral-health-a-national-perspective/untreated-caries-prevalence

11 National Oral Health Plan 2015–2024: performance monitoring report, Periodontitis prevalence - Australian Institute of Health and Welfare. (2020). Retrieved 2 June 2023, from https://www.aihw.gov.au/reports/dental-oral-health/national-oral-health-plan-2015-2024/contents/our-oral-health-a-national-perspective/periodontitis-prevalence

Falling through the gaps?

An adult cohort we're concerned about comprises adults who do not qualify for public dental care, who may or may not have PHI coverage, who may be employed, but whose net income after tax and other necessary liabilities are deducted may genuinely not enable them to privately fund their own clinically necessary treatment. We encourage the Committee to attempt to identify and consider the experiences of this 'silent' cohort. While many dentists offer payment plans, individuals in this situation might choose to delay or limit treatment.

It would be financially prudent for this cohort to practice excellent oral hygiene and limit dietary sugar, to reduce their need for complex treatment. The ADA regularly disseminates public health advice to support this preventative approach, however a key opportunity exists for the Government to partner with ADA's annual Dental Health Week, which publicises expert-led oral health prevention measures all over Australia each August. Government funding and support in publicising the event and increasing awareness will create an even more impactful campaign. Current reach is significant but necessarily constrained by the budget limitations of the ADA. As the assets already exist, we would be able to rapidly scale to further provide preventative oral care advice to target demographics should Government support become a reality.

Affordability related statistics

- Around 1 in 6 (16%) reported that cost was a reason for delaying or not seeing a dental professional.[12]
- Around 1 in 4 (23%) dentate adults aged 15 years and over who visited a dentist in the last 12 months reported that cost prevented recommended dental treatment.[13]

Recommendations

1. Review public dental program waiting list criteria and consider the clinical appropriateness and equity implications of 'priority access' arrangements.
2. Develop nationally consistent essential and medically urgent dental care criteria.
3. Consider a model that enables overflow patients from the public system to attend private practitioners using a voucher-based, publicly funded program, in a way that enables the patient to receive holistic rather than stand-alone emergency care.
4. Attempt to identify and consider the experiences of the 'silent' cohort described above.
5. Support the ADA's Australian Dental Health Week campaign.

12 Australian Institute of Health and Welfare. (2022). Oral health and dental care in Australia: Summary. Retrieved 22 May 2023 from https://www aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/summary

13 Australian Institute of Health and Welfare. (2020). Oral health and dental care in Australia: Costs. Retrieved 22 May 2023 from https://www.aihw gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/costs

The adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas

Adequacy and availability of public dental services

Data published in 2018 indicates that an estimated 36% of the Australian population was eligible to receive public dental care. Despite the availability of these services, the COAG Health Council estimated that then current funding for public oral health services allows for treatment of only about 20% of the eligible group.[14]

Information obtained under the *Freedom of Information Act 1982* similarly indicates that the public sector in Victoria has only ever had the capacity to service less than 25% of the eligible population in any given two-year period. This capacity declined during pandemic lockdowns but has since returned to pre-pandemic levels. While there is significant demand for dental services, the availability of public dental care falls short, resulting in lengthy waiting times for treatment and limited access for some of those who might depend on publicly funded dental care.

The limited capacity of public dental services in Australia necessitates a focus on treating problems rather than a greater focus on prevention. Public dental clinics receive funding based on the Dental Weighted Activity Unit model, which is based on the complexity and length of time required to complete a dental procedure. This type of model does not necessarily reward preventative care.

Contrast between metropolitan and non-metropolitan areas

In major cities and metropolitan areas, public dental services are generally more accessible, with a range of options available to patients. However, in outer-metropolitan, rural, regional, and remote areas, availability challenges arise. These areas frequently experience limited access to public dental clinics, and a shortage of dental professionals, leading to longer waiting times for appointments.

We would be interested to see detailed evidence of variation in care delivery and outcomes in metropolitan and non-metropolitan areas. The 'Australian Atlas of Healthcare Variation' series could be an appropriate vehicle for such analysis; however, it doesn't comment on any oral health topics.

Remote area challenges

The lack of resources and infrastructure in regional areas can lead to difficulties in accessing preventative and routine dental care, which may contribute to differences in oral health observed between urban and rural populations.

Overall, people living in regional and remote areas of Australia have poorer oral health than those living in major cities, and oral health status generally declines as remoteness increases. people living in rural areas have access to fewer dental practitioners than their city counterparts, which, coupled with longer travel times and limited transport options to services, affects the oral health care that they can receive.[15]

Australia's geography and population distribution characteristics make it both challenging and costly to ensure equal access to dental services for all Australian residents, regardless of their location. The low population density in many remote and very remote areas cannot sustain a permanent dental workforce and/or the required dental facilities. In some cases, there may be facilities but not staff. We are aware of anecdotal information suggesting

14 A discussion of public dental waiting times information in Australia 2013–14 to 2016–17. Retrieved 22 May 2023, from https://www.aihw.gov au/getmedia/df234a9a-5c47-4483-9cf7-15ce162d3461/aihw-den-230.pdf.aspx

15 Oral health and dental care in Australia, People living in regional and remote areas - Australian Institute of Health and Welfare. (2023). Retrieved 22 May 2023, from https //www.aihw.gov au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/priority-populations/people-living-in-regional-and-remote-areas

public dental chairs are not being utilised in some rural areas due to lack of funding and staff.

Government subsidy directed to remote and very remote dental care should be directed to utilise already established dental clinics in those regions as set out in the ADA's Australian Dental Health Plan. In some cases, a practice may have reached capacity with dental demand in the area not being able to be met. The provision of capital assistance to such a practice to provide an additional dental chair (surgery) and the recruitment of an additional practitioner may be the most expeditious utilisation of funding to achieve improved dental care delivery in that community.

A key argument for issuing provider numbers to allied dental practitioners was that it would increase access to care in rural and remote areas. This does not seem to have eventuated since the implementation in July 2022 and suggests difficulty with recruitment and retention in remote areas is the underlying issue for all dental professionals. As such the ADA does not see increasing the number of independent dental practitioners as a solution.

Efforts to recruit and retain dentists to remote areas, and specialist dentists to regional and remote areas capable of sustaining a dental workforce should be a priority. For those areas where it is difficult to recruit dentists, efforts should include:

- inclusion of dental students in existing Commonwealth education and training initiatives, such as scholarships and housing support
- local community support and incentives
- working conditions and incentives for public practitioners.

Dental Relocation and Infrastructure Support Scheme

The now closed Dental Relocation and Infrastructure Support Scheme (DRISS) aimed to address the poor state of dental services in rural and remote areas, and to incentivise relocation and rebalance the oversupply of dentists in some larger Australian cities.

Grants available under DRISS varied according to the location from which the dentist was relocating and the destination location. The largest grant of $120,000 could be obtained by moving from a major city to a very remote area. We understand that much smaller grants for less extreme relocations were the most prevalent. Dentists eligible for the relocation grant could also apply for an infrastructure grant, tiered by remoteness, of up to $250,000 to assist in the purchase of equipment and equipping facilities.

One of the limitations was the fact that the recipients were only allowed to provide a small percentage of treatment to public patients. Had practices been allowed to operate as a provider to public patients as well as continue to offer private services on demand, more practices could have met the threshold for viability in remote or rural areas with lesser socioeconomic characteristics.

Any future scheme should be flexible enough to allow the dental practitioner to treat any patient, based on their oral health requirements, rather than binding the practitioner to quotas of, for example, public or private patients.

Patient evaluation by non-dental professionals

Oral health evaluation by non-dental health professionals offers potential benefits in promoting overall oral health and well-being – particularly in remote or rural locations where dental professionals may not be as accessible. These professionals, such as physicians, nurses, and pharmacists, could play a helpful role in early detection, prevention, and referral of oral health issues, however it is vital that the type of diagnosis expected of

these professionals should be basic, reflecting their lack of oral health training.

By including basic oral health assessments as part of routine health check-ups in areas without a dentist, non-dental health professionals could identify obvious oral health problems and refer them to dental professionals for further evaluation and treatment.

The Healthy Kids Check[16] aims to gather health information, identify health problems, and promote healthy lifestyles around the time of the 4 years of age vaccinations. It consists of a checklist of examinations and assessments, six of which are mandatory, including checking oral health. The RACGP notes that most GPs have not received training in the assessment of oral health in children.[17]

The Senior Health Assessment[18] is a comprehensive assessment of health, physical, psychological, and social function. It helps to assist in the early identification of care needs. Those aged 75 years or over living in a community setting are eligible. The health professional undertaking the health assessment *may* consider the patient's oral health and dentition.

Persons who identify as an Aboriginal or Torres Strait Islander person and who hold a Medicare card, can get a free health check[19] every year. The health check can take up to an hour and includes oral and dental health.[20] The Health Assessment for people with an intellectual disability[21] does not appear to include an oral health check so far as we are aware.

Key statistics

- Around 142,269 people do not have access to dental services within a 60-minute drive time.[22]
- In 2020–21, the rate of potentially preventable hospitalisations due to dental conditions (per 1,000 population) was found to increase, as remoteness increased, ranging from 3.0 per 1,000 population in major cities to 4.8 per 1,000 population in very remote areas.[23]
- Between 2016–17 and 2020–21, the rate of potentially preventable hospitalisations due to dental conditions was consistently higher for those living in very remote areas than those living in major cities.[24]

16 Medicare item 10986 for Healthy Kids Check conducted entirely by the practice nurse, and Medicare items 701, 703, 705, 707 (time based health assessments) for Healthy Kids Check requiring GP input

17 How to perform a 'Healthy Kids Check'. Retrieved 31 May 2023, from https://www racgp.org.au/getattachment/06ff48c0-a723-4457-a6a5-830db7d2cc93/Healthy-Kids-Check.aspx

18 MBS item 701 (brief), 703 (standard), 705 (long) or 707 (prolonged)

19 Medicare Benefits Schedule - Item 715

20 Aboriginal and Torres Strait Islander health check – Adults (25–49 years). Retrieved 31 May 2023, from https://www.racgp.org.au/getmedia/4f527434-7c7d-4b5d-9f3c-a42a2ed79c43/Health-check-Adults.pdf.aspx

21 MBS Items 701 (brief), 703 (standard), 705 (long) or 707 (prolonged)

22 Gardiner, F. W., Bishop, L., de Graaf, B., Campbell, J. A., Gale, L., Quinlan, F. (2020). Equitable patient access to primary healthcare in Australia. Canberra, The Royal Flying Doctor Service of Australia

23 Australian Institute of Health and Welfare. (2022). Oral health and dental care in Australia: Hospitalisations. Retrieved 22 May 2023 from https //www.aihw.gov au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/hospitalisations

24 bid

Recommendations

6. Monitor and aim to reduce the number of people who do not have access to dental services within a 60-minute drive time by motor vehicle through establishment of permanent facilities or visiting clinics.
7. Examine the effectiveness of the DRISS program in incentivising dentists to establish clinics in rural and remote regions and consider reintroducing a scheme with similar intent but greater flexibility.
8. Consider enhancing oral health training through the National Rural Generalist Pathway and the Rural Generalist Nurse Program.
9. Explore promoting oral health evaluation in the Senior Health Assessment and the Health Assessment for people with an intellectual disability.

The interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services

Most dental care in Australia is privately funded and privately delivered

Overall, individuals directly fund a significant proportion (59% in 2020–21[25], higher when PHI is considered) of total expenditure on dental services, and most dental services (approximately 80–90%) are delivered by the private sector on a fee-per-item basis.[26] A small proportion of services are provided by federal, state and territory government sources either directly through public dental services, or by funding private practitioners to provide services.

Commonwealth responsibility for the provision of dental services

The nature of the Commonwealth's responsibility to make laws for the provision of dental services pursuant to section 51(xxiiiA) of the Australian Constitution and the extent to which the Commonwealth was fulfilling that responsibility is discussed in detail at Chapter 4 of the Senate Standing Committees on Community Affairs' Inquiry into Public Dental Services 1998 report.[27]

The ADA understands that the Commonwealth, like the states and territories, has the right, but not the obligation, to make laws and other arrangements such as funding, for the provision of dental services.

Funding trends

Australian Government expenditure

- Australian Government expenditure on dental services fluctuated over the decade to 2020-21, from a high of $1.8 billion in 2011–12 to a low of $1.2 billion in 2019-2020 with expenditure remaining relatively stable between 2014-15 and 2020-21 at around $1.3 billion. Across the period, expenditure declined at an average annual rate of 1.6%.[28]
- Between 2010–11 and 2020–21, Australian Government per capita expenditure on dental services fluctuated between $49 in 2019-2020 and $82 in 2011-2012, declining overall at an average annual rate of 3.0%.[29]

State and territory government expenditure

- Overall, state and territory government expenditure on dental services grew at an average annual rate of 0.7%. Expenditure fluctuated over the decade; ranging from lowest expenses of $711 million in 2012–13 to highest expenses of $946 million in 2020–21.[30]
- State/territory and local government per capita expenditure fluctuated during the period 2010–11 to 2020–21, ranging from $31 in 2012–13 to $40 in 2010–11. Across the period, expenditure declined at an average annual rate of 0.8%.[31]

25 Oral health and dental care in Australia, Costs - Australian Institute of Health and Welfare. (2023). Retrieved 21 May 2023, from https://www.aihw gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/costs

26 Public and private dental services in NSW: a geographic information system analysis of access to care for 7 million Australians. Vol. 24(4) 2014 NSW Public Health Bulletin

27 Chapter 4 - Commonwealth's responsibility for the provision of dental services. (2023). Retrieved 19 May 2023, from https //www.aph.gov.au/parliamentary_business/committees/senate/community_affairs/completed_inquiries/1996-99/dental/report/c04

28 Oral health and dental care in Australia, Costs - Australian Institute of Health and Welfare. (2023). Retrieved 22 May 2023, from https://www.aihw gov.au/reports/den/231/oral-health-and-dental-care-in-australia/contents/costs

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National Partnership Agreement on Public Dental Services

Under the National Partnership Agreement on Public Dental Services, the Australian Government provides funding to states and territories to improve public dental services across the country. We understand that a predetermined funding formula considers factors such as population size and service delivery needs. The funds are intended to increase the capacity of public dental services, reduce waiting lists, and provide treatment to priority groups.

States and territories rely on this funding, which has been subject to annual extensions. This arrangement offers limited assurance to states and territories regarding planning services effectively. The current funding model of the Agreement is extended annually towards the end of each funding period. This annual extension approach limits the ability of the state service to plan adequately in the medium to long term and therefore has an adverse effect on the implementation of strategic initiatives aimed at meeting the community need for dental services. It also adversely affects the retention and recruitment of skilled staff, especially in rural and remote areas.

The additional funding has been provided by the Australian Government since 2013 through National Partnership Agreements and the CDBS since 2014. Ultimately, funding is not certain, as the Australian Government can choose to discontinue them (in the case of the National Partnership Agreement) or legislate to close it (in the case of the Child Dental Benefits Schedule) at any time.

Although efforts are underway to develop a Federal Funding Agreement for oral health, which would bring some stability to funding agreements, the delay in finalising such an agreement continues to restrict the capacity of states and territories to provide services to individuals reliant on public dental care. A long term, secure approach to funding is vital to enable consistent improvement of oral health.

Public dental care – state programs

Most programs provide free or subsidised care to eligible children. Adults generally require a healthcare card or Centrelink pensioner concession card to be eligible. Depending on the state or territory, treatments may be free of charge or a partial payment for the treatment may be required. A summary of state-based public dental program arrangements is enclosed.

While arrangements vary between states and territories, Victoria is a reasonably representative example, covering around 25% of the national population. In Victoria, the following people are eligible for public dental care:

- all children aged 0–12 years
- young people aged 13–17 years who hold a healthcare or pensioner concession card, or who are dependents of concession card holders
- people aged 18 years and over, who are health care or pensioner concession card holders or dependents of concession card holders
- all children and young people in out-of-home care provided by the Department of Families, Fairness and Housing, up to 18 years of age (including kinship and foster care)
- all people in youth justice custodial care
- all Aboriginal and Torres Strait Islander people
- all refugees and asylum seekers.

Victorian residents who have priority access to dental care are offered the next available appointment for general care. They are not placed on the general waiting list. If the person has denture care needs, then they will be offered the next available appointment for denture care or placed on the priority denture waiting list. The following people have priority access to public dental services:

- Aboriginal and Torres Strait Islander people
- children and young people
- people who are homeless or at risk of homelessness
- pregnant women
- refugees and asylum seekers
- people registered with mental health or disability services, who have a letter of recommendation from their case manager or a special developmental school.

All other people seeking routine dental or denture care need to place their name on a waiting list.

The program is selective through eligibility criteria. It then rations treatment via queuing, except for individuals with 'priority access' identity characteristics, who may skip the queue.

Public waiting lists

Waiting lists are a common occurrence in the public dental system, particularly for non-urgent or elective procedures. The length of waiting times can range from weeks to months, and in some cases, years. Priority is sometimes given to individuals with urgent dental needs, such as those experiencing severe pain or infection. However, for individuals requiring routine or preventive care, the waiting times can be longer, and the type of treatments that may be clinically recommended by a dentist may not be approved by the state authority.

The length of waiting lists is influenced by factors such as availability of dental practitioners, the funding allocated to public dental services, and the demand for services in an area. In some cases, patients may choose to seek private dental care to bypass waiting lists, but for many who qualify for public dental services this option may not be viable.

Public wait times data

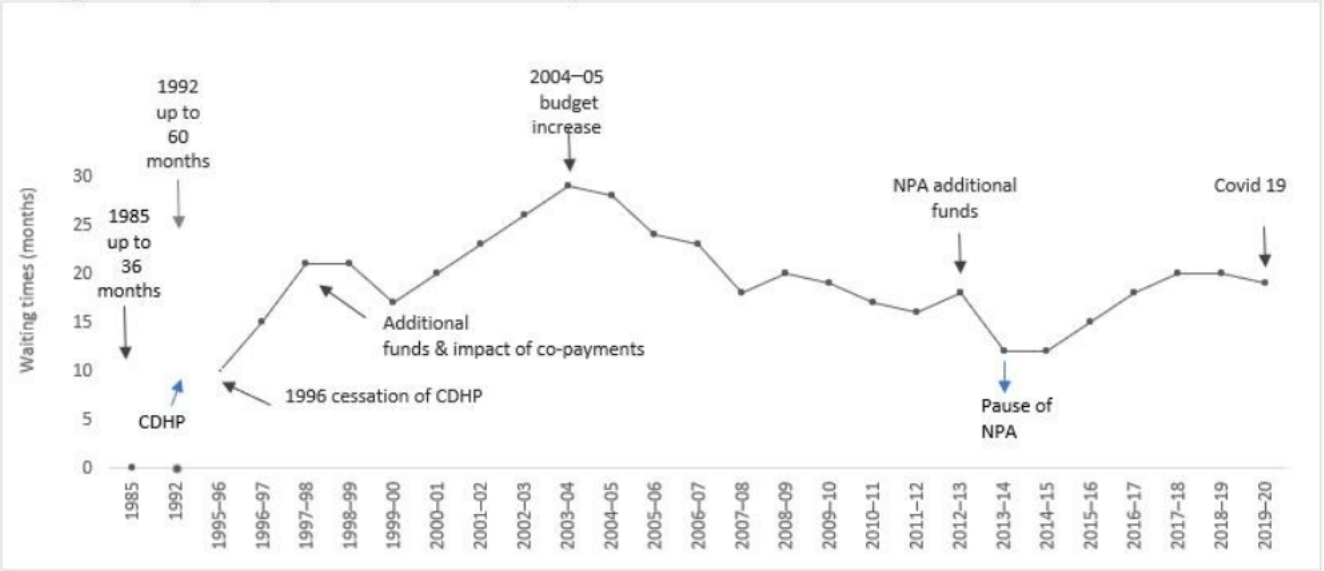
States report public dental wait times to the Australian Institute of Health and Welfare (AIHW) using the Public Dental Wait Times National Minimum Data Set (PDWT NMDS). One significant drawback of the PDWT NMDS data is that it pertains to public dental programs that operate with variations in arrangement and delivery across different states and territories. Consequently, the data's utility for comparing jurisdictions or providing a comprehensive national overview of public dental waiting times is restricted. Standardisation of patient data collection across all states and territories is required to make meaningful comparisons nationwide. Therefore, there is a necessity for funding or otherwise ensuring a nationally accepted waitlist data set that allows for easy comparison across jurisdictions.

Time to treatment is an important metric for service effectiveness. Public performance reporting of patients treated within clinically acceptable waiting times (benchmarked by risk category) would improve accountability and identify areas for performance improvement.

The following chart[32] describes Victorian wait time in months for public sector care, and demonstrates influences of Commonwealth funding on wait times:

32 Chart made/provided courtesy of Dr John Roders, previously Principal Oral Health Policy Advisor in the Victorian Department of Health

Waiting times for general public dental care in Victoria, 1985 to 2020 in months



Voucher programs

Some states and territories have implemented voucher programs to assist eligible individuals to access dental treatment. Details vary between states and territories. Typically, eligible individuals receive a voucher that can be used to cover a portion of the cost of dental treatment at participating private dental clinics.

For example, in NSW, in addition to services provided in public dental clinics, vouchers may be offered to eligible patients under the Oral Health Fee for Service Scheme (OHFFSS). Dental vouchers are issued in emergency cases or when the public dental service cannot provide the required treatment. The type of voucher issued is dependent on the dental needs of the patient and the resources available to the public dental service.

Utilising private practice infrastructure and practitioners makes economic sense. It has proven successful in reducing the number of patients on public dental waiting lists and freeing up the public system to treat more patients. Outsourcing dental care and utilising private infrastructure has reduced the public dental waiting lists and has made a significant positive impact.

In some cases, the voucher may not be adequate for optimal care, such as in cases where a tooth could be saved with root canal treatment, but the voucher only covers the cost of extraction. In such cases, the tooth may be extracted in favour of more costly alternatives.

Commonwealth historic programs

A summary describing historic dental programs in Australia and the Commonwealth's role in dental service provision/funding is enclosed.

Recommendations

10. Assess the declining trend in government funding allocated to public dental care over the past decade.
11. Encourage swift completion of Federal Funding Agreement for oral health negotiations, allowing for the establishment of multi-year arrangements that cover, at the very least, the forward estimates period.
12. Ensure that a nationally accepted waitlist data set that allows for easy comparison across jurisdictions is developed and utilised.

The provision of dental services under Medicare, including the Child Dental Benefits Schedule

Provision of dental services under Medicare

Considerations in relation to any potential future provision of dental services under Medicare should include factors such as cost implications, personal responsibility, existing PHI coverage, and administrative challenges. As a legislative instrument Medicare is complex and presents a significant number of challenges for the provision of medical and allied health care let alone incorporating dentistry into its remit. The ADA is of the opinion that the *Dental Benefits Act 2008* represents the preferred legal instrument for public dental services because of its ability to be responsive to changing need.

This Act was easily amended to replace the Medicare Teen Dental Plan with the Child Dental Benefits Schedule and has a built-in review process which includes relevant key stakeholders. It has served patients and the sector well. Furthermore, practitioners and services offered under this legislation are subject to the same professional services review as would occur under Medicare legislation. It has also allowed public dental services to provide services to eligible patients without compromising the integrity of services covered in public dental hospitals under Medicare.

If new public schemes were to be implemented by the Australian Government, we would expect to suggest those schemes have regard to the principles and structure of the CDBS and be governed by the *Dental Benefits Act 2008*.

Child Dental Benefits Schedule

The CDBS allows eligible children to receive basic dental services and benefits up to $1,052 over a two-year period. Children must be between 0 and 17 years old for at least one day that calendar year, and the parent or guardian, or the child, must be eligible to receive one of several Centrelink payments at least once that calendar year. This limit is enough to cover regular dental check-ups and preventive care but not enough to cover the cost of extensive treatments.

The ADA has called for the introduction of additional treatments to be covered by the CDBS during both the 4th and 5th Reviews of the Dental Benefits Act.

Custom-made mouthguards

For children participating in sports or other leisure activities that involve a high risk of oral injury, wearing mouthguards is crucial. The mouth is a vulnerable area prone to injuries such as soft tissue damage, broken teeth, and fractured jaws. By wearing a mouthguard, children can significantly lower the risk of these injuries and potentially prevent the need for costly dental treatments and long-term oral health issues.

A custom-made mouthguard professionally fitted by a dentist provides superior protection for children in high-risk activities. Unlike over the counter or boil-and-bite mouthguards, custom-made mouthguards are crafted to fit an individual's unique dental anatomy. By taking precise impressions of the child's teeth and gums, it allows for a personalised and secure fit. Offering enhanced comfort, coverage, and shock absorption and are therefore more likely to be worn.

The CDBS currently cannot be used for custom-made mouthguards. We would like this to change. By including custom-made mouthguards in the CDBS, children from lower-income families could have access to these superior devices, promoting preventive care, and reducing likelihood of trauma.

Silver diamine fluoride

Evidence shows the effectiveness of silver fluorides for arresting caries in primary teeth for children and root caries for older patients. We think it would be favourable to include silver diamine fluoride (SDF) in the CDBS. SDF is a non-invasive treatment that effectively halts the progression of tooth decay, avoiding the need for more invasive and costly procedures. By including SDF in the CDBS, children who may have limited access to dental care can receive an effective and timely preventive treatment. SDF application is simple and painless, making it suitable for young patients who may have dental anxiety. The inclusion of SDF in the CDBS would extend appropriate preventive care to more children.

Treatment under general anaesthesia

Children who require extensive dental treatment or cannot handle treatment while awake may need to undergo dental treatment under general anaesthesia, which can be performed in public and private hospitals. However, despite their eligibility for care under the CDBS, they cannot use it if they are having their treatment provided under general anaesthetic. The difficulty is then compounded when the parents must also fund hospital stay costs and anaesthetist fees – sometimes even when the services are being provided in a public facility. In essence, the subset of paediatric patients who require more advanced interventions is disadvantaged by the lack of access to general anaesthetic, and delays to their treatment add to the overall cost and complexity of their care.

Uptake rates

Even though it is a generous initiative, the CDBS has experienced relatively low uptake hovering around or below 40% of eligible children. The Committee may like to explore reasons for this. The Australian National Audit Office has recommended a focus on improved communication with the target population.[33] Issuing actual 'vouchers' or conducting a targeted advertising campaign are initiatives we'd expect to drive greater awareness and action.

Cleft Lip and Cleft Palate Scheme

Medicare card holders under the age of 28 who have been diagnosed by a medical practitioner with cleft lip, cleft palate or other eligible conditions can receive some dental treatments under Medicare. Treatment must begin before the age of 22 and includes, extractions, some general, prosthodontic, orthodontic, and oral and maxillofacial services.

Department of Veterans' Affairs

The Department of Veterans' Affairs (DVA) provides dental services to eligible veterans and their dependents through the Veterans' Dental Program where clinically necessary. Annual monetary limits apply for certain items unless the veteran is an ex-prisoner of war the treatment is related to a service-related injury, or the treatment is for cancer. No co-payments are allowed, and certain treatments require pre-approval.

Recommendations

13. Include custom-made mouthguards within the CDBS limit.
14. Include silver diamine fluoride within the CDBS limit.
15. Include the dental component of in-hospital treatment under general anaesthesia within the CDBS.
16. Examine reasons for the apparently low uptake of the CDBS.
17. Consider appropriate responses to low CDBS uptake such as: improved communication with the target population, issuing actual vouchers, and enhanced promotion.

33 Administration of the Child Dental Benefits Schedule: Australian National Audit Office (ANAO) https //www.anao.gov au/work/performance-audit/administration-child-dental-benefits-schedule

The social and economic impact of improved oral healthcare

Overview of social and economic impact

Access to improved oral healthcare can greatly enhance the overall well-being and quality of life for individuals. Good oral health contributes to better physical health, allowing people to eat, speak, and smile with confidence. It also has positive psychological effects, boosting self-esteem and mental well-being. Improved dental care can lead to reduced pain and discomfort associated with oral health issues, enhancing quality of life.

Failure to prevent dental problems leads to personal and societal costs. For an individual, the costs can be substantial. Dental treatments can be expensive, especially if they require extensive procedures like root canals, dental implants, or orthodontic treatments. Untreated dental problems can lead to chronic pain, discomfort, and a decreased quality of life, affecting daily activities such as eating, speaking, and even sleeping.

If dental decay is not addressed, it can result in infections. These infections can become severe and require hospitalisation, which could be prevented if detected and treated early on. Gum disease begins with gingivitis and, if not treated, can progress to periodontitis. Neglecting treatment for periodontitis can result in infections, harm to the gums and bones, and, eventually, the loss of teeth.

Enhanced oral healthcare offers economic benefits at a societal level. By maintaining good oral health, individuals are more likely to remain productive in their work or education, reducing absenteeism and improving productivity. Preventive dental care and early intervention can help prevent costly oral health problems, such as advanced tooth decay or gum disease, which may require extensive treatments or tooth loss. This, in turn, reduces the financial burden on individuals, families, and the healthcare system. Improved oral healthcare can lead to cost savings for governments by minimising the need for emergency dental treatments and reducing the strain on public health services and hospital emergency departments.

Seeking pain relief medication and antibiotics from GPs

The National Advisory Council on Dental Health has estimated that there are more than 750,000 GP consultations each year for dental problems, with the most common treatment being prescriptions for pain relief medication and antibiotics.[34]

Medicare and Pharmaceutical Benefits Scheme subsidies

Patients often access the services of medical practitioners, including for prescriptions antibiotics and painkillers, for treatment for oral disease. This imposes a cost through Medicare subsidies – for GP consultations – and Pharmaceutical Benefits Scheme (PBS) subsidies – for certain medications prescribed by GPs and dental practitioners. While there have been some attempts to quantify the cost of Medicare subsidies – estimates range widely from $10 million per annum to $300 million per annum, with the cost of PBS subsidies not estimated.[35]

Potentially preventable hospitalisations

- In 2020–21, about 83,000 hospitalisations for dental conditions could potentially have been prevented with earlier treatment.[36]
- In 2020–21, the rate of potentially preventable hospitalisations due to dental conditions was highest in those aged 5–9 years (10.9 per 1,000 population).[37]

34 Grattan Institute. Filling the gap, A universal dental scheme for Australia (2019) Stephen Duckett, Matt Cowgill and Hal Swerissen, p.25

35 Report of the National Advisory Council on Dental Health (2012), p.19

36 Oral health and dental care in Australia, Hospitalisations - Australian Institute of Health and Welfare. (2023). Retrieved 2 June 2023, from https //www.aihw.gov au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/hospitalisations

37 bid

The impact of the COVID-19 pandemic and cost-of-living crisis on access to dental and related services

COVID-19 Pandemic

The COVID-19 Pandemic has had a significant impact on access to dental and related services in Australia. The profession developed policies to minimise the risk of COVID-19 transmission in dental settings, considering the uncertain nature of the virus. These restrictions on dental services were deemed necessary to protect both patients and dental staff.

The implementation of infection control measures and the need to preserve personal protective equipment (PPE) resulted in the temporary closure or reduction of non-essential dental services. Routine check-ups, preventive treatments, and elective procedures were postponed or canceled, leading to limited access to regular dental care for many individuals. This disruption in services had the potential to delay necessary treatments and exacerbate oral health issues.

The focus of dental practices shifted toward emergency and urgent dental care. Dentists continued to provide essential services to address pain, infections, and dental trauma. The emphasis on emergency care aimed to manage immediate oral health needs and reduce the strain on hospital emergency departments. However, this shift in focus limited access to routine care and preventive treatments, potentially impacting long-term oral health outcomes and increased burden of disease.

Demand for dental and related services

We understand there has been recent increased demand from patients for dental services following the relaxation of movement and other restrictions that were imposed to restrain the spread of COVID-19 between 2020 and 2022. This could be expected to increase dental workforce demand generally for a time. However, the increased demand could abate and return towards longer term trends. We include recommendations below that may help the Committee in assessing this trend.

Key statistics

- In 2020–21, around 1 in 8 (12%) adults aged 15 years and over delayed seeing or did not see a dental professional at least once in the last 12 months due to COVID-19.[38]

Cost-of-living pressures

A complex interplay of macro factors including inflation, housing affordability, energy and essential service costs, unemployment, and wage growth rates – interacting with variable individual circumstances such as location, health, and spending obligations influence cost of living.

Dental services can be expensive, particularly for treatments not covered by PHI or public dental services. For individuals or families experiencing financial constraints due to their cost of living, prioritising dental care can be a challenge. As a result, some people may delay or forgo necessary dental treatments.

One might expect cost-of-living pressures may lead some individuals or families to opt for more basic PHI plans with more limited dental coverage or to forego insurance altogether to reduce expenses. If this were to occur, then the individuals without adequate coverage may be deterred from seeking care due to lesser subsidisation. However, the most recently available data on PHI statistics published by APRA shows the opposite trend:

38 Oral health and dental care in Australia, Summary - Australian Institute of Health and Welfare. (2023). Retrieved 2 June 2023, from https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/summary

- An increased proportion of the population held hospital coverage at December 2022 (45.1%) relative to June 2020 (43.7%).
- And an increased proportion of the population held general treatment coverage (which typically includes dental) at December 2022 (55.1%) relative to June 2020 (53.0%).[39]

The public dental system in Australia often faces high demand, limited resources, and long waiting lists. We might expect cost-of-living pressures to exacerbate these issues, as more people may qualify for public dental services and therefore face challenges accessing timely care due to capacity limitations and rationing by queuing.

Private practice fees

The ADA does not set a schedule of recommended dental fees. Australian dentists in private practice are free to set or negotiate fees charged for the services that they render to patients.

The ADA's Dental Fees Survey provides a comprehensive summary of the level of dental fees charged by general practitioners and specialist members in private practice. Services commonly performed by dentists in Australia, such as oral examinations, calculus removal and various restorative services are included, as well as some more specialised, less frequently performed services, like orthodontic items.

Key findings

- On average across the 122 items surveyed, the fees charged by general practitioners increased by 3.7% from 1 July 2020 to 1 July 2022.
- Changes in prior recent years were also modest, or declining, i.e. 2020 (0.5%), 2019 (-1.9%), 2018 (-0.1%).
- This indicates that private practice fees increased by about 2.14% overall between 2017 and 2022 – a period in which inflation increased by about 14.5%.[40]

Private practice cost pressures

Like other small businesses, private practices have been confronting inflationary cost pressures including wages, rent, energy, equipment, training, and insurance. Tax liabilities are another area where relief is required, i.e. we understand some state revenue authorities are interpreting recent case law in a way such that independent contractors working under a service facility agreement may be deemed employees for the purposes of payroll tax, leading to sudden and significant liabilities, a major blow to the viability of a dental practice. Should this escalate, dental practices will experience severe financial pressure, which may impact on their ability to provide services to patients.

As costs increase, businesses must look to increase prices. While private sector treatment fees have remained suppressed in recent years, the current inflationary environment in Australia suggests it might be challenging to continue this trend.

Recommendations

18. Request treatment data from PHI firms and/or APRA to help ascertain trends in private dental service provision.
19. Request treatment data from state authorities to ascertain trends in public dental service provision.
20. Exclude dental practices from payroll tax liability where the practitioner is working under a service facility agreement.

39 Quarterly private health insurance statistics | APRA. (2023). Retrieved 21 May 2023, from https //www.apra.gov.au/quarterly-private-health-insurance-statistics

40 Inflation Calculator | RBA. Retrieved 26 May 2023, from https://www.rba.gov.au/calculator/annualDecimal.html

Pathways to improve oral health outcomes in Australia, including a path to universal access to dental services

Pathways to improve oral health outcomes in Australia

Oral health conditions are very common but are largely preventable and can be treated in their early stages. Most oral diseases and conditions share modifiable risk factors such as tobacco use, alcohol consumption and an unhealthy diet high in free sugars. These risk factors are also common to the leading noncommunicable diseases (cardiovascular disease, cancer, chronic respiratory disease, and diabetes).[41]

Considerable improvements can be made through correct and consistent oral hygiene practices and regular dental care. By prioritising oral health, patients can maintain healthy teeth and gums, reduce the risk of dental issues, and enjoy enhanced overall well-being. Preventative habits can help patients avoid the discomfort and expenses associated with extensive treatments.

Regular brushing and interdental cleaning help remove plaque and food particles that can lead to tooth decay and gum disease. Brushing twice a day with fluoride toothpaste, along with daily interdental cleaning, effectively removes harmful bacteria and prevents cavities. These simple habits, incorporated into one's daily routine, when combined with low consumption of sugar, significantly support oral health.

Routine dental visits also play a vital role in prevention. Regular check-ups allow dentists to identify and address potential issues early. Dental cleaning removes stubborn plaque and tartar, while fluoride treatment strengthens tooth enamel. Dentists can also provide personalised coaching on maintaining good oral health and healthy eating habits. Early detection of oral diseases, such as oral cancer, is also aided through regular dental visits, improving the chances of successful treatment.

Sugar-sweetened beverages

Sugar-sweetened beverages are a large contributor of added sugar to Australian diets. Australia is one of the largest per capita consumers of sugary drinks in the world, and consumption is particularly high amongst children and young people, and in socio-economically disadvantaged households. Sugary drinks are a leading contributor to tooth decay, given that they contain acid that weakens tooth enamel, and produce more acid when the sugar combines with bacteria in the mouth.

The WHO recommends that children and adults limit their daily intake of free sugars to around 10% of their daily energy intake and notes scientific evidence that this lower intake is associated with lower rates of dental caries. For a healthy adult, this means limiting free sugar intake to around 50 grams (or roughly 12 level teaspoons a day). WHO adds that further reducing intake to below 5% of daily energy intake (or roughly 6 teaspoons a day) appears to provide even greater health benefits – particularly related to dental health.

A single can of sugar-sweetened soft drink contains on average around 10 teaspoons, or 40 grams of free sugars. In 2022, the 19 leading public health bodies behind Rethink Sugary Drink, of which the ADA is a member, published results describing how 7-Eleven's Slurpee Sour Orange Mega product topped their table with *49 teaspoons of sugar* – more than eight times the daily added sugar intake recommended by the WHO.[42] Australian children are consuming products such as this.

It is not uncommon for dentists to have the experience of needing to remove all, or a significant proportion, of a

41 Oral health. (2023). Retrieved 22 May 2023, from https://www.who.int/news-room/fact-sheets/detail/oral-health

42 Sweet nothings: heavily promoted frozen drinks contain up to 49 teaspoons of sugar - Rethink Sugary Drinks. Retrieved 23 May 2023, from https //www.rethinksugarydrink.org.au/media/sweet-nothings-frozen-drinks-contain-up-to-49-teaspoons-sugar.html

child's baby teeth because of decay fueled by excessive free sugar intake. In some of these cases, guardians are understood to routinely fill infant bottles with soft drink or commercially packaged fruit juice. This is sometimes consumed overnight when the protective effects of saliva are reduced. Such patients and their guardians may even arrive at the dental surgery for treatment appointments carrying soft drinks with them. They simply do not understand or are not sufficiently concerned about the consequences. Some of these cases could approach the threshold of child neglect. Sadly, attempts at education may be ineffective in changing behaviour that is so entrenched.

Section 343 of the *Children and Young People Act 2008* (ACT), as a point of reference, deems that neglect, of a child or a young person, means a failure to provide the child or young person with a necessity of life if the failure has caused or is causing significant harm to the wellbeing or development of the child or young person.

Limiting daily intake of free sugars to around 10% of daily energy intake is difficult for many. Sugary drinks are extensively marketed and ubiquitously available. And food-labelling rules provide insufficiently clear information about sugar content to assist consumers to make informed choices in line with dietary guidelines and WHO recommendations.

The ADA favours introducing a levy on sugary drinks to increase the price by 20%, supporting a social marketing campaign to highlight the impact of sugary drinks on oral and general health and encourage people to reduce their consumption; and changing food-labelling laws to require that added sugars be clearly listed on all packaged food and drink products through front-of-pack labelling.

Oral health education in schools

The ADA worked with SugarByHalf and Cool Australia, a leading education not-for-profit organisation to create school lessons that integrate oral health and nutrition into core subject areas, providing a real-word spin to routine schoolwork. At Cool Australia, the lessons are made for teachers, they are curriculum aligned, easily adapted, and create positive change through action-based education. The teaching resources are free and include lessons on understanding the nutrition information panel, sugar, acids, and tooth decay and other topics.[43]

A presentation by a visiting (or pre-recorded) dentist could be another way to promote oral health literacy in schools. We don't know of any such programs currently offered in schools but understand the Australian Defence Force has in the past run such programs for cohorts of new recruits with anecdotally positive effects. The ADA would willingly develop such resources, upon request from education departments, and make them available through our consumer website: teeth.org.au.

Establishing a Senior Dental Benefit Schedule

Recommendation 60 of the Royal Commission into Aged Care Quality and Safety is to Establish a Senior Dental Benefits Schedule. This is consistent with proposals made by the ADA in submissions to the Commission and in Federal Budget submissions from 2016.

The Government Response to the Royal Commission report indicates that this recommendation is subject to further consideration by 2023. A phased approach to introducing a Senior Dental Benefits Schedule would allow Government to control expenditure. Key features of the scheme would include providing individual seniors with access to $1,052 of oral and dental care over two years. This is an area of focus we would particularly like to highlight, which is also further discussed in detail in the enclosed Australian Dental Health Plan.

43 Cool Australia lessons - Australian Dental Association. Retrieved 23 May 2023, from https //www.teeth.org.au/teeth/Cool-Australia-School-lessons#section-304493

Universal access to dental services

Universal access to dental services refers to ensuring all individuals have equitable and unrestricted access to necessary dental services, regardless of factors including socioeconomic status, geographic location, or other personal characteristics and aiming to eliminate barriers and disparities. It is important to separate the concept of universal *access* from universal *schemes* (such as the British National Health System).

Because claims and competing priorities relating to full or partial achievement of universal access are complex, and prone to contention about the extent to which they're achieved, we will explore the ambition of universal access with reference to jurisdictions offering the concept of 'universal dental schemes', i.e. where provision of publicly funded dental care is available for all persons regardless of their means.

Universal dental scheme

The cost of offering universal dental care was estimated in 2019 by the Grattan Institute at $6.5 billion per year.[44] Allowing for inflation since the time of that estimate, and for the possibility that public services might not capture some efficiencies of private services[45] – the real cost could be higher. It seems reasonable to extrapolate that the total cost could in fact approach the more recent actual 2020–21 overall spend on dental services of $11.1 billion.

Internationally, comprehensive oral health care and satisfactory oral health outcomes have been difficult to achieve with universal dental schemes. In particular, the national health services in the UK and Germany have resulted in oral health outcomes worse than those of Australia. All countries, including those with universal dental schemes, exhibit disparities in oral health.

We therefore do not consider a universal dental scheme a practical solution to improving oral health outcomes for Australians. Instead, we recommend targeted schemes, subsidised by public funding.

Water fluoridation

The therapeutic benefits of water fluoridation are clear. An extensive review undertaken by the National Health and Medical Research Council affirmed that water fluoridation reduces dental decay by 25–44%, and that there is no evidence that the concentration of fluoride used in public water supplies in Australia causes any health-related harm.[46] The ADA believes that all localities with 1,000 or more residents that have mains supplied (reticulated) water should have water that is accessible and fluoridated.

Recommendations

21. Establish a Senior Dental Benefits Schedule.
22. Introduce a health levy on sugary drinks with the aim of increasing their retail price by 20%.
23. Adjust food-labelling rules to require that added sugars are clearly listed on all packaged food and drink products through front-of-pack labelling.
24. Support state and local governments to extend access to fluoridated water to more communities with reticulated water supplies and promote the benefits of water fluoridation to the Australian public.
25. Explore adding oral health to school curricula through lessons or visiting (or recorded) presentations by a dentist.

44 Equivalent to around $7.19 billion 2022 dollars.

45 Discussion herein about how private practice fees have increased at a rate well below inflation in recent years suggests those efficiencies may be substantial

46 NHMRC Public Statement 2017. Water Fluoridation and Human Health in Australia. https://www.nhmrc.gov.au/aboutus/publications/2017-public-statement-water-fluoridation-and-human-health

The adequacy of data collection, including access to dental care and oral health outcomes

Data on access to dental care and oral health outcomes

Public dental services largely exist in a silo with little integration with the broader health system, or between the public and private dental sectors. Drawing upon public sector data from de-identified digital patient data to better inform targeting of resources within the sector should be used to improve access to oral health services, and ultimately improvements in health outcomes.

Dental practitioners should be able to smoothly access digital health records, such as My Health Record. This would enhance patient safety through dentist awareness of drug or procedure interactions and assist in tracking patients over time and across services, improve triaging processes.

These reforms would enable governments to improve their stewardship of public dental services and establish the evidence base needed to better identify people at high risk of oral disease within the population, including those who do not currently present to public dental services.

Epidemiological studies

Epidemiological studies of child and adult oral health across Australia are conducted every 10 years (National Child Oral Health Study and the National Survey of Adult Oral Health). The National Child Oral Health Study took place during 2012-2014, while the National Study of Adult Oral Health was conducted in 2017-2018.

These surveys are contingent upon funding. We consider it crucial for the Government to allocate consistent funding for conducting these surveys regularly to gain a deeper understanding of the oral health status of Australians.

Workforce characteristics

The ADA makes use of National Registration and Accreditation Scheme statistics published by AHPRA, i.e. Dental Board of Australia Registrant data quarterly reports.

We have supplied feedback to AHPRA through its public consultation on a draft data strategy that the reports contain a variety of tables, the nature of which suggest to us that data could be published in more granular fashion. For example, there are five divisions of dental practitioners, and data is presented in aggregate for divisions whose workforce characteristics we know to vary significantly. The ADA is not alone is proposing that there is value in having the data expressed in more specific ways.

Along with technical matters such as practitioner qualifications, there is increasing interest in identity characteristics such as age, gender, ethnicity, languages spoken, Indigenous status, etc. Data that expressed such variables, by division, by state, would be valued.

We would also value enhanced notification and detail about complaints, which could help inform our development of clinical guidelines. Lastly, we are interested in workforce trends such as number of 'exits', i.e. practitioners who have moved to non-practising status, or who did not renew their registration during the reporting period.

Recommendations

26. Ensure funding consistency for National Oral Health surveys.
27. Enhance AHPRA data and reporting relating to dental practitioner characteristics.

Workforce and training matters relevant to the provision of dental services

The dental workforce

The provision of dental services in Australia relies heavily on a well-trained and skilled workforce which encompasses various professionals, including dentists, dental hygienists, dental therapists, oral health therapists, dental prosthetists, and dental assistants. These individuals play vital roles in delivering high-quality oral healthcare to the population.

Australia places significant emphasis on training and education. Dental professionals undergo rigorous education and training programs to acquire the necessary knowledge and skills to meet the country's dental needs. Dental schools and training institutions provide comprehensive dental education, covering areas such as oral health promotion, disease prevention, diagnosis, and treatment. Additionally, ongoing professional development programs and continuing education opportunities are available to dental professionals, enabling them to stay updated with the latest advancements in dentistry.

The importance of workforce data

Accurate contemporary workforce data sorted by occupation is important in understanding the dynamics of job markets and making well-informed decisions. Policymakers rely on this data to inform workforce policies aimed at delivering service and addressing skills gaps.

We have advised the National Skills Commission, and expect to advise the Australian Bureau of Statistics, that the Australian and New Zealand Standard Classification of Occupations (ANZSCO) classification 252311 – dental specialist, currently incorporates seven specialisations. However, there are 13 dental specialties in Australia which are approved by the Australian Health Workforce Ministerial Council. Further, the seven existing dental specialisations are not assigned unique ANZSCO classifications. These two issues appear to structurally limit workforce data availability relating to dental specialists.

Dental assistants

The ADA has advised the National Skills Commission that it considers the occupation of dental assistant to be in national shortage, in each Australian state and territory, in both regional and metropolitan areas. We have also requested the Government consider the addition of this occupation to a relevant migration skilled occupation list, to allow employer-sponsored skilled workers to enter Australia and supplement workforce needs.

Employment data we examined in 2022, published by the Australian Industry and Skills Committee (AISC), indicated that the total number of dental assistants employed nationally fell significantly following the outbreak of COVID-19. However, when last we checked, the AISC appeared to be undergoing restructuring, and no longer published this information. We located data from another source but had concerns about relying on it because of inconsistencies with the AISC data.

Employment levels appear to need to recover to at-least levels around those prevailing in 2019 to meet contemporary demand. But employers report difficulty in filling positions across the country – particularly in non-metropolitan areas. At time of writing there are more than 2,000 jobs listed on SEEK in Australia for the term ‘dental assistant’.

The ADA continues to explore opportunities to support enhanced supply of dental assistants. A coordinated cross-sector approach is likely required to address the shortage. This may include collaboration across the education (secondary school and vocational training) and health sectors to promote, train and incentivise dental assisting as a desirable career path.

Maldistribution of the dental workforce

Major cities had the highest rate of dentists employed in the private sector (52.1 FTE per 100,000 population) whilst remote and very remote areas had the highest rate of dentists employed in the public sector (9.5 FTE per 100,000 population) in 2020.[47]

The DRISS scheme, discussed above, may hold lessens for any government-led effort to redistribute the dental workforce from areas of higher to lower concentration. Also, we understand comparable efforts are being considered or pursued in other health profession divisions which might be extended to dentists.

More dentists practice in metropolitan areas rather than rural areas. This is often influenced by several factors including the viability of a practice in rural populations, and other issues related to lifestyle, job prospects for their spouse, education opportunities for their children, and social connections. Metropolitan areas tend to offer a wider range of lifestyle activities, such as cultural events, entertainment options, and amenities, provide better job prospects for spouses. Additionally, metropolitan areas tend to have more established educational institutions, offering a broader range of educational opportunities for children.

Australian universities

Most dentists practicing in Australia have completed a relevant tertiary qualification at an Australian university. So far as we are aware, Australian universities do not appear to be considering workforce requirements when deciding on student cohorts gaining admission to programs. We understand that proportions of international to local students have increased in recent years, and that about half of international dental students return abroad following graduation.[48]

The ADA understands tertiary dental schools are under pressure to meet budgets due to the high cost of providing dental education, and that full-fee-paying and international students assist with this. There may be opportunities for tertiary institutions to enhance consideration of workforce requirements when determining student intakes, if funding to the dental academic sector was more adequately supported.

Indicative first year full-time study tuition fees for international students undertaking year one (of four years full-time study) in the 2024 intake of the Doctor of Dental Medicine at the University of Sydney, are $89,000. Certain unavoidable costs aren't included in this figure. Fees are subject to annual increase each year.[49]

Overseas trained dentists

In select countries, qualification and registration requirements mirror those in Australia relatively closely. Dentists registered in those countries can have their qualification recognised and obtain registration in Australia in a reasonably efficient manner.

Dentists trained in countries other than those referred to above, must either complete an Australian qualification (anew) or pass a dental practitioner assessment process with the Australian Dental Council (ADC) for registration with the Dental Board of Australia. This process involves the assessment of qualifications and professional skills, and is completed across three stages: initial assessment, written examination, and practical examination.

We hear from some candidates that they find the latter approach described above challenging, in terms of costs, processes, and success rates. Helping protect the health and safety of the public by ensuring overseas trained dental practitioners meet the high standards required of dental professionals in Australia is very important.

47 Oral health and dental care in Australia, Dental workforce - Australian Institute of Health and Welfare. (2023). Retrieved 2 June 2023, from https //www.aihw.gov au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/dental-workforce

48 As is their right, or indeed their obligation, depending on visa conditions.

49 Doctor of Dental Medicine. Retrieved 26 May 2023, from https //www.sydney edu.au/courses/courses/pc/doctor-of-dental-medicine0.html

Exploring how this can achieved, while balancing the experience of candidates, is something the ADA would be pleased to contribute to.

Recommendations

28. Publish accurate contemporary workforce data sorted by occupation.
29. Consider addition of occupation 423211, dental assistant, to an appropriate migration skilled occupation list.
30. Consider requesting from dental schools data relating to admissions, graduations, and forecasts.
31. Explore incentivising universities to recruit students from rural or remote areas to pursue dental education.
32. Explore incentivising dentists to practice in rural or remote areas.

International best practice for, and consideration of the economic benefit of, access to dental services

Does greater expenditure improve oral health?

With a generally high burden of untreated oral disease for all populations and countries, the differences in spending indicate great differences in availability of and priority for oral health care. However, the level of national expenditure is not necessarily correlated to better or worse oral health status.[50]

Japan's 8020 campaign

To tackle the high prevalence of oral diseases, the Japanese government initiated the 8020 Campaign in 1989, aiming to create a healthy and long-living society by building public policies, creating supportive environments, developing personal skills, and reorienting health services. The 8020 Campaign is a long-term national oral health promotion strategy. The rationale was built on the premise that if people can keep at least 20 functioning teeth by 80 years of age, they have a better chance of remaining healthy because of their ability to chew effectively, eat a range of foods, and maintain good nutrition, thereby providing a positive influence on general health and well-being.

It has been reported that the 8020 Campaign has been successful as the results of the Japanese national survey 2016 showed that more than half of the people aged 80 years retained 20 or more teeth. However, as indicated in a systematic review, the outcomes of the 8020 Program have not been well evaluated in terms of reliable evidence.[51]

In-hospital treatment under general anaesthesia

A program in British Columbia offers children under 19 in families on assistance basic dental coverage including an additional $1,000 per year to cover the cost of dental treatment in a hospital under a general anaesthetic.[52] It would be beneficial to explore the possibility of implementing a similar measure here.

In Nova Scotia, the Individuals with Special Needs Oral Health program provides coverage for the basic dental needs of residents who have been diagnosed to have an intellectual disability that makes it necessary for their dental care to take place in a hospital setting under a general anesthetic or acceptable alternative.[53] And the Exceptional Circumstances program allows dentists to seek coverage on behalf of their patients for medically necessary treatment services that are not covered under any other public dental programs.[54]

Xylitol chewing gum in schools

Studies have found several positive findings related to the consumption of xylitol chewing gum including reduction in tooth decay, as it inhibits the growth of bacteria that cause cavities and promotes remineralisation of teeth, increased saliva flow which helps in neutralising acids in the mouth, which can protect teeth from acid erosion, and alleviation of dry mouth symptoms and help prevent oral health issues associated with reduced saliva flow.

50 WHO Global oral health status report Towards universal health coverage for oral health by 2030, p.26

51 Takehara, S., Karawekpanyawong, R., Okubo, H., Tun, T., Ramadhani, A., & Chairunisa, F. et al. (2023). Oral Health Promotion under the 8020 Campaign in Japan—A Systematic Review. International Journal Of Environmental Research And Public Health, 20(3), 1883. doi: 10.3390/ijerph20031883

52 Dental coverage - Province of British Columbia. Retrieved 2 June 2023, from https://www2.gov.bc.ca/gov/content/family-social-supports/income-assistance/on-assistance/supplements/dental

53 Government of Nova Scotia. (n.d.). Dental programs. Retrieved from https://novascotia ca/dhw/dental-programs/

54 bid

Several countries have implemented programs that provide xylitol chewing gum to students as part of their oral health initiatives. Finland is known for its extensive use of xylitol in oral health programs. The country has implemented school-based initiatives that provide xylitol chewing gum to students, aiming to reduce dental caries and promote good oral hygiene practices. Thailand, Japan, Denmark, and South Korea are other counties which have incorporated xylitol chewing gum into school-based oral health initiatives.

Recommendations

33. Consider the experience in British Columbia of its in-hospital treatment under general anaesthesia program, and if this could inform similar arrangements under the CDBS.

Any related matters

Government program evaluation

We gather that interventions in certain jurisdictions can be exponentially more expensive than others, and outcomes of even costly interventions can sometimes be disappointing. Governments should develop oral health outcome measures to improve their understanding of the effects of public dental services on users' oral health.

Coding of dental treatment under general anaesthesia in a hospital facility

Dental treatment under general anaesthesia in a hospital facility is commonly more extensive, more resource intensive, and more complex than that performed in dental practice rooms. This is even more evident in difficult to treat paediatric and adult patients. Some cases are so complex that a simple examination and radiographs cannot be performed other than in the operating theatre.

The current 'catch-all' structure of Diagnosis Related Groups (DRG) D40Z is not appropriate for a growing number of paediatric and special needs patients who urgently need dental treatment under GA. Many dental patients are not being allocated the theatre time and hospital resources needed to deal with the complexity of their individual cases because the DRGs and National Efficient Price (NEP) erroneously assume that all dental cases can be dealt with efficiently and in a short period of time.

The inadequacy of activity-based funding allocations and PHI benefits for dental services provided under GA are having the effect of reducing access to care, or curtailing the length of episodes of care for patients who need longer, more complex dental treatment in hospital.

Feedback from our members includes that it can be difficult to secure operating theatre time because funding incentives militate against the use of operating theatres in private hospital settings for dental procedures. State and territory government dental directors with the support of the ADA have called on a review of the national efficient price for dental procedures and the need for a complexity component to be added. The Committee may wish to explore this area further.

Links between oral health and general health

Evidence of the links between poor oral health and general health also continues to mount. For example, there is increasing evidence of a two-way relationship between diabetes mellitus and periodontitis, and recent studies have found that the bacteria that causes periodontitis may raise the risk of Alzheimer's disease, or hasten its progression.

It has also been found that frail older people with poor oral hygiene also have an increased risk of bacterial infections of the blood and aspiration pneumonia. Australia needs a oral healthcare system that ensures all Australians can access timely treatment of oral disease as well as preventive oral healthcare. This will have positive flow-on effects on general health and well-being and reduce the direct and indirect costs of poor oral health to individuals and taxpayers in general.

Health savings accounts

The ADA released a report in 2018 titled *Saving for Ones' Care – Understanding how Health Savings Accounts can help fund the health of Australians*[55], to provide fresh impetus for Government to re-examine how ancillary

55 The Centre for International Economics, Savings for one's care, 2018. Available from https://www.ada org au/Assets/Publications/Final-Report_ADA_Saving-for-ones-care-23-Feb-2018.aspx

services are delivered in Australia. Commissioned from the Centre for International Economics, the report proposes tax incentives which would allow Australians to save for their own dental and other allied[56] health care.

By using tax incentives to encourage community-wide saving for extras health care needs, Australians would be rewarded for proactively managing their health in a way that overcomes the limitations of extras cover and retains their freedom of choice in the practitioner they use. It is expected that an average of $1,226 would be saved annually by Australians because of the savings incentives on offer. The cost to the Australian Government of incentives designed for the purposes of the review is estimated to be $157 million in the first year.

Recommendations

34. Explore the option of introducing health savings accounts to empower Australians to save for future ancillary health care costs and avoid certain inefficiencies inherent with PHI.
35. Consider introducing a complexity split for DRG D40Z dental extractions and restorations.

56 such as physiotherapy and optical

List of appendices

1. ADA Tasmanian Branch comments
2. Australian Dental Health Plan
3. Water fluoridation in Australia comments
4. Australian Government's historical dental program involvement
5. Public dental programs synopsis
6. State specific public sector workforce discussion
7. Historical government inquiries synopsis

Appendix 1

Australian Dental Association
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30 May 2023

Eithne Irving
Deputy CEO & General Manager, Advocacy Media and Professional Services
eithne.irving@ada.org.au

Dear Eithne

Senate Select Committee into the Provision of and Access to Dental Services in Australia

The Tasmanian branch of the Australian Dental Association (ADA) welcomes the opportunity to submit a submission to complement the Federal ADA's submission to reinforce some concerns specific to our State.

Australia's National Oral Health Plan 2015-2024 identifies the following priority populations:

- People who are socially disadvantaged or on low incomes
- Aboriginal and Torres Strait Islander people
- People living in regional and remote areas
- People with additional or specialised health care needs.

According to 2021 ABS Census data, Tasmania has:

- the lowest average annual income nationally
- the highest rate of depending on social welfare in Australia.
- 30 000 people in Tasmania identify as Aboriginal and Torres Strait Islanders (this is 5.4% of the population).
- the highest rate of multimorbidity in Australia.
- a small population and is more regionally dispersed than other States (50% of Tasmanians live outside of the capital city).

These statistics demonstrate that Tasmanians are more likely to experience poor health at higher rates than other sectors of the population.

Tasmania has no dental school and has traditionally had difficulty attracting dentists to the State. The Graduate Programme introduced by the Tasmanian State Government in the past two years has encouraged newly graduated dentists and oral health therapists to seek employment in Tasmania. Partnerships with mainland universities in the form of student placements has also been effective at encouraging new graduates to seek employment in Tasmania. Current universities who are placing students in Oral Health Services Tasmania are James Cook University and Adelaide University. ADATas would encourage the continuation of the Graduate Programme and the relationships with mainland Universities that encourage graduates to seek employment in Tasmania.

Access to specialist dental care in Tasmania is an issue:

1. Tasmania has no full time prosthodontist, only mainland specialists who visit periodically.
2. Tasmania has no special needs dentist. Previous arrangements have involved an interstate specialist visiting sporadically.
3. Tasmania has no oral medicine specialist.
4. There is a shortage of orthodontists, with the current waiting list for new patients being over twelve months in Hobart.
5. There is one specialist paediatric dentist in the entire State.

The COVID pandemic has had an effect on the dental workforce in Tasmania. Dental assistants are at a shortage, and Oral Health Services Tasmania reports a 20% reduction in oral health therapists. This may be related to workers wanting to work in closer proximity to their interstate families.

Access to emergency dental care is generally limited to business hours Monday to Friday through the private and public systems. Some private practices may operate extended hours on weekdays or on Saturdays. The Northern region of the state is the only emergency on-call dental service operating on Sundays and public holidays and is operated by private practitioners. The Southern and North-West regions have no emergency on-call dental services operating after hours. There is no public after-hours emergency dental service.

Tasmania has the oldest population in the country, with greater than 20% of the population aged over 65, and 8.4% of the population aged over 75. Older adults are particularly vulnerable to poor oral health due to changes in diet, increased medications and the inability to care for their personal hygiene needs. Research has linked poor oral health to serious medical conditions such as dementia, cardiovascular disease and diabetes. This increases the burden on Tasmania's already overloaded dental and medical system.

The National Survey of Adult Oral Health in 2018 showed that Tasmania had the highest rate of edentulousness in adults overall, and the highest overall DMFT in the adult dentate population.

Thank you for the opportunity to outline our concerns regarding the provision of and access to dental care in Tasmania.

Yours sincerelv

Dr Fiona Tann
President

Percentage of adults with complete tooth loss (NSAOH 2017 - 2018)

	TOTAL	15-24	35-54	55-74	>75
TAS	6.5	0	2.0*	9.9	30.3
ACT	1.0	0	0*	1.4	11.0
NT	2.4	0	1.8*	6.0	22.6
NSW	4.1	0	1.2*	8.3	18.6
VIC	4.6	0	0.9*	11.2	19.8
QLD	3.5	0	1.0*	6.7	19.4
SA	4.6	0	1.2*	7.0	24.1
WA	3.3	0	1.2*	4.2	26.9

Mean number of decayed, missing or filled teeth per person, in the adult dentate population, Tasmania (NSAOH 2017-2018)

	TOTAL	15-24	35-54	55-74	>75
TAS	12	3.2	10.6	20.4	23.0
ACT	9.7	3.3	8.7	18.8	24.9
NT	9.7	5.2	9.7	19.0	21.7
NSW	11.3	4.7	10.3	18.3	25
VIC	10.8	3.5	10.3	19.3	24.7
QLD	11.6	4.3	10.6	20.7	23.9
SA	11.8	4.0	10.6	19.9	22.9
WA	11.0	3.8	10.3	20.2	24.4

Appendix 2

AUSTRALIAN DENTAL ASSOCIATION

The Australian Dental Health Plan

Achieving Optimal Oral Health

2019

Introduction

A primary objective of the Australian Dental Association (ADA) is to increase the dental and general health of the Australian population.

The Australian Dental Health Plan (ADHP) seeks to provide a considered solution to this objective, whilst incorporating the considerable changes that have occurred in the dental healthcare environment over the past few decades. These changes have been driven by the following:

- *Increasing efficacy of dentistry,* through advances in dental knowledge and increased public interest, which have seen the means of dental-care provision advance enormously in the last 100 or so years from very basic and not very effective care. Dental technology and treatment modalities have advanced at an accelerating rate and transformed the range and sophistication of available dental services.
- *Increasing value placed on access to dental healthcare,* due to acceptance by patients and government that such access is part of the basic standard of living in a developed and modern country. In response to this there has been a widespread establishment of auxiliary dental service providers to attempt to secure access to dental care for all, regardless of capacity to pay, although the evidence indicates this has not been fully effective.
- *Rising real cost of state-of-the-art dental healthcare,* partly because of the inflationary (on balance) impact of technological progress, advanced treatments becoming available for previously untreatable conditions, and the complexities of bringing new healthcare modalities into Australia.

Funding for public dental care has been erratic over the years with various schemes introduced all with varying eligibility, often transient (apart from the DVA scheme), and often underutilised by the public and the profession.

In the national interest, the ADA feels there is a very real need for government-funded dental-care programs that are targeted, have clear eligibility criteria, cover a broad spectrum of dental services, can be introduced in phased stages, and have minimal, if any, capital costs.

On this basis the ADA presents the Australian Dental Health Plan.

Objectives

The Australian Dental Health Plan outlined in this paper is the ADA's vision for the Australian Government's involvement in the delivery and funding of dental care in Australia.

Background

Australia's Oral Health

Good oral health is a basic right enshrined in the World Health Organization's Liverpool Declaration and contributes to overall health, wellbeing and quality of life.

All Australians should be able to enjoy optimal oral health. However, despite improvements in the last 20–30 years, there is still evidence that too many Australians experience poor oral health.

The estimated avoidable costs of poor oral health to Australia exceeds $818 million per year.[1] According to recent Australian Institute of Health and Welfare (AIHW) reports:[2]

- Over 4 in 10 children aged 5–10 (42%) have experienced tooth decay in their primary ('baby') teeth; almost one-quarter of children aged 6–14 (24%) have had decay in their permanent teeth;
- Over 1 in 4 (26%) of young Australians and adults aged 15 and over have untreated dental decay; and
- Over 50% of Australians over the age of 65 years have gum disease or periodontitis; almost 1 in 5 (19%) of this age group have complete tooth loss.

Across all age groups, disadvantaged Australians experience relatively high rates of poor oral health, and many adults and older Australians in this group say they find it difficult to access timely dental treatment when they need it.[3]

The reality is that many Australians do not receive appropriate care or have the determinants of their oral diseases addressed. They are instead forced to incur expenses they can ill afford or remain on waiting lists for more invasive treatment of diseases that may have caused pain, discomfort or social and economic disadvantage for years.

As oral health deteriorates while people defer care or sit on waiting lists, costs to individuals, governments and the wider community—in the form of lost productivity, absences from work, presentations to GPs and emergency departments, PBS scripts for antibiotics and pain relief, the eventual dental treatment and avoidable hospitalisations—all increase significantly.

High sugar diets, poor oral hygiene, smoking and excessive alcohol intake all increase the risk of tooth decay, periodontal (gum) disease, oral infections, oral cancer and other oral conditions. They are also linked to increased risk of developing obesity and non-communicable diseases such as diabetes, cancer, cardiovascular and cerebrovascular disease, and chronic respiratory diseases.[4]

Evidence of the links between poor oral health and general health also continues to mount. For example, there is increasing evidence of a two-way relationship between diabetes mellitus and periodontitis,[5] and recent studies have found that the bacteria that causes periodontitis may raise the risk of Alzheimer's disease, or hasten its

1 Productivity Commission 2017, *Introducing competition and informed user choice into human services: reforms to human services (Chapter 12)*. Report No. 85, Canberra, and references therein. Available at https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms.pdf

2 AIHW. (2019). *Oral health and dental care in Australia*, web report edition updated 20 March 2019, Cat. no. DEN 231; AIHW (2018). *Older Australians at a glance*, web report edition updated 10 September 2018, Cat. no. AGE 87.

3 Ibid; ABS. (2018). *Microdata: patient Experiences in Australia* 2016–17, Cat. no. 4840.0, Canberra.

4 World Health Organisation. (2018). *Oral health: key facts*, September 24, https://www.who.int/news-room/fact-sheets/detail/oral-health; Dietrich, T et al. (2017). 'Evidence summary: The relationship between oral and cardiovascular disease', *British Dental Journal*, 222, pp. 381–5; Pillai, R S et al. (2018). 'Oral health and brain injury: causal or casual relation?' *Cerebrovascular diseases extra*, 8( ), pp. 1–15.

5 Mealey, B & Rethman, M (2003). 'Periodontal disease and diabetes mellitus: bi-direc ional relationship', *Dentistry Today*, 22, pp. 107–13; Preshaw, PM et al. (2011). 'Periodon itis and diabetes: a two-way rela ionship', *Diabetologia*, 55, pp. 21–3.

progression.[6] It has also been found that frail older people with poor oral hygiene also have an increased risk of bacterial infections of the blood and aspiration pneumonia.[7]

Australia needs a dental healthcare system that ensures all Australians can access timely treatment of oral disease as well as preventive oral healthcare. This will have positive flow-on effects on general health and well-being and reduce the direct and indirect costs of poor oral health to individuals and taxpayers in general.

The ADA understands the oral health needs of the population and what is required to meet existing gaps in service delivery.

Current Australian Government involvement

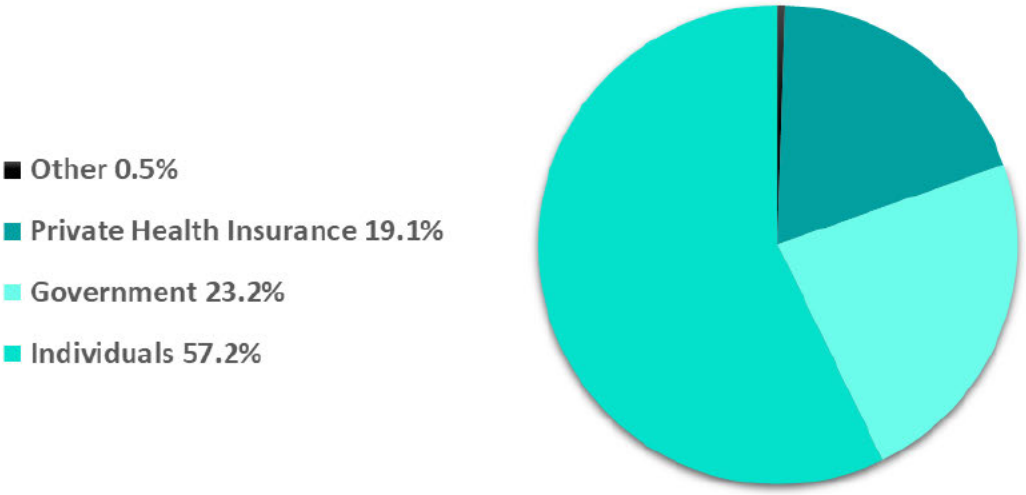
A number of Australian Government dental schemes are in operation. These are the Child Dental Benefits Schedule (CDBS), the Cleft Lip and Palate Scheme, and the Department of Veterans' Affairs (DVA) Scheme.

This paper proposes a modified version of the CDBS as a model for additional targeted dental schemes to make quality care, with a greater focus on prevention, more accessible to other population groups with significant unmet oral healthcare needs.

Current national dental expenditure

According to the latest AIHW report, *Health Expenditure in Australia 2017–18*, total expenditure on dental healthcare in 2017–18 was estimated at $10.5 billion. Governments at all levels contributed $2.4 billion of this amount. After medication expenses, dental-care costs are an individual's next largest health expense.

Dental Expenditure in Australia 2017–18



6 Dominy, S et al. (2019). 'Porphyromonas gingivalis in Alzheimer's disease brains: evidence for disease causation and treatment with small-molecule inhibitors', *Science Advances*, 5(1), eaau3333.

7 Maarel-Wierink CD et al. (2011). 'Risk factors for aspiration pneumonia in frail older people: a systematic literature review', *Journal of the American Medical Directors Association*, 12, pp. 344–354.

The Australian Dental Health Plan (ADHP)

Australia needs a dental healthcare system that is cost-effective, administratively efficient, reduces dental disease in the community, and ensures that Australians of all ages can access timely, affordable and clinically optimal oral healthcare in their local area.

The ADA proposes a model that would retain the CDBS (with some modifications) and use it as the template for additional schemes of targeted dental benefits assistance for other population groups demonstrated to have relatively poor oral health and significant unmet dental treatment needs.

The ADA has designed an Australian Dental Health Plan (ADHP) that will deliver on the goals of *Australia's National Oral Health Plan 2015–2024*[8] by:

- providing a system based on targeted schemes governed by a uniform and simple set of administrative rules and regulations;
- allowing for the staged introduction of each targeted scheme over time;
- providing quality care to these eligible target populations on an equitable, efficient and sustainable basis; and
- addressing the risk factors that lead to poor oral and general health.

Current and former Australian Government dental schemes have varied in terms of the types of services funded, eligibility requirements and administrative arrangements. By contrast, the ADA proposes an ADHP with the following uniform features:

- a common schedule and set of treatment descriptors for eligible dental services;
- a specified and manageable budget with the imposition of Annual Monetary Limits (AML) on the potential treatment subsidy available to each eligible patient over a specified period;
- consistent eligibility criteria and terminology;
- a common fee schedule; and
- measurable outcomes.

This uniform model will minimise administrative complexity and costs, both for government and dental practitioners, and improve the efficiency of all schemes that operate under the model.

As with the existing CDBS program, patients (or their parents/guardians/carers) could check their eligibility and the balance of their remaining monetary entitlement under the scheme through their Medicare online account or myGov. Practice staff can check the same details through HPOS, the Australian Government's Health Professionals Online Service portal.

Australian Dental Health Plan Principles

The ADHP will adopt the following principles for each scheme that is created under the model:

- eligibility criteria determined by the Australian Government;
- administration through the Department of Health/Department of Human Services with funding provided by an amendment to the *Dental Benefits Act 2008* to suit each scheme;
- utilisation of both private and public sector clinics;

[8] COAG [Council of Australian Governments] Health Council. (2015). *Healthy mouths, healthy lives: Australia's National Oral Health Plan 2015–24*, http://www.coaghealthcouncil.gov.au/Portals/0/Australia%27s%20National%20Oral%20Health%20Plan%202015-2024_uploaded%20170216.pdf

- utilisation of a common schedule and glossary of dental terms – the ADA's *The Australian Schedule of Dental Services and Glossary*;[9]
- access to all services based upon the current edition of the ADA Schedule;
- benefit levels to be set at the DVA Schedule for Dentists and Dental Specialties[10] and indexed annually;
- opportunity for participating private dentists to be able to bulk bill or charge usual and customary fees with a co-payment through a rebate system that parallels Medicare;
- public clinics must bulk bill;
- prior approval to be obtained by the treating dentist for complex treatments;
- AML to be applied;
- differential Fees for GP and Specialist Dentists; and
- coverage of dental services delivered in private and public clinics as well as under general anaesthetic/sedation in day procedure and hospital facilities.

Eligibility for the ADHP

The ADHP proposes three aged-based dental schemes that will cover Australians of *all* ages who need better access to timely, quality oral and dental health care. The three schedules proposed include a modified version of the existing CDBS scheme, and two new income-tested schemes – one for adults aged 18–64, and another for seniors aged 65 and over.

It is proposed that the eligible population for the Adult scheme would be those aged 18–64 who hold any type of Health Care Card or Pensioner Concession Card issued by the Australian Government, plus their eligible dependents.

For the Seniors scheme, the eligible group would be those aged 65 and over who hold a Pensioner Concession Card, a Commonwealth Seniors Health Card, or a Health Care Card issued by the Australian Government (and, in a small number of cases, any eligible dependents).

By extending eligibility to those who hold one of these Commonwealth concession cards, these two new schedules would cover all adults and seniors in receipt of Commonwealth income support payments, and some on similarly low incomes who just miss out on eligibility for payment of Commonwealth pensions/allowances.

Specifically, these concession card holders include adult/senior Australians who:

- receive a part or full disability support pension, aged pension, or double orphan pension;
- receive a part or full income support allowance payment (e.g. Newstart, Carers Payment, Youth Allowance, Austudy, Parenting Payment, Sickness Benefit), because they are:
  - a full-time carer for a person or persons who are frail aged, seriously ill or disabled;
  - a person with a partial disability who does not meet eligibility requirements for the Disability Pension and receives Newstart (the unemployment payment) instead;
  - unemployed or underemployed, including parents of young children and all other single/partnered Australians in this situation aged up to 65;

[9] The Australian Dental Association (ADA) has developed this publication in conjunction with all sectors of the profession, private health insurers and all levels of government. Currently in its 12th edition, it was first created in 1986 and serves as the definitive and universally accepted coding system of dental treatment and is endorsed by the National Centre for Classification in Health (NCCH). Like the Medicare Benefits Schedule, it lists dental treatments and allocates a number for each service.

[10] Department of Veteran's Affairs. (2019). *Fee schedule of dental services for dentists and dental specialists*, https://www.dva.gov.au/providers/fees-schedules/dental-and-allied-health-fee-schedules

  - sole parents/principal carers of children in receipt of Parenting Payment (single) or Parenting Payment (couple);
  - in receipt of Sickness Allowance as they are unable to work at their job or attend enrolled full-time study commitments for an extended period due to illness or accident, or
  - in receipt of Youth Allowance or Austudy as they are full-time post-secondary students or apprentices aged 16 or over;
- are a working parent(s) with children under 8 whose income is low enough to make them eligible for the full rate of Family Tax Benefit Part A;
- are a farmer/farming couple in financial hardship receiving Farm Household Allowance;
- are working singles or couples on very low incomes who have a Low-Income Health Care Card; or
- are self-funded retirees who meet the aged pension income test but are ineligible for it as they just exceed the assets test. (This group gets a Commonwealth Seniors Card that provides access to PBS medicines and bulk-billing by GP's).

Targeted Schedules

What follows are some recommendations for modifying the CDBS and creating similarly targeted schemes for other sectors of the community.

1. Child Dental Benefits Schedule (CDBS)

The existing CBDS is the foundation model upon which the ADHP is based. The scheme covers children between the ages of 2 and 17 from both low and middle-income households.

Directing a focus to this age group was, and will continue to be, a sound investment in Australia's long-term dental health, as it will reduce the incidence of oral disease and costs of dental care into the future.

The CDBS has been embraced by participating dentists, who promote the scheme in their practices. Utilisation of the scheme has gradually increased since it was introduced in 2013, up to almost 38% of eligible children in 2018.[11] However, a poll conducted in 2018 found that some 25% of eligible families are not yet aware of the scheme.[12]

To improve the effectiveness of the CDBS, several additional program features and conditions should be introduced to the scheme and applied consistently across other schemes that may be developed for other population groups (e.g. adults and seniors).

The recommended improvements to the existing CDBS are as follows:

- eligibility should be from 0–17 years of age, to ensure that parents of babies and pre-toddlers can access professional advice on how to care for their oral health, as primary (baby) teeth can be present at birth;
- AML should reflect the current costs of dental services and the needs of the sector being targeted;
- AML and fees should be increased on an annual basis;

[11] Murphy, B et al. (2019). *Report on the Fourth Review of the Dental Benefits Act 2008*, https://www1.health.gov.au/internet/main/publishing.nsf/Content/5AE86FB9D21A8277CA257BF0001F952F/$File/Report%20on%20the%20Fourth%20Review%20of%20the%20Dental%20Benefits%20Act%202008.pdf

[12] https://www.rchpoll.org.au/wp-content/uploads/2018/03/NCHP10_Poll-report_Child-oral-health.pdf

- access to a full range of services;
- dental treatment in hospital and day procedure facilities under general anaesthetic to be funded under the scheme;
- as poor oral health levels are more pronounced amongst disadvantaged groups and in rural/remote areas, a 50% increase in the AML should be introduced to meet the exceptional needs of some sectors of the population such as:
  - children of Aboriginal and Torres Strait Islander descent;
  - children residing in remote and very remote regions as per Modified Monash Model (MMM2019) categories MM6 and MM7;
  - children with disability and special needs.
- no AML for children eligible under Cleft Lip and Palate Scheme.

2. Seniors Dental Benefits Schedule (SDBS)

It is expected that by 2056 there will be one in four people living in Australia over the age of 65 years and 1.8 million people will be over the age of 85 years. Increasing numbers of older people are retaining their natural teeth and by 2021 only 3% of the population will have complete tooth loss.

This will result in high demand for ongoing dental care by the elderly, many of whom may have complex and chronic medical conditions.

The SDBS will have:

- AML set at specific limits;
- eligibility confined to a specific age group, e.g. people who are 65+ years and who are in receipt of a Pensioner Concession or Commonwealth Seniors Health Card;
- access to all services based upon the current edition of the ADA Schedule and Glossary;
- dental treatment in hospital and day procedure facilities for general anaesthetic funded under the scheme;
- given specific issues that impact on the dental health of this cohort, an AML limit increased by 50% for seniors:
  - of Aboriginal or Torres Strait Islander background;
  - living in Remote and Very Remote communities as per Modified Monash Model (MMM 2019) Categories MM6 and MM7;
  - with disabilities and special needs;
  - living in residential aged care; or
  - receiving Level 4 Home Care Packages.

3. Adult Dental Benefits Schedule (ADBS)

There are many adults who suffer from disadvantage as a result of low income, unemployment or poor health. Poor oral health is strongly correlated with low socioeconomic status. People in this group rarely visit a dentist for preventive care and when they do attend, it is often only when a serious problem has developed.

On average, Aboriginal and Torres Strait Islander people experience poor oral health earlier in their lifespan and in greater severity and prevalence than the rest of the population. Adults living in regional or remote areas have higher levels of tooth loss and more untreated decay.

All states and territories offer some form of public dental care to eligible adults; however, infrastructure and the size of the dedicated dental workforce in these facilities vary considerably, resulting in discrepancies in services provided and long waiting times for treatment. In a majority of the states and territories, adults who may be living on poverty-level incomes still have to pay co-payments to access public health services, even though they are eligible, which further reduces access to care.

Considerable impact was made on waiting lists when additional funds were available for dental care under the National Partnership Agreements (NPAs) between the Australian Government and the states and territories. Most jurisdictions used the additional monies provided under the NPAs to purchase services from private sector dentists who were in oversupply and will continue to be in oversupply for many years, as confirmed by Health Workforce Australia. This is a long-term sustainable model for dental service provision.

Committing federal or state funding to build new public dental infrastructure in areas that are well serviced by existing private (or public) infrastructure is an inefficient use of resources better spent on treatment provision.

NPA funding should be made available for use under the ADBS, which would adopt the key elements of the CDBS.

The ADBS scheme would have:

- eligibility limited to 18–64 years of age;
- means testing or targeting criteria applied;
- access to all services based upon the current edition of the ADA Schedule and Glossary;
- dental treatment in hospital and day procedure facilities under general anaesthetic funded under the scheme;
- AML imposed as determined appropriate;
- AML increased by 50% for adults:
  - of Aboriginal and Torres Island background;
  - living in Remote and Very Remote communities as per MMM 2019 MM6 and MM7 classifications; or
  - with significant disability and special needs.

Funding the ADHP

Proposed funding options for the introduction of the ADHP components could include one or more of the following:

- Phasing out the Private Health Insurance Rebate for general treatment policies. The total projected cost of the premium rebate for hospital and general treatment policies in 2019–20 is $6.3 billion, and around $800 million of this amount will subsidise benefits for dental costs paid out by health funds.[13] A component of this subsidy could be allocated towards funding the ADHP;
- Introduction of a tax on the consumption of sugary drinks;
- Increased taxation of tobacco products; and/or
- An increase of 0.5% to the Compulsory Medicare Levy. The current 2% levy raised $15.8 billion in 2017–18, so a 0.5% increase would initially raise an additional $3.9 billion per annum.

[13] 2019–20 Health Portfolio Budget Statements, *Budget Related Paper 1.9*, Section 2, Outcome 4: Individual health benefits, p. 85. Estimate of dental costs that will be funded by the PHI premium rebate were derived using the AIHW's methodology, and data on private health insurer expenditure in the year to March 2019 contained in APRA (2019). *Quarterly Private health Insurance Statistics March 2019*.

Adjunct Initiatives

The Australian Government must acknowledge that to be fully effective, funding of dental care treatment must be supported by immediate action to strengthen the foundations of good oral health.

Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024 includes a range of preventive initiatives that have the ADA's full support. These initiatives are critical to improving the oral health of the nation and should be funded and implemented by the Australian Government in cooperation with the states.

In the short-term, the ADA considers that the Australian Government should prioritise urgent action on the following fronts to build better foundations for improved oral health in Australia:

Foundation Area 1: Promote awareness of the importance of good oral health

Although perceived cost is a reason that many Australians avoid seeking dental treatment, or getting recommended treatment they need, the evidence suggests that it is often not the only reason.

Many people give lack of time as a reason for avoiding dental care, and for people who are frail, disabled, or living a long way from the nearest dental clinic, transport or transport costs can be a problem.

Importantly, though, there is also evidence that low-income Australians, Australians living in rural and remote locations, and frail older Australians are less likely than higher income Australians to report that they *need* dental care, even though statistics suggest they suffer more oral health problems.[14] Amongst other living expenses, dental care is often accorded a low priority unless there is a serious problem causing pain.

Oral diseases are often viewed almost as an inevitable part of ageing and not worth treating unless they are causing considerable pain. Across the community, there also appears to be little understanding of the negative impacts poor oral health can have on *general* health.

Education of the population as to the importance of oral health, its impact on general health, and the cost-benefits of dental care (most particularly attending the dentist regularly for check-ups and preventive treatment) is a sound investment for a federal government. If the overall population recognised the importance of good oral health and preventive oral health care, and made positive changes, overall health levels would improve, individual and government health expenditure would decline, and other economic costs associated with poor oral health (such as lost productivity) would decline too.

The ADA, its branches, and its members already expend considerable resources producing oral health promotion materials, conducting media campaigns, and spreading the message through direct communication with patients and the public. However, much more needs to be done. Australian Government action on this front is also needed to raise awareness, and the ADA would be happy to provide expert advice on the content of any national oral health promotion campaign.

The ADA calls on the Australian Government to:

- **Fund a major national oral health promotion campaign in order to educate Australians about the importance of oral health, and what they can do to support their own oral health and that of their families.**

[14] ABS. (2018). *Microdata: patient experiences in Australia, 2016–17* (Cat. No. 4840.0); Barnett, T et al. (2016). 'Sorry, I'm not a dentist': perspectives of rural GPs on oral health in the bush', *Medical Journal of Australia*, 204(1), https://www.mja.com.au/journal/2016/204/1/sorry-im-not-dentist-perspectives-rural-gps-oral-health-bush; Lewis A, Wallace J, Deutsch A & King P (2015). 'Improving the oral health of frail and functionally dependent elderly', *Australian Dental Journal*, 60 (1 – Supplement), p. 97; Webb, BC et al. (2016). 'Oral and dental care in aged care facilities in New South Wales, Australia. Part 3 concordance between residents' perceptions and a professional dental examination', *Gerodontology*, 33, pp. 363–372.

Foundation Area 2: Fluoridation

The therapeutic benefits of water fluoridation are clear. An extensive review undertaken by the National Health and Medical Research Council (NHMRC) has recently affirmed that water fluoridation reduces dental decay by 25–44%, and that there is no evidence that the concentration of fluoride used in public water supplies in Australia causes any health-related harm.[15]

The ADA believes that all localities with 1,000 or more residents that have mains supplied (reticulated) water should have water that is accessible and fluoridated. Non-mains supplied localities should have subsidised alternative forms of dental prevention made available to them. Under the ADHP, there should also be an incentivised payment for topical fluoride application in non-fluoridated areas.

The ADA calls on the Australian Government to:

- **Promote the benefits of water fluoridation to the Australian public; and**
- **Support state and local governments to extend access to fluoridated water to all Australian communities with reticulated water supplies.**

Foundation Area 3: Dietary and sugar control

It is well established that dietary carbohydrates and especially 'free sugars' (monosaccharides and disaccharides) play a major role in the causation of dental decay. Causes of non-carious tooth structure loss (dental erosion) include the exposure to acid from the consumption of soft drinks, sport drinks, fruit and fruit juices, wine, vinegar, and chewable vitamin tablets. Pre-existing conditions such as Sjogren's disease, gastric reflux or multiple medications exacerbate these effects. Consumption of foods that combine simple carbohydrates and food acid can be particularly destructive to teeth.

Sugar-sweetened beverages are a large contributor of added sugar to Australian diets. Australia is one of the biggest consumers of sugary drinks in the world, and consumption is particularly high amongst children and young people, and in socio-economically disadvantaged households.[16] Sugary drinks are a leading contributor to tooth decay, given that they contain acid that weakens tooth enamel, and produce more acid when the sugar combines with bacteria in the mouth.

A single can of sugar-sweetened soft drink contains on average around 10 teaspoons, or 40 grams of free sugars. The World Health Organisation (WHO) recommends that children and adults limit their daily intake of free sugars to around 10% of their daily energy intake and notes scientific evidence that this lower intake is associated with lower rates of dental caries.[17]

For a healthy adult, this means limiting free sugar intake to around 50 grams or 12 level teaspoons a day. WHO adds that further reducing intake to below 5% of daily energy intake (or roughly 6 teaspoons a day) appears to provide even greater health benefits particularly related to dental health.[18]

However, this is difficult to do, given the mass marketing and availability of sugary drinks and Australia's current inadequate food-labelling laws, which do not provide enough clear information about the sugar content in drinks and other foods to allow consumers to make informed choices in line with dietary guidelines and WHO recommendations.

15 NHMRC Public Statement 2017. *Water Fluoridation and Human Health in Australia*. https://www.nhmrc.gov.au/about-us/publications/2017-public-statement-water-fluoridation-and-human-health

16 http://www.rethinksugarydrink.org.au/facts; *Roy Morgan Young Australians Survey, July 2015–June 2016,* http://www.roymorgan.com/findings/7101-sweet-drinks-much-more-popular-with-kids-than-older-aussies-201701031624; ABS. (2014). *Australian Health Survey: Nutrition First Results – Foods and Nutrients, 2011–12*, Cat. No. 4364.0.55.007.

17 World Health Organisa ion. (2015). 'WHO calls on countries to reduce sugars intake among adults and children', Media release, 4 March, https://www.who.int/mediacentre/news/releases/2015/sugar-guideline/en/

18 Ibid.

The ADA calls on the Australian Government to:

- **introduce a health levy on sugary drinks to increase the price by 20%;**
- **support a social marketing campaign to highlight the impact of sugary drinks on oral and general health and encourage people to reduce their consumption; and**
- **change food-labelling laws to require that added sugars be clearly listed on all packaged food and drink products through front-of-pack labelling.**

Foundation Area 4: Tobacco control

The detrimental effects of tobacco on general and oral health are well documented.[19] Tobacco use harms nearly every organ of the body and is the single most preventable cause of premature mortality and morbidity.

From the dental perspective, tobacco:

- is an aetiological factor in the development of oral cancer, leukoplakia, erythroplakia and keratosis;
- is an important risk factor in the development of periodontal disease;
- contributes to greater levels of tooth loss;
- contributes to development of acute ulcerative gingivitis;
- contributes to xerostomia, abrasion and erosion;
- causes increased staining of teeth;
- delays wound healing; and
- causes increased risk of failure in osseointegrated implants.

All these consequences add substantially to the costs of dental care borne either by individuals or government. Timely cessation of smoking will usually result in improvements to general and oral health and will achieve substantial savings for both individuals and government.

Government initiatives to date in the areas of public education on the risks of smoking, tobacco product labelling, advertising and taxation have helped to achieve considerable reductions in the initiation of smoking and rates of smoking cessation in Australia, but they have not yet eradicated it.

Although e-cigarette products have been touted as potential smoking cessation aids, there is now growing evidence implicating e-cigarettes in a range of harms to individual and population health.[20] Given this, the ADA supports the decision of the Therapeutic Goods Administration (TGA) not to approve e-cigarette products as therapeutic smoking cessation products, and will continue to do its part to raise awareness of the potential dangers of vaping and e-cigarettes.

The ADA calls on the Australian Government to:

- **continue restrictions on the marketing of tobacco products**
- **increase taxation on their sale;**
- **continue subsidisation of TGA-approved smoking cessation products; and**
- **continue raising awareness of the dangers of vaping/e-cigarettes and water pipes.**

[19] Reibel, J. (2005). 'Tobacco and oral health', *Bulletin of the World Health Organisation*, 83(9), pp. 641-720.
[20] Joint Statement of the Chief Medical Officer and State and Territory Chief Health Officers. (2019). 'E-cigarettes linked to severe lung illness', https://canceraustralia.gov.au/sites/default/files/statement_on_e-cigarettes_in_australia.pdf

Appendix 3 – Water fluoridation in Australia

Fluoridated water has been one of the most successful public health campaigns. Australian studies show fluoride in water reduces tooth decay at a range of 26% - 44% in children and 27% in adults. 89% of Australians have access to fluoridated water. Those who do not, should be supported with access to fluoride or supplementary fluoride safely through their dentist.

There is no central authority maintaining a map of fluoridated and non-fluoridated communities in Australia. The enclosed fluoridation map was published by NHMRC in 2017, and it roughly shows the percentages of people in each state and territory with access to fluoridated drinking water. Queensland should be 72%, not 76% as in this map, but otherwise it's still pretty accurate. There will always be small variations - states often add small communities to the fluoridated column, and sometimes fluoridation plants cease operations for a while for maintenance reasons or councils playing saving money.

The main problem area is Queensland. The south-east Queensland water grid covering Brisbane, Gold Coast, Sunshine Coast, Logan, Ipswich etc. has been fluoridated since 2008. Townsville has been fluoridated since 1964. But most regional and remote Queensland communities are not fluoridated, and we know that people living regionally and remotely tend to have 1. Poorer access to dental care, particularly the full range of dental care, and 2. Poorer oral health. So, the people with the greatest dental needs who would benefit most from fluoridated drinking water are the people missing out.

In the rest of Australia, almost all major towns and cities are fluoridated, and by world standards this is an exceptional achievement. The largest non-fluoridated community outside Queensland is Byron Bay, and that's due to the higher proportion of alternative lifestyle and 'natural' health believers in that community, and their council being unwilling to tackle what can be an emotive and controversial (in some sectors, but not by health professionals and scientists) decision. All the other large non-fluoridated Australian communities (Cairns, Mackay, Rockhampton, Maryborough and Wide Bay, Gladstone, Mount Isa) are in Queensland. The problem is that since 2012, Queensland legislation places responsibility for fluoridation decision making in the hands of local councils, despite local councils usually having little scientific or population health expertise and being particularly susceptible to influence from anti-fluoridation advocacy groups. The Australian Government should be considering encouraging/pressuring states through financial incentives/disincentives to introduce fluoridation wherever practical and warranted.

Ensuring Australians have access to high quality dental care is always going to be more difficult to achieve in regional communities and even more so in remote communities. Some of those difficulties may not be completely overcome, which makes it even more important to reduce the levels of oral disease in the first place.

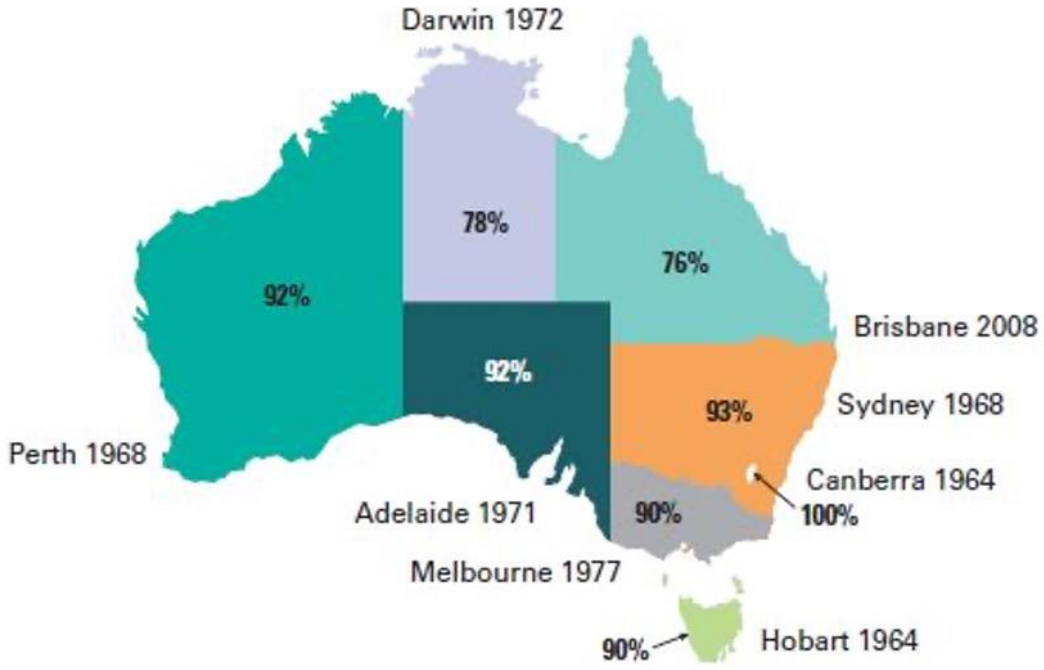
Water fluoridation is a wonderful health measure, described by the CDC in 2001 as one of the ten great public health achievements of the 20th century, but it's not always practical or warranted. Some towns rely on untreated bore water, and don't have a water treatment plant. Some community water supplies (often bore water) already contain beneficial levels of fluoride, even if they're not optimal levels. If we already have beneficial levels of fluoride (probably above 0.5 mg/L), no one is going to spend a large amount of money building a fluoridation plant that will provide only a tiny additional benefit. In some communities, e.g., Nanango in Queensland, the water tastes terrible and few people drink it. There's no point building a fluoridation plant if few people drink the water.

Historically, the major limiting factor for water fluoridation has been population size. A population of 1,000 has often been set as the practical, cost-effective limit for a community to fluoridate its water supply, although one NZ study claimed that a smaller, but high caries risk community could still make it worthwhile to introduce water fluoridation.

But we also have practical issues. In smaller, remote communities getting and retaining trained water treatment plant operators can be difficult, and the cost of transporting chemicals will be much greater than for larger cities with their much greater economy of scale. Many of the smaller remote Aboriginal and Torres Strait Islander communities also have a more limited ratepayer base, acting as a disincentive for local councils to spend money on fluoridation. Caries is of course much higher, but treatment costs and aerial ambulance costs to transport emergencies to Cairns or Mount Isa are paid by the state government, not the local council. But despite some of these issues, most Northern Territory Aboriginal communities have fluoridated drinking water. In Queensland, not a single Aboriginal or Torres Strait Islander community (except for Kowanyama with good natural levels of fluoride in the water).

Fig - Fluoridation[1]

Figure 1 Percentage of population with access to fluoridated water as at February 2017[i] and dates of introduction of water fluoridation to Australian capital cities[ii] (Sources:[i] Confirmed with state and territory government health departments;[ii] based on reference 3)



1 V. Dickson-Swift, L.C., S. Bettiol, S. Bracksley-O'Grady,, Access to community water fluoridation in rural Victoria" It depends where you live... Australian Journal of Rural Health, 2023: p. 10.

Appendix 4 – The history of dental services provision/funding in Australia and the Commonwealth's role in dental service provision/funding

Commonwealth Dental Schemes

1973

- In 1973, the School Dental Service program was established. This was a joint initiative between the Commonwealth and states and territories with the Commonwealth providing funding, leadership and coordination and the jurisdictions responsible for implementation, delivery, and administration.

Treatment was provided by dental therapists under the supervision of a dentist.

Funding consisted of $7.9m with the Commonwealth meeting 75 per cent of the capital and operating costs of the training facilities for dental therapists, 75 per cent of the capital costs and 50 per cent of the operating costs of the school dental clinics. Funding was initially through specific purpose grants to the states, but levels of funding were gradually subsumed into general purpose grants to the states by the Fraser Coalition Government in the early 1980s, effectively ending direct Commonwealth funding and responsibility for the scheme from this time.

1994

- Then under the Keating Government we saw the introduction of the Commonwealth Dental Health Program. This scheme commenced in January 1994 and was targeted to financially disadvantaged adults & dependents (concession card holders). It aimed to reduce barriers and improve equity while at the same time taking a more preventive approach to care.

It allowed for both general and emergency care, services which could be provided by both public and private providers, but it excluded dentures, orthodontics and crown and bridge work.

Rebates were paid at the DVA level, annual caps of $100 – emergency and $400 for general treatment were applied and States and Territories were required to maintain their current level of effort and funding.

The scheme closed in 1996 with the change in government. The argument for closing the scheme was that waiting lists had been addressed and there was no further need for the scheme. The Commonwealth was handing back full responsibility to the states and territories.

Interestingly though, a short time after the scheme closed, reports state that waiting lists grew at a rapid rate.

The Commonwealth argued that because of the subsidy of PHI premiums they were in effect indirectly funding dental care. Those of different political persuasion argued that the all the government had achieved was a significantly greater subsidy for the rich.

2004

- Under the Medicare Plus initiatives, the Howard Government introduced limited Medicare benefits for patients whose medical condition significantly exacerbated their dental problems or vice versa.

Known as the Allied Health and Dental Health Care Initiative or Enhance Primary Care as it was more commonly referred to certainly in the dental sector at least, provided eligible patients on referral from a GP to three dental treatments a year to a cap of $220. Once again, it did not include

dentures, crown and bridge work or implants which were by this stage a well-recognised treatment option.

Low uptake for the first few years and with an election looming saw the Howard government increase the capped amount available to eligible patients to $4,250 over two calendar years and included the provision of dentures as an eligible treatment. The Chronic Disease Dental Scheme was born. These changes saw a significant increase in the uptake of services by patients under the scheme in the next three months. The scheme was not without its problems.

2007

- 2007 saw a change in government again and the CDDS was closed on the basis that the funding budgeted under the scheme would be redirected to states and territories to address the long public waiting lists once again. This new program was scheduled to commence in July 2008, but the necessary legislation did not pass both houses in time.

At the same time the government introduced the Medicare Teen Dental Plan which allowed teenagers between the age of 12 and 17, from families who were receiving Family Tax Benefits A, or themselves receiving ABSTUDY or Youth Allowance to receive dental services under a voucher to the value of $150. This scheme was heavily underutilised and while indexed, it did not cover treatment beyond a check-up.

2014

- In 2014 under pressure from the Greens and with the professional advice of the Australian Dental Association the Australian Government introduced the CDBS. Eligibility was as per the MTDP but extending that eligibility to 2–17-year-olds and increased the amount to $1,000 over two years. Over three million children have accessed dental services through this program since its inception.

Additional funding was also given to states and territories under a National Partnership Agreement to reduce adult dental waiting lists. The combination of these initiatives was referred to as the Child and Adult Public Dental Scheme (caPDS) with the overall aim of improving access to dental care for adults as well as children from low-income families.

Total investment for the caPDS was $5b but included the funding for the DVA dental scheme, the CLaCP and the PHI rebate. $615m/annum was provided for children and $425/annum for adults.

In 2019, the Australian Government announced plans to merge the caPDS with the existing public dental services offered by state and territory governments.

Appendix 5 – Public dental programs synopsis

ACT

Children

Government dentist services are available to children that fit the following criteria:

- all children under 5 who live in the ACT.
- all children between 5 and 14 years who live or attend school in the ACT.
- young people under the age of 18 with a Centrelink Pension Concession or Health Care Card.

Standard fees apply:

- Children aged 5 to 14 – $72.60 per child per 'course of care'.
- Children under 5 years (who require treatment) – No fee.
- Children under the age of 18 years who are listed on a Health Care Card or Pension concession card – No fees for general treatment.
- Co-payments apply for children for items such as space maintainers, splints and if eligible orthodontic services.

There may be a small co-payment for a course of care if a child is not covered by a Centrelink pension concession or health care card or eligible for Child Dental Benefits Scheme (CDBS).

Adults

Dental health services for ACT residents aged 18 years and over is available to those that hold:

- a Centrelink issued Pension Concession or Health Care Card.
- a Veteran's affairs card.
- an ACT Services Access card.

Co-payments may apply.

NSW

Children

All children under 18 years of age can access free dental care provided by NSW Health at public dental clinics. In some locations of NSW, children who attend participating primary schools can get free dental care through the Primary School Mobile Dental Program.

Adults

Adult NSW residents must be eligible for Medicare and have their name listed on one of the following Australian Government concession cards:

- Health Care Card.
- Pensioner Concession Card.
- Commonwealth Seniors Health Card.

There may be more criteria if an individual needs to see a dental specialist or receive in-hospital care.

NT

The criteria to access free public dental services in the Northern Territory.

- Children under 18 years of age - as long the child has not finished school and does not work full time.
- Individuals part of the Federal Government's Cleft Lip and Palate Scheme.
- Holders of a Centrelink Pensioner Concession Card or a Centrelink Health Care Card.
- Remote residents needing emergency dental care and who do not have access to private dental services and are more than 100km from the nearest health service.
- Refugees within six months of arrival.

To receive free orthodontic services, children must also meet all the following:

- holder or dependant of a Health Care Card or Pension Concession Card.
- meet strict clinical criteria based on clinical assessment of a public orthodontist or dentist.
- orthodontic treatment will be completed by the age of 18.

Some children are also eligible for a free mouthguard (max 2) if they have:

- a Medicare card.
- a recent oral health examination and any dental decay treated.
- 4 upper front fully grown permanent teeth.
- a letter from their sports coach or registration receipt from a sporting club.

QLD

Children

Children and young people eligible for public oral health services include those who are:

- be aged four years or older and have not completed Year 10, or
- be eligible for the Medicare Child Dental Benefits Schedule, or
- be listed as a dependent on, a valid Centrelink concession card.
- They must be a Queensland resident or attend a Queensland school and be eligible for Medicare.

Adults

Adults in Queensland can access Government dental care if they are a Queensland resident and are eligible for Medicare. They must also be receiving benefits from one of the following concession cards:

- Pension Concession Card Issued by the Department of Veterans' Affairs.
- Pensioner Concession Card issued by Centrelink.
- Health Care Card.
- Commonwealth Seniors Health Card.
- Queensland Seniors Card.

For eligible adults, eligibility is extended to dependents that are named on the adult's concession card.

Public dental services in Queensland are free to all eligible people.

SA

Children

Individuals under 18 years of age can access public dental care through the School Dental Service clinic. A small fee may apply for all other children accessing dental care through School Dental Services.

There are no out-of-pocket costs for the following children.

- Children not yet at school.
- Eligible for the Medicare Child Dental Benefits Schedule (CDBS).
- Covered by a Pensioner Concession card, Health Care Card, or School Card Scheme.

Adults

Adults living in South Australia who have a current Health Care Card or Pensioner Concession Card can access dental care at SA Dental clinics.

Adult dependents (under 19 years) of the card holder whose names are on the card, can access dental care.

TAS

Children

All children up to the age of 18 years can access government dental treatment at Oral Health Services Tasmania.

Adults
General dental care and denture services are provided in government dental clinics to all eligible Tasmanian adults. Eligible adults include people who have a current Pensioner Concession Card or Health Care Card.
There is a small cost for all treatments provided to adult patients.

VIC

Children
To be eligible for public dental services, children must:

- Be eligible for the Child Dental Benefits Schedule (2 - 17 years).
- They or their parents hold a Health Care Card or Pension Card (13 – 17 years).
- Be a youth justice client in custodial care, regardless of age.
- Be in out-of-home care, provided by the Children Youth and Families Division of the Development of Human Services (up to 18 years).

Children aged 0 -12 years are eligible for dental care, no matter their family's income.

Adults
Adults aged 18 years and over may be eligible for public dental care if they live in Victoria and hold one of the below cards:

- Centrelink Health Care Card.
- Centrelink Pensioner Concession Card.
- Department of Veteran's Affairs (DVA) Veteran Gold Card.
- Department of Veteran's Affairs (DVA) Veteran Pensioner Concession Card.
- Refugee or asylum seekers and Aboriginal and/or Torres Strait Islander people are eligible for public dental care.

WA

Children
Children aged 0 to 4 whose name appears on their parent's Health Care or Pension Concession Card are eligible to attend a government general dental clinic for care.

The School Dental Service (SDS) provides free dental care to students aged 5 to 16 or until the end of year 11, (whichever comes first) and attending a Department of Education recognised school.

This dental care is delivered state-wide through 100 dental therapy centres (DTC), which are co-located with schools. Forty mobile DTCs travel to 150 schools where an onsite dental clinic is not present.

Adults
General dental clinics provide reduced cost (subsidised) general and emergency dental care for individuals aged 17 and over and who hold a current Health Care or Pension Concession Card.

WA Dental Health Services (DHS) also provide care to:

- Consenting residents of metropolitan aged care residential facilities who undergo a dental assessment by a visiting dental practitioner.
- Prisoners in metropolitan and major rural Department of Corrective Services facilities (generally prison- based clinics).
- Eligible Disability Services Commission clients.

- Visiting services to eligible patients at Royal Perth Hospital and Graylands Hospital.

WA residents living in remote locations without access to a private dentist can have dental treatment at a public dental clinic. However, this is a full fee service.
In addition, WA DHS facilitate subsidised general and emergency dental care for financially or geographically eligible people through:

- the Country Patients Dental Subsidy Scheme. If there is no public dental clinic in town, may allow a resident to go to a private dentist to receive dental care. It's aim is to compliment care provided through country public dental clinics and usually operates in locations with no reasonable access to a government dental clinic, in which case DHS approved private dentist are used.
- Metropolitan Patients Dental Subsidy Scheme (MPDSS): when funding permits provides opportunity for eligible metropolitan patients on a public dental waiting list to be issued on authority to undergo a course of non-urgent subsidised general dental care at participating private dental practitioners.
- Private Orthodontic Subsidy Scheme (POSS) - the POSS enables eligible country patients contacted by DHS to receive subsidised specialist orthodontic services closer to home, as all subsidised specialist services are currently only available in Perth.

Patients receiving emergency or general dental care at a public dental clinic or private dental practitioner who participates in the Dental Subsidy Scheme are charged a fee and will be issued with an account (or the parent/guardian in the case of minors).

All dental charges are in line with the Commonwealth Department of Veterans' Affairs schedule of dental fees. Treatment obtained at a public dental clinic or a participating private dental clinic is subsidised by the Western Australian government up to a maximum of 75% of the cost of the treatment. The actual level of dental subsidy a person is entitled to is based upon their Centrelink income which is assessed by DHS.

Appendix 6 – State specific public sector workforce discussion

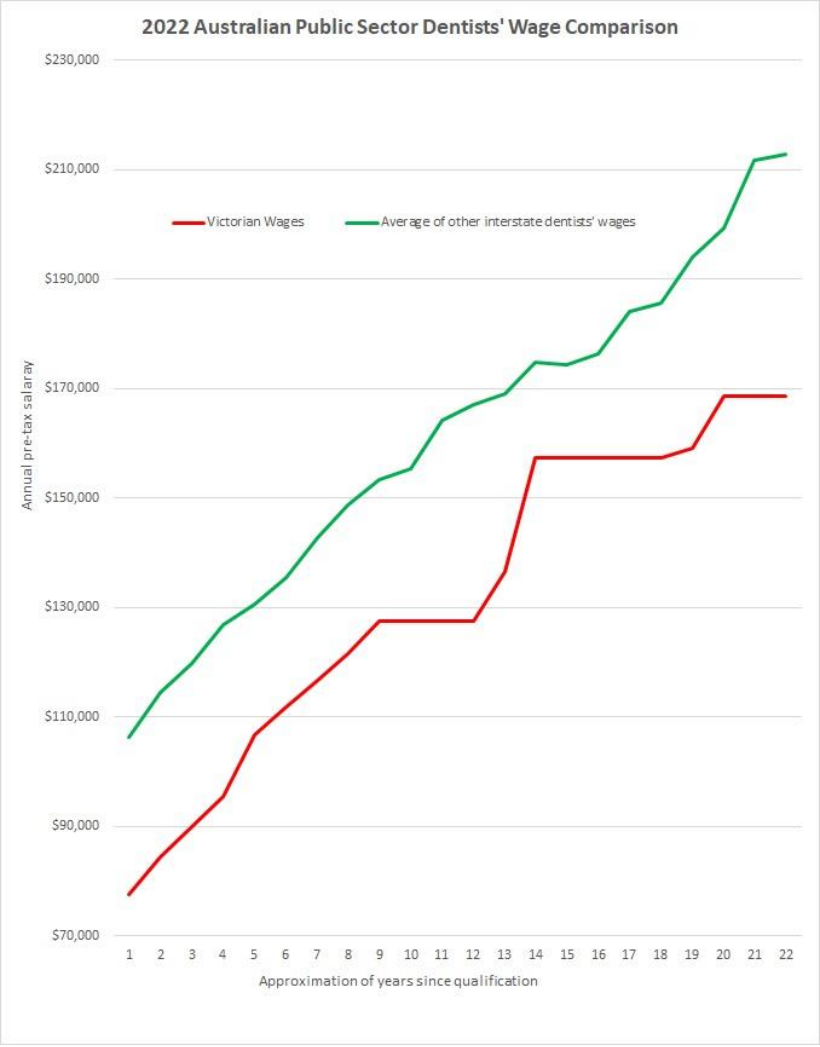
Information supplied to the ADA reflects public sector dental figures in Victoria. Recruitment and retention challenges seem apparent. The table below indicates the total count of dental practitioners (EFT) employed in the Victorian public sector reduced by around 18% in recent years.

Statewide Ratio of Practitioner Type by EFT

	Dentist	DT/OHT/DH	Prosthetist	Total clinician EFT:
Dec 2018	8	5	1	360.1
June 2019	7	5	1	364.9
Dec 2019	7	5	1	357.0
June 2020	8	4	1	324.3
Dec 2021	8	5	1	298.7

Drops by 18%
= 61.4 EFT

In the case of Victorian public dentists, one probable driver could be lower wages than those prevailing in other jurisdictions. We understand Queensland and the Northern Territory to be jurisdictions offering substantially higher wages to attract staff.



Appendix 7 - Historical government inquiries synopsis

Area of inquiry:	2012 – National Advisory Council on Dental Health	2013 – House of Reps Report on the inquiry into adult dental services	2015 – 2024 – National Oral Health Plan	2017 – Reforms to Human Services	2019 – Final Report from Royal Commission into Aged Care
Experience of children and adults in accessing and affording dental and related services	Aspiration 3: Resolved to increase availability of public dental programs for children. 80% of children have seen a dentist in last 12 months. Inconsistency between states in what programs are provided. Aspiration 2: There is a maldistribution of workforce, lack of minimum standards which causes issues for patients		Pg 27: 18.8% of population did not see a dentist out of cost concerns. Pg50: 40% of those earning under $20,000 annually have untreated tooth decay. Pg52: Integrated oral health services for low socioeconomic groups. Pg57: Increases to engagement with Aboriginal communities required to satisfy service demands. Expansion of existing primary health practise networks required.	Dental conditions made up the second highest cause of acute preventable hospitalisations in 2015-16. Recommendations 13.1,2,4,6: Blended payment systems should be established. Access to care should be based on triaging according to risk. Basic plans should be made available to all eligible.	Pg45: Older Australians are more likely to have poor oral health. A Senior Dental Benefits Scheme should be established. Pg116: Older people need improved access to public health services yet experience long wait lists and high private dental costs. A SDBS would help to alleviate this issue.
The adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas;	Aspiration 4: There is a desperate need to improve oral health promotion. Coordination of promotion messaging from a young age. Extension of fluoridation, Aspiration 2: There are long wait lists for public care, maldistribution of services.	Recommendation 5: The federal governments should incentivise state and territory governments to focus on preventative services. Recommendation 1 & 4: Efforts should be made	Pg 22-7: There should be an extension of fluoridated water to more communities. Broaden availability of evidence-based oral health promotion programs. Strengthen and embed nutrition and oral health policies in at risk communities.	Pg1: Ad hoc use of vouchers has not resulted in improvements in the public system. Those who receive public dental care get little choice in who provides that care and when and where it will occur.	Pg66: Federal home care programs chronically underspend on allied health and dental. Pg116: Govt should fund comprehensive health assessments for those beginning residential aged care.

	Aspiration 6: 1/3 of Australians are eligible for public dental care but only a tiny proportion access those services. Long wait times, system is skewed to emergency care, issues with retention of staff in rural and regional locations. Increased funding required to stem the damage being done. Rural areas are more reliant on public dental services and experience more severe impacts when funding is not adequately provided. Aspiration 7: It is recommended that the workforce be strengthened and refocused to target rural and growth corridor locations through targeted scholarships, financial and non-financial incentives.	to improve public linkages with private and not-for-profit organisations for patients living in remote and underserviced areas.		Recommendation 12.1: All State govts should publicly report waiting times split by risk-based priority levels. Provider reporting should be published monthly.	
The interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services;	Aspiration 3: Public dental is provided by states but eligibility for programs differs between states. Some states bar some children from accessing care due to differing definitions of what a 'child' is. This system should be made uniform. Aspiration 5: Commonwealth has had a sporadic involvement in funding of dental services. CDHP program 1994-6 improved outcomes for public dental patients but was	Recommendation 5: It is recommended that the Federal Government to incentivise states to invest in preventative dental services. Recommendation 6: A formula should be created for funding to state govts based on eligible population.	Pg 23: There should be an extension of fluoridated water to more communities. All communities over 1000 should be fluoridated. Pg38: Support should be given so that private and public oral health services can be accredited to National Safety and Quality Health Service Standards.	Recommendation 12.2: All levels of government should work to implement and expand the Value based health care models worked on by DHSV.	Pg254: The Australian Government should amend the *Quality of Care Principles 2014* (Cth) to clarify the responsibility of approved providers to deliver dental health care among other allied health services.

	withdrawn. It is recommended to reduce duplication of funding to improve effective use of limited dollars. One level of govt should be responsible for service delivery, roles of levels of govt should be clarified.	Recommendation 10: A Commonwealth Chief Dental Officer should be established to improve coordination between levels of government, engagement with private sector, and provide independent policy advice on dental and oral health. Recommendations 6-9, 11, 12: A commitment to a National Partnership Agreement between levels of government to improve access, range of services provided, and funding stability is recommended.			
The provision of dental services under Medicare, including the Child Dental Benefits Schedule;			Pg30: There should be increased promotion of CDBS for priority populations.	Recommendation 13.3: Federal govt should introduce a new blended payments model for CDBS	Pg116: A Senior's Dental Benefits Scheme should be established to provide and fund public care for the elderly. Minimal gap payments for services.

The social and economic impact of improved dental healthcare;			Pp 10 – 14: Oral disease contributes to poor tooth function, infection, nutrition, and ulcers. This leads to increased GP and hospital visits. Poor appearance leads to low self esteem and a decreased quality of life. This leads to economic costs of decreased productivity, fewer days at work or school, increased community burden. Pg64: Poor oral health links with cardiovascular disease, diabetes, obesity, malnutrition, and osteoporosis. Chronic conditions can lead to higher incidents of HIV and Hepatitis C.		Pg 70: Dental health in aged care settings is not treated as a priority. Daily oral care is not undertaken and the impact on the elderly is acute. Pg116: Seniors with low socioeconomic status experience social isolation, functional impairment, pain and discomfort, ill health, and early death because of poor oral health
The impact of the COVID-19 pandemic and cost-of-living crisis on access to dental and related services;					

Pathways to improve oral health outcomes in Australia, including a path to universal access to dental services;	Aspiration 1 – It is recommended that Oral health be incorporated into General Health. Better integration of IT, data, links between health service provider networks. Aspiration 7: The workforce is distributed poorly across the nation. Larger numbers of dental practitioners work in urban areas. This maldistribution needs to be addressed and resolved. Aspiration 8: Recommendation that data collection should be improved. Patient-level data collection improvements need to be made. Any improvements in public system need to be matched in the private. More regular surveys are required, extra funding would help us understand the picture better.	Recommendation 13: Adoption of a strategic policy approach to progress toward universal access to dental services.	Pg26: Capacity improvements for community service and education workers should be fully funded. Pg27: There should be increased coordination between levels of government. Pg30: Elective surgery patients should have uniform access to hospital services. There is no uniform list system across the states, data is difficult to analyse. Pg34: It is recommended that there be further integration of IT systems across health services.	Recommendation 12.3: State govts should implement comprehensive digital oral health records ASAP. They should be incorporated within the My Health Record system.	