Victorian Oral Health Alliance

SUBMISSION

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

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To whom it may concern,

The Victorian Oral Health Alliance (VOHA) is a group of health, professional and consumer bodies that have united to advocate for measures to improve access to public dental care for those at the highest risk of oral disease. For a list of member organisations and examples of our work please visit our website: **voha.org.au.**

VOHA has provided a detailed submission here, but our key points are as follows.

SUMMARY POINTS

- Oral health care remains an outlier in the Australian health system because of its reliance on private practice, poor accessibility for public care, a lack of integration with other health services, and the fact that consumers pay a lot more of the overall cost of the system than governments do.
- Dental caries (decay) is the disease condition with the highest expenditure in Australia and is attributed to high rates of potentially preventable hospitalisations, yet is largely preventable.
- The cost of dental care is often significant and the majority of it in Australia is paid for out-of-pocket by the people receiving care. For many it is prohibitive. This contrasts sharply with the partially subsidised services available for most other health conditions through Medicare.

- For the large numbers of Australians unable to regularly afford private dental care, waiting lists for public care are typically unacceptably long. In Victoria people on average wait over 20 months and some up to 40.
- 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.
- Many Victorians with higher oral health needs wait many months, and sometimes years, longer than is clinically recommended for care. Most public Victorian services spend at least half of their dental appointments responding to emergency/urgent care.
- Many Australians experience specific access issues, e.g., those living in rural, regional and remote areas are substantially impacted by service gaps.
- Aboriginal and Torres Strait Islander people face unique issues accessing health services that are deep and systemic and any/all recommendations to improve access on behalf of first nations people should be community-led.
- People with disabilities, LGBTQIA+ members of the community, asylum seekers and refugees, people who are incarcerated and institutionalised, people without housing, and people suffering domestic abuse and violence all experience particular access and safety issues that current services are poorly funded to address.
- VOHA recommends the establishment of a national Senior Dental Benefits Scheme, as per the recommendations from the Royal Commission into Aged Care Quality and Safety.
- There is inadequate access to timely and affordable specialist level services (treatment outside the scope of general dental practitioners, including dental treatment under general anaesthetic).
- There has historically been poor funding for cost-effectiveness evaluations but also unconnected data systems that hinder such work, and hence a lack of accurate information to inform policy development and system improvement.
- There needs to be significantly better coordination between the Federal and state governments in addressing Australia‘s oral health status and service provision, most importantly requiring the Commonwealth to appoint Australia’s first Chief Dental Officer.

- There are significant workforce issues that constrain optimum system performance.
- VOHA suggests that a mixed system federal excise tax on sugar-sweetened beverages would be an appropriate source of revenue to reinvest into expanding the provision of dental services.
- Prevention for oral health has had a very low priority by governments despite the research on cost-effective preventive strategies available internationally and within Australia (including community water fluoridation, comprehensive health promotion approaches, improving health literacy and tailored public awareness campaigns).

PREVIOUS KEY REPORTS

While VOHA is pleased that the Green's Health Spokesperson Senator Jordon Steele-John is bringing much-needed attention to the issues facing Australians in accessing dental services, many of these issues have been investigated, reported on, and have remained unaddressed several times, since the introduction of Medicare.

Attached, as an appendix to our submission, is a summary table we have compiled of the recommendations from several previous governmental reports prepared on this topic, including:

- Senate Standing Committee on Community Affairs, Report on public dental services 1998
- Report of the National Advisory Council on Dental Health 2012
- House of Representatives Standing Committee on Health and Ageing Inquiry into Adult Dental Services in Australia: "Bridging the Dental Gap" Report 2013
- Healthy mouths, healthy lives - Australia's National Oral Health Plan 2015-2024
- Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services – Inquiry report, Section on Public Dental Services 2017
- The Royal Commission Into Aged Care Quality and Safety. Final Report Volume 1: "Care, Dignity and Respect"

Noting that while some of the recommendations from the various inquiries have been actioned many of the same concerns and conditions exist.

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The following submission has been organised according to what the committee will inquire into and report on.

a. the experience of children and adults in accessing and affording dental and related services;

Access to care has been defined as "the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs".[1]

Sadly, the experience of children and adults in access to appropriate and affordable dental services in Australia remains out of reach for most of those who are at highest risk of oral disease.

Consumer stories collected by the Victorian Oral Health Alliance (VOHA):

"*Its going to cost me $5,000 dollors to get my teeth done…I have so much problems now with my teeth. I have tried getting a loan so I can get this done. because im only casual I cant get a loan …..*" [sic]

"*Private dentists way too expensive. Public dentists can't get in - have to wait 3 years in my area.*"

Frequency of dental visits and the reason for dental visits are key aspects related to access to dental care.[2] Making a recent dental visit is indicative of access to the dental care system while visiting for the reason of a check-up is considered more likely to be associated with better health outcomes than visiting for a dental problem such as relief of pain.[3] Hence, the dental profession tends to advocate a visit pattern of attending for annual dental check-ups to access preventive dental care or allow diagnosis of dental problems at an early stage, which can facilitate treatment before the disease progresses.[4]

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[1] Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(1), 18–18. https://doi.org/10.1186/1475-9276-12-18

[2] Roberts-Thomson, K., Brennan, D. S., & Spencer, A. J. (1995). Social inequality in the use and comprehensiveness of dental services. *Australian Journal of Public Health*, *19*(1), 80–85. https://doi.org/10.1111/j.1753-6405.1995.tb00302.x

[3] Crocombe, L. A., Brennan, D. S., & Slade, G. D. (2012). The influence of dental attendance on change in oral health-related quality of life: Dental attendance and quality of life. *Community Dentistry and Oral Epidemiology*, *40*(1), 53–61. https://doi.org/10.1111/j.1600-0528.2011.00634.x

[4] G. Do, L., Do, L. G., & Spencer, A. J. (2016). *Oral health of Australian children : The National Child Oral Health Study 2012-14* (L. G. Do & A. J. (Andrew J. Spencer, Eds.). University of Adelaide Press; Riley, P., Worthington, H. V., Clarkson, J. E., Beirne, P. V., & Riley, P. (2013). Recall intervals for oral health in primary care patients. *Cochrane Database of Systematic Reviews*, *2013*(12), CD004346–CD004346. https://doi.org/10.1002/14651858.CD004346.pub4

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In Victoria, the public sector has only ever had the capacity to see less than 25% of the population eligible for public dental services in a 24-month period, with many individuals languishing on waiting lists for *years*. Most people requiring specialist level care currently must wait additional time on a specialist waiting list and travel to a singular location in Carlton, Melbourne to the Royal Dental Hospital to receive specialist care.

The majority of dental care received in Australia is paid for out-of-pocket by the people receiving care, as described in Grattan's 2019 "Filling the Gap" report,[5] which can be prohibitively expensive, especially at a time when the cost of living is impacting many. Consumers pay for 58% of the oral health system (plus private health insurance premiums). These high costs contrast sharply with the partially subsidised services available for most other health conditions through Medicare (where consumers pay approximately 11% of total primary health costs and 5% for hospitals).

According to the biennial Fee Survey run by the Australian Dental Association (federal branch), the cost of having one average-sized filling replaced is equivalent to a full week of rent in Melbourne (~$450-500).

[5] Stephen Duckett, Matthew Cowgill, & Hal Swerissen. (2019). *Filling the gap: a universal dental care scheme for Australia*. Grattan Institute.

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To summarise opportunities for children and adults to access oral health care in Victoria:

	CHILDREN	ADULTS
PUBLIC SECTOR	• In Victoria children are eligible for priority access, for low or no fee dental care until age 12. • On top of that the State Government has developed "Smile Squad", a reboot of the school dental service. • Specialist level care is difficult to access due to geographical location and long waiting times.	Healthcare card holders can be seen: • for an "emergency" appointment if they meet triaging requirements. • for general care without waiting if they belong to a "priority access" demographic (~17%) • for general care 80% of the eligible population must go on a waiting list which currently can be as long as 40 months (3.3 years).[6] • Specialist care is difficult to access due to long wait lists.
PRIVATE SECTOR	• Eligible children can use $1,052 of "credit" (federally funded Child Dental Benefits Scheme) over 2 calendar years in private practice. • Parents/guardians/carers can pay out of pocket. • Children can be subsidised by family private health insurance rebates.	• Adults either pay out of pocket or have dental services subsidised by private health insurance. • Eligible veterans have their dental care costs covered by DVA.

- In 2012–14 approximately 81% of children (aged 5–14 years) attended a dental visit within the previous 12 months.[7]

[6] ADAVB data collected under the Freedom of Information Act up to date as at 31 Dec 2022.

[7] G. Do, L., Do, L. G., & Spencer, A. J. (2016). *Oral health of Australian children : The National Child Oral Health Study 2012-14* (L. G. Do & A. J. (Andrew J. Spencer, Eds.). University of Adelaide Press; Riley, P., Worthington, H. V., Clarkson, J. E., Beirne, P. V., & Riley, P. (2013). Recall intervals for oral health in primary care patients. *Cochrane Database of Systematic Reviews*, *2013*(12), CD004346–CD004346. https://doi.org/10.1002/14651858.CD004346.pub4

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- In 2017–18 approximately 16% of children (aged 5–14) last visited a **school dental service**, and 70% last visited a private dental practice (This was similar to the trend observed in 2013).[8]
- In 2017–18, **56%** of adults aged 15 years and over saw a dental practitioner in the last 12 months, however in 2020–21 **only 48%** Australians had consulted a dentist or dental professional in the last 12 months.[9]
- In 2018, 2.8 million children had been notified that they were eligible for the CDBS, but less than 40% had accessed/utilised the program.[10] There are yet no known projects to evaluate why the program is being significantly underutilised.

We have consistently heard that access to day-surgery facilities for the provision of oral health services under general anaesthetic (for pre-cooperative aged children, and adults with additional needs and/or specific requirements, and/or extensive oral surgery) is ***dire***, in both the public and private sectors.

b. the adequacy and availability of *public* dental services in Australia, including in outer-metropolitan, rural, regional and remote areas;

'I have had a 72 year old who endured much before finally being placed on the waiting list for Periodontics at the Dental Hospital. Being accepted at all was a great feat and took over six months. Been on the waiting list now for 2 years and 2 months...believes she will have lost her remaining teeth by the time she is eventually seen. No-one will tell her when. Cost of local Periodontist appointment - $500 approx for 1st appointment. Subsequent appointments are around $300 - $400. Not feasible on an Age pension.'

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 dropped further during the Victorian lockdowns throughout the pandemic but has since rebounded to pre-pandemic levels.

[8] Australian Institute of Health and Welfare. (2023, March 17). *Oral health and dental care in Australia, Healthy mouths - Australian Institute of Health and Welfare*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/healthy-mouths
[9] Ibid.
[10] Australia. Department of Health (2013-2022) issuing body. (2019). *Report on the fourth review of the Dental Benefits Act 2008*. [Canberra] : [Department of Health]

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Dental practitioners generally advise *everyone* to have an annual oral health check from when the first tooth erupts, to the end of life. The purpose of these check-up appointments is to monitor the oral environment for evidence of disease activity (mainly dental decay, gum disease and oral cancer) which includes people without any natural teeth because dental practitioners are best placed to identify oral cancer lesions in their early stages. Individuals and families considered to have a "higher risk" (of developing oral disease) due to a combination of socioeconomic factors and individual risk factors might be advised to have even more regular monitoring.

This is an ***impossibility*** for many people relying on the public system. In Victoria unless you belong to a "Priority Access" group you must first wait a year since your most recent appointment before you're even able to put your name on a waitlist again. Eighty-three per cent (83%) of the adult individuals seen in the financial year of 2021/22 did not belong to a priority access group, meaning they are not permitted to even have their name on a waitlist until twelve months (12) have passed since they've finished general care.

Given half of Victoria's public dental agencies have a waiting list of *over 12 months* the majority of people accessing care can't be seen within 24 months (2 years) for general care. Most of these community members would be clinically assessed as high-risk by virtue of their eligibility status and their socio-economic circumstances.

Even if individuals and families ***are*** able to get an appointment in a public clinic, there are only a limited spectrum of dental services available. For example, it is fairly common for public agencies not to provide a crown, or bridge or other fixed prostheses to protect fragile teeth or replace missing teeth. Root canal treatment is only provided to save strategically important teeth (like first permanent molars).

The Australian Dental Association Victorian Branch publishes maps made using data obtained under the Freedom of Information Act which demonstrate visually that wait times are worse in rural and regional areas.

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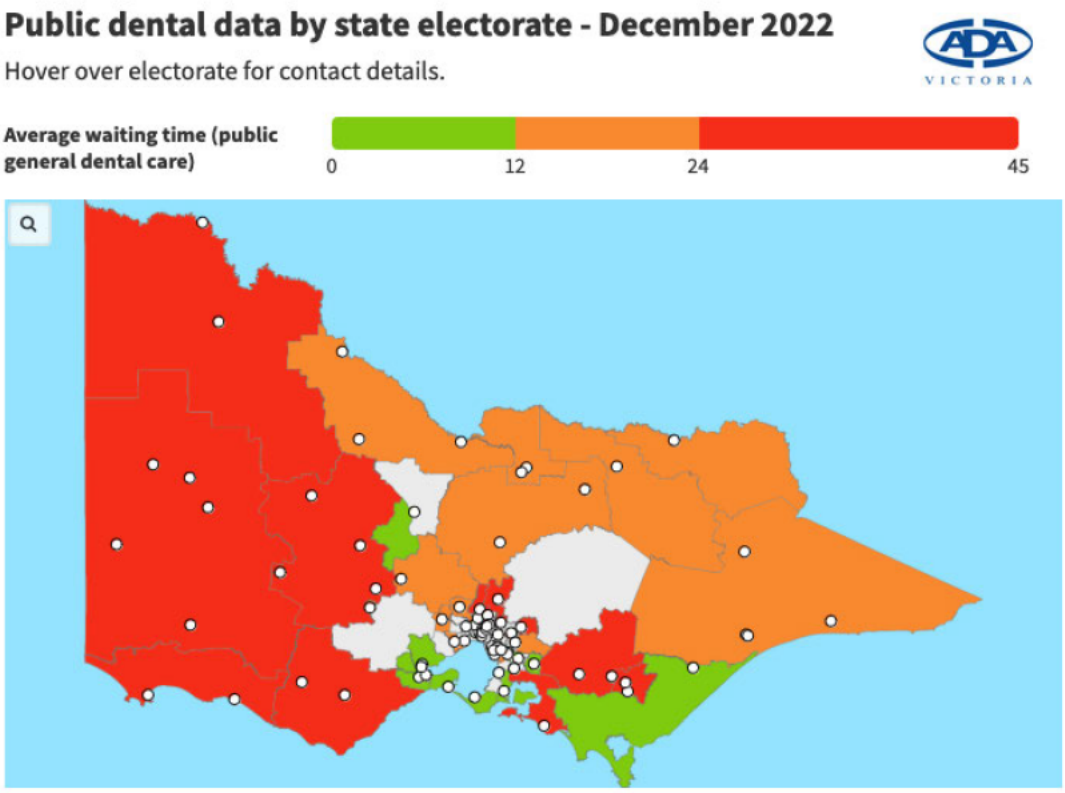

The Commonwealth of Australia House of Representatives' Select Committee on Regional Australia published a report in 2022 titled; "Pride of Place: Inquiry into the future of Regional Australia" which also notes that Australians living in regional struggle to access appropriate dental services.

Overall, people living in regional and remote areas of Australia have poorer oral health than those living in *Major cities*,[11] and oral health status generally declines as remoteness increases. People living in rural areas have lower levels of water fluoridation,[12] and access to fewer dental practitioners than their city counterparts, which, coupled with longer travel

[11] COAG (Council of Australian Governments) Health Council 2015. Healthy mouths, healthy lives: Australia's National Oral Health Plan 2015–2024. Adelaide: South Australian Dental Service.
[12] Dickson-Swift, V., Crocombe, L., Bettiol, S., & Bracksley-O'Grady, S. (2023). Access to community water fluoridation in rural Victoria: It depends where you live. *The Australian Journal of Rural Health*. https://doi.org/10.1111/ajr.12973

times and limited transport options to services, affects the oral health care that they can receive.[13]

KPI #19 in Australia's National Oral Health Plan 2015–2024: performance monitoring report from 2020 indicates there's been an unfavourable increase in potentially preventable hospitalisations for dental conditions, with highest rates affecting children in remote and very remote areas, almost double the rate in major cities.

The relative likelihood of being diagnosed with head & neck cancer is 31% more likely for community members living outside Victoria's major cities according to data from the Victorian Cancer Registry.

There are 50 community dental agencies that provide public oral health services across Victoria. While sector-wide data is scarce, individual reports from community providers indicate that many clinics have the physical infrastructure to provide much more care. Apparently, many clinics operate with spare unutilised or underutilised chairs which sit idle, unfunded and cost money to maintain. To highlight a report from one rural location, the Benalla clinic has two chairs but no dental practitioners due to an inability to attract and retain qualified practitioners. Similar stories are reported from Maryborough, Omeo, Bairnsdale, Seymour, Boort, Nhill, Creswick/Daylesford, Colac, St Arnaud and Ouyen.

This problem is not limited to rural and regional areas, metropolitan providers also find it extremely difficult to retain staff due to low pay rates and poor conditions. Reports from staff working at IPC in Western Metropolitan Melbourne indicate that the organisation has 10 chairs but only operates with two full-time staff and a rotating roster of part-time staff, meaning there is significant capacity to upscale services but no ability to due to funding and staffing levels.

[13] COAG (Council of Australian Governments) Health Council 2015. Healthy mouths, healthy lives: Australia's National Oral Health Plan 2015–2024. Adelaide: South Australian Dental Service.; Bishop LM & Laverty MJ 2015. Filling the gap: Disparities in oral health access and outcomes between metropolitan and remote and rural Australia. Canberra: Royal Flying Doctor Service of Australia.

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The collection of data under the Freedom of Information Act shows that over the last five (5) years the equivalent full-time dental practitioners working clinically in the public sector has decreased by ten percent (10%) while the ratios of different types of practitioners remaining relatively stable.

Statewide breakdown of clinical EFT by practitioner type

	Dentist	DT/OHT/DH	Prosthetist	Total EFT:
Dec 2018	57%	36%	7%	360.1
June 2019	57%	35%	8%	364.9
Dec 2019	58%	34%	8%	357.0
June 2020	60%	32%	7%	324.3
Dec 2021	58%	35%	7%	298.7
June 2022	54%	40%	7%	335.6
Dec 2022	56%	38%	6%	314.0

c. the interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services;

The area of most obvious overlap of responsibilities and funding between the Commonwealth and states is services for children. The Commonwealth's Child Dental Benefits Schedule (CDBS) offers eligible children up to $1,052 in benefits over a two-year calendar period for basic dental services, with services provided in both the public and private sector. Approximately 50% of children are eligible to access the CDBS, but there is poor uptake, with the most recent review indicating only 40% of eligible children utilised the scheme.

In Victoria, children have been eligible for free or low-fee priority access care in the public sector until age twelve (12) utilising both state government funding and the CDBS. In 2019 the Victorian government launched the Smile Squad school dental program with the aim of providing free dental care to all children at Victorian government primary and secondary schools, massively increasing the number of children who would be able to access publicly funded dental care. However, with around 80% of children already accessing dental care, and the poor uptake of Smile Squad (particularly in secondary schools), there remain questions about the value of this program in improving the oral health of those children most at need.

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Additionally, the Commonwealth's Child Dental Benefits Schedule (CDBS) offers eligible children up to $1,052 in benefits over a two-year calendar period for basic dental services. Uptake of the CDBS Program has been disappointing at under 40%, for reasons unknown although likely to be from lack of promotion and complex eligibility requirements.

In 2013 the Commonwealth of Australia House of Representatives Standing Committee on Health and Ageing published the results of the "Bridging the Dental Gap; Report on the Inquiry into adult dental services".[14] **The Committee's Terms of reference included many of the same concerns as this inquiry:**

> Specifically, the Committee will consider:
>
> - demand for dental services across Australia and issues associated with waiting lists;
> - the mix and coverage of dental services supported by state and territory governments, and the Australian Government;
> - availability and affordability of dental services for people with special dental health needs;
> - availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations;
> - the coordination of dental services between the two tiers of government and with privately funded dental services; and
> - workforce issues relevant to the provision of dental services.

[14] Australia. Parliament. House of Representatives. Standing Committee on Health and Ageing, author. & Hall, Jill. (2013). *Bridging the dental gap : report on the inquiry into adult dental services*. Canberra: Parliament of the Commonwealth of Australia, http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=haa/dental/report.htm

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It would be prudent for the Senate to review the thirteen (13) recommendations from the 2013 House of Representatives report. We reiterate the importance of implementing the tenth (10th) recommendation from the 2013 report, that

> *The Department of Health and Ageing, in consultation with state and territory governments and other key stakeholders, examine the case to appoint a Commonwealth Chief Dental Officer or establish an independent advisory body to:*
>
> - *improve coordination between the Australian Government, and state and territory governments;*
> - *increase engagement with the private sector, particularly private providers of dental services; and*
> - *provide independent policy advice on dental and oral health.*

As oral health is a matter/issue that affects all Australians (bar ***none***) and therefore it would seem appropriate that the Commonwealth take more responsibility for this aspect of health.

The Federation Funding Agreement (previously the "National Partnership Agreement") for Public Dental Services for Adults ***requires longer-term commitment***, as per Principle 5 of the Federation Funding Agreements Framework (Funding certainty: New agreements that fund ongoing services will provide states with funding certainty where possible).[15]

VOHA is advised that this lack of funding security prevents community health agencies that provide public dental services from putting some staff on permanent contracts, which in turn decreases job security for the workforce, and prevents employers from meeting best practice employment standards (i.e., conversion of staff on rolling fixed-term contracts onto permanent contracts).

[15] Federal Financial Relations. (2022). *Public Dental Services for Adults – 2022-23.* https://federalfinancialrelations.gov.au/agreements/public-dental-services-adults-2022-23

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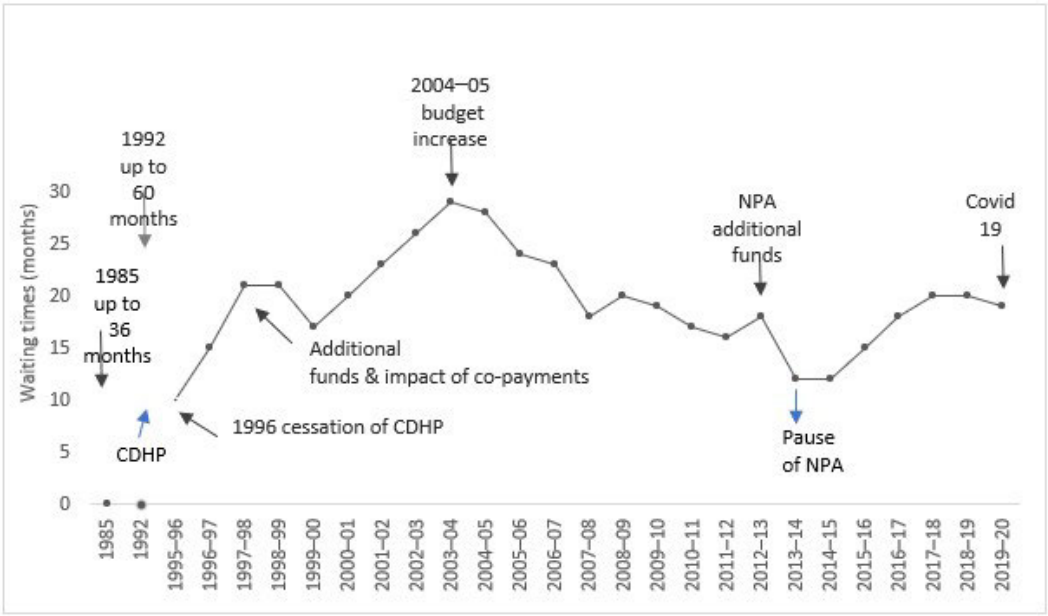
The below graph was prepared by Dr John Rogers previously the Principal Oral Health Policy Advisor in the Victorian Department of Health. It demonstrates that **injections of additional funds from the Federal Government can have a real and measurable impact on reducing wait time**. In other words, federal money ***does*** equate to greater access to care.

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



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d. the provision of dental services under Medicare, including the Child Dental Benefits Schedule;

VOHA recognises that there are multiple legislative options for oral health services which can potentially be administered by the Commonwealth, each with advantages and disadvantages.

It is the preference of the Australian Dental Association for the provision of dental services to be expanded under the *Dental Benefits Act 2008* (Cth), as it is reportedly easier to amend and modify than the *Health Insurance Act 1973* (Cth), as the former is reviewed every four years and therefore there are greater opportunities to implement change (such as indexation) under the existing structure of the Dental Benefits Act.

However, it's been pointed out that this arrangement has made it difficult for non-dental professionals to access certain dental items that would be relevant to their practice, which maintains the status quo of a 'closed' free market for oral health. It also means no safety net for individuals, unlike the Health Insurance Act.

VOHA strongly supports the provision of a Senior Dental Benefits Scheme, as per the recommendations from the Royal Commission into Aged Care Quality and Safety, as well as expansion for other groups at higher risk of oral health problems (such as our Aboriginal and Torres Strait Islander people, people with disabilities, the LGBTQIA+ members of the community, asylum seekers and refugees, people who are incarcerated and institutionalised, people without safe housing, people suffering domestic abuse and violence and people with chronic health conditions) as the first steps in the pathway to universal coverage.

VOHA suggests there are several economic levers available to help provide the revenue for the expansion of oral health services. For example:

- a mixed system federal excise tax on sugar-sweetened beverages (as recommended for high-income countries in the 2022 WHO manual on sugar-sweetened beverage taxation policies to promote healthy diets),
- increase the Medicare levy, and/or
- redirect funding from private health insurance (as per Grattan Institute recommendations).

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e. the social and economic impact of improved dental healthcare;

Oral health is 'produced' by exposure to multiple determinants of health; that is, factors that influence health and the risk of disease. Individuals may have very little control over their exposure to the determinants of health, for example, whether they have exposure to fluoride through their water supply.

We have long had evidence to support assertions that oral health problems disproportionately affect socially and economically vulnerable populations. As with other non-communicable diseases, the prevalence of oral diseases follows a social gradient, whereby oral health and quality of life worsen with socioeconomic disadvantage.[16] This is re-emphasised in the WHO Global oral health status report "a higher disease burden for the most vulnerable and disadvantaged population groups within and across societies".

Poor oral health increases risks associated with other chronic non-communicable diseases (cardiovascular diseases, depression, dementia and cognitive impairment, diabetes mellitus, Type 2 Diabetes, some cancers and obesity)[8] in addition to inhibiting social inclusion, employment opportunities, and workforce participation.[17] A person's smile is one of the clearest social indicators, a very visible sign of wealth or of poverty.

See the Australian Dental Association Victorian Branch fact sheet (Appendix B) for statistics on the preventable costs of poor oral health.

See also; a health economics report commissioned by the Brotherhood of St Laurence titled "End the decay: the cost of poor dental health and what should be done about it".

[16] Nguyen, T. M., Bridge, G., Hall, M., Theodore, K., Lin, C., Scully, B., Heredia, R., Le, L. K.-D., Mihalopoulos, C., & Calache, H. (2023). Is value-based healthcare a strategy to achieve universal health coverage that includes oral health? An Australian case study. *Journal of Public Health Policy*. https://doi.org/10.1057/s41271-023-00414-9

[17] Halasa-Rappel YA, Tschampl CA, Foley M, Dellapenna M, Shepard DS. Broken smiles: the impact of untreated dental caries and missing anterior teeth on employment. *J Public Health Dent*. 2019;79(3):231–7. https:// doi. org/ 10. 1111/ jphd. 12317; Gift, H. C., Reisine, S. T., & Larach, D. C. (1992). The social impact of dental problems and visits. *American Journal of Public Health*, *82*(12), 1663-1668.

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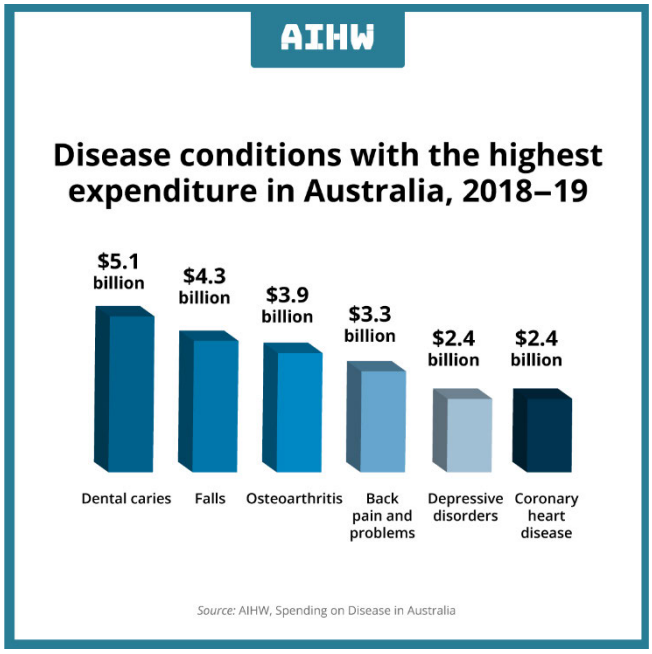

The Australian Institute of Health and Welfare (AIHW) reported that in 2018/19 dental caries (decay) was the disease condition with the highest expenditure in Australia.

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

The COVID-19 pandemic has had an impact on both patients and dental professionals in terms of the number of services, type of services and the way in which services are delivered. Early in the pandemic, the Australian Health Protection Principal Committee (AHPPC) issued advice to National Cabinet that recommended dental practices implement restrictions whereby dental practitioners should only perform dental treatments that do not generate aerosols, or where treatment generating aerosols is limited and that all routine examinations and treatments should be deferred. That meant for lengthy periods of time, patients were not able to access routine dental care, and that was experienced most profoundly in Victoria with more than 200 days of restrictions impacting on dental care. Beyond those restrictions, fewer dental services were provided as dental practices modified their infection prevention and control procedures to manage the pandemic – for example by increasing the time between appointments to minimise the risk of patient-to-patient transmission of COVID-19.

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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.[18]

Over recent years, there has been a noticeable change in people's attitudes towards health checks and health-seeking behaviours, and the impact of the COVID-19 pandemic has had a significant effect on cancer diagnoses in Victoria.

A review of dental services provided to children through the Child Dental Benefits Schedule found that the pandemic had a significant impact on the provision of services to children from lower socioeconomic backgrounds who already experience higher levels of dental disease and disadvantage in accessing dental care. Over the period of March to September, there were 881,454 fewer dental services provided in 2020 than in 2019, with the largest decline seen in April when there was a lockdown affecting all of Australia. The greatest decline was in preventive and diagnostic services. A second wave of COVID-19 in Victoria saw 198,609 fewer dental services provided from July to September 2020 than in 2019. Dental service provision had still not returned to pre-COVID-19 levels across Australia by September 2020.[19]

According to the Victorian Cancer Registry,[20] there has been a concerning 7% decline in cancer diagnoses in 2020, with a further decline of 4.3% in 2021, resulting in approximately 3,800 fewer cancer diagnoses in Victoria over this period.

The cost-of-living crisis is having an impact on dental health, as dental practices experience increased costs in terms of materials and equipment, staff wages and power costs. Invariably these costs have to be passed on to patients. Cost is already seen as a major barrier for many patients in accessing dental care, and some are now deferring necessary dental care as they are forced to prioritise their spending. Unfortunately with dental being treated separately from Australia's other primary and allied health services (particularly through the Medicare system), patients often view dental treatment as a luxury item however as we have highlighted this is not at all the case.

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[18] Australian Institute of Health and Welfare. (2023, March 17). *Oral health and dental care in Australia, Summary – Impact of COVID-19 on dental services.* https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/summary#COVID

[19] Hopcraft, M., & Farmer, G. (2021). Impact of COVID-19 on the provision of paediatric dental care: Analysis of the Australian Child Dental Benefits Schedule. *Community Dentistry and Oral Epidemiology*, *49*(4), 369–376. https://doi.org/10.1111/cdoe.12611

[20] Cancer Council Victoria. (2022, December 8). *VCR annual statistics and trends report.* www.cancervic.org.au/research/vcr/fact-sheets-and-annual-reports

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g. pathways to improve oral health outcomes in Australia, including a path to universal access to dental services;

Any pathway to improve oral health outcomes must acknowledge the factors that influence oral health in the first place (i.e., the determinants of health) and an appreciation that while access to care does influence health outcomes, only a small degree of oral health is attributable to utilisation of dental services.

The World Health Organization (WHO) published their Global oral health status report (GOHSR) in November last year, subtitled; "Towards universal health coverage for oral health by 2030" and highlights challenges and opportunities to accelerate progress towards universal coverage for oral health. Twenty years after the publication of The World Oral Health Report 2003 and in alignment with the landmark WHA 74.5 Resolution on oral health, the GOHSR is intended to serve as a reference for policymakers and provide orientation for a wide range of stakeholders across different sectors; and guide the advocacy process towards better prioritisation of oral health in global, regional and national contexts.

In 2021, the WHO developed the draft "Implementation guidance to integrate non-communicable disease services into other programmatic areas and health systems" as a public health product for the benefit of countries across multiple WHO regions. The WHO included an Australian model as one of the case studies within this global guidance document, which was highlighted as compatible, acceptable, and feasible, with a "goodness of fit" with existing services. This case study is Integrating oral health promotion in midwifery practice through human resources development in Australia.

The rest of the Australian health workforce has a very limited understanding of oral health. To integrate oral health as a part of holistic care (and from a multidisciplinary care model), attention must be paid to the core oral health competencies required of the primary healthcare workforce. After competencies are integrated into existing training and accreditation systems, interprofessional collaboration can be further facilitated by the development and implementation of shared electronic medical records, screening tools, outcome measures and funding models.

Training in oral health for other health professionals including speech therapists, dieticians, general practitioners, nurses, pharmacists, Aboriginal Health Workers etc. can help fill gaps in geographical areas with poor access to dental practitioners and facilitate an

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interprofessional approach to oral health which is consistent with the recommendations from WHO. The WHO recommends that interprofessional collaborative practice (IPCP) can best be achieved through interprofessional education.[21]

Another example of interprofessional practice meeting a workforce gap is the Senior Smiles program developed in New South Wales for residents of Residential Aged Care Facilities (RACFs). Senior Smiles is estimated to deliver tangible value in the order of $4.13 and $3.14 of benefit within the health care system for every $1 invested in the project for the pilot and the current implementation respectively. A further $4.87 and $3.66 are identified in social benefits for every $1 invested (respectively for the pilot and the current project). Sensitivity testing around the base-case indicates that the overall benefits generated per $1 invested range between $7.16 and $11.12 for the pilot and between $5.44 and $8.35 for the current project. Should Senior Smiles be rolled out it is estimated to deliver an overall gross benefit of $6.80 and $6.07 for every $1 invested respectively for a regional and a national spread.[22]

In summary, the pathway to universal coverage for oral health care is to bolster the oral health competencies of the rest of the health workforce (facilitating interprofessional practice) and expand eligibility to subsidised dental care by first targeting our most in need/affected community members and ensuring adequate evaluation occurs to demonstrate intended outcomes are being achieved.

h. the adequacy of data collection, including access to dental care and oral health outcomes;

Economic evaluation has been defined as "ensuring that the value of what is gained from an activity outweighs the value of what has to be sacrificed"[23] reflecting the fundamental economic principles of scarcity, choice and opportunity cost. In order to determine whether the benefits produced by a particular programme exceed the opportunity costs of providing that programme a method of measuring and comparing outcomes is required.

[21] World Health Organization. (2010, September). *Framework for action on interprofessional education & collaborative practice*. https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice

[22] Senior Smiles. (2019, January 31). *Cost benefit analysis of the Senior Smiles pilot*. https://www.seniorsmiles.org.au/research/publication-9/. The University of Newcastle Australia.

[23] Elizabeth Williams & Haworth Continuing Features Submission (1983) Building Tales, Activities, Adaptation & Aging, 4:1, 63-69, DOI: 10.1300/J016v04n01_08

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Currently there is no standardised way of measuring, recording or capturing the starting points (baseline oral health status) and end points (outcomes of care) of an oral health care cycle (also known as a "course of care"), and so our evaluations of both clinical effectiveness and cost-effectiveness in both the public and the private settings are *acutely* lacking.

The lead agency for public oral health in Victoria, Dental Health Services Victoria (DHSV) invested in the development of a 'standard set' of adult oral health outcome measures intended for global use by the International Consortium of Health Outcome Measures (ICHOM).[24] ICHOM's standard sets have an emphasis on Patient Reported Outcome Measures (PROMs) to ensure there remains a focus on outcomes that matter to people receiving care.

A vicious cycle exists; better data is required to make a stronger case for the need for more public dental funding, but a significant amount of funding is required to obtain more accurate data.

Because electronic oral health records have not been routinely incorporated into Australia's national electronic health record ("My Health Record") we have no national repository of oral health information available for secondary research and evaluation purposes. Further, it's a difficult sell to healthcare providers to share information due to logistical and security concerns. It would require a significant investment to set up the infrastructure required and the staff and support to maintain a repository like the BigMouth dental data repository in the United States.[25]

Crucially, dentistry has the lowest ratio of research funding to disease burden in Australia.[26]

Separate from the lack of clinical data there are also a dearth of other related relevant information. For example, the Victorian public sector doesn't collect or analyse data on workforce size and retention rates. In the context of value-based health care this is potentially

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[24] Riordain, R. N., Glick, M., Mashhadani, S. S. A. A., Aravamudhan, K., Barrow, J., Cole, D., Crall, J. J., Gallagher, J. E., Gibson, J., Hegde, S., Kaberry, R., Kalenderian, E., Karki, A., Celeste, R. K., Listl, S., Myers, S. N., Niederman, R., Severin, T., Smith, M. W., … Williams, D. M. (2021). Developing a Standard Set of Patient-centred Outcomes for Adult Oral Health – An International, Cross-disciplinary Consensus. *International Dental Journal*, *71*(1), 40–52. https://doi.org/10.1111/idj.12604

[25] Walji, M. F., Spallek, H., Kookal, K. K., Barrow, J., Magnuson, B., Tiwari, T., Oyoyo, U., Brandt, M., Howe, B. J., Anderson, G. C., White, J. M., & Kalenderian, E. (2022). BigMouth: development and maintenance of a successful dental data repository. *Journal of the American Medical Informatics Association : JAMIA*, *29*(4), 701–706. https://doi.org/10.1093/jamia/ocac001; Kalenderian, E., Tokede, B., Ramoni, R., Khan, M., Kimmes, N., White, J., Vaderhobli, R., Yansane, A., Feilzer, A., & Walji, M. (2016). Dental clinical research: an illustration of the value of standardized diagnostic terms. *Journal of Public Health Dentistry*, *76*(2), 152–156. https://doi.org/10.1111/jphd.12124

[26] Ghanbarzadegan, A., Ivanovski, S., Sloan, A., & Spallek, H. (2023). Oral health research funding in relation to disease burden in Australia. *Australian Dental Journal*, *68*(1), 42–47. https://doi.org/10.1111/adj.12949

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the single biggest area of public resource waste, that is; costs associated with high staff turnover, (e.g., lost productivity when understaffed, costs associated with recruitment estimated to vary between $40,000 and $110,000 per person, lost productivity during onboarding and training, and impact on morale and workplace culture when teams are understaffed).

The WHO makes specific recommendations regarding the use of oral health information in their 2022 report for filling crucial knowledge gaps, improving the quality of oral health care and ultimately promoting better oral health for individuals and populations. “This should include research on learning health systems, implementation sciences, workforce models, digital technologies, health economics and the public health aspects of oral diseases and conditions. Other research priorities include developing mercury-free dental restorative materials, identifying and overcoming access barriers in oral health care, addressing oral health inequalities, promoting oral health in key settings like schools, promoting environmentally sustainable practices and identifying cost-effective interventions through economic analysis.” See Figure 37 from the 2022 GOHSR below.

Fig. 37. Uses of oral health information

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Victoria has only ever 'treated' (seen) 25% of the population eligible for public oral health services. There is no data available to understand this issue. It is unknown whether there is a lack of understanding about the availability of the services, whether community members perceive that the services available are inadequate and would rather pay to be seen in the private sector, whether community members can't take time off work, or can't arrange childcare to attend the service etc.

In terms of understanding the complex funding arrangements, the state budget and the State Government's statement of priorities provide inadequate detail regarding how financial resources are distributed to the agencies from whom dental services are purchased. It is unclear how need is determined, how physical infrastructure available relates to funding for staffing, and how these calculations relate to local populations and community need.

Public health surveillance is required to understand the changing needs of the population. There have only been three National Adult Oral Health Surveys in the last thirty-six (36) years. i.e., 1987/88, 2004-06, 2017/18. While the costs of conducting dedicated, regular national oral health surveys are high, the benefit of a better understanding that data collection and analysis could provide cannot be understated.

i. workforce and training matters relevant to the provision of dental services;

With regards to workforce:

- Only 20% of registered practising dentists work in the public sector, despite the highest burden of disease existing within the population reliant on the public sector for care.
- It has been alleged that there exists an oversupply of dental practitioners, but this could very reasonably be reframed as a *maldistribution* of dental practitioners between sectors and in geographical terms.
- Recruitment of public sector dental practitioners is dramatically problematic in Victoria, and retention of clinical staff is similarly a significant issue.
- Universities are also reporting that retention of dental academic and clinical supervision staff is an increasing challenge faced at the tertiary educational institutions.

- There are a lack of incentive and scholarship programs for rural practitioners, and underfunded student rural placement programs. Graduate programs that focus on the redistribution of the workforce are needed.
- 80% of services delivered in the public sector are potentially within the scope of Oral Health Therapists (with extended scope of practice to provide basic restorative services to adults).
- Working in the public sector in Victoria is unappealing for several reasons:
    - Dental practitioners are remunerated significantly more for care in the private sector.
    - There is less continuity of care which results in less job satisfaction compared to caring for the same people and families over time.
    - The medical, social, and economic circumstances faced by community members accessing public sector care are often extremely confronting and upsetting to be exposed to, increasing risks of compassion fatigue and occupational burnout.
    - The funding model has productivity targets that reward invasive and irreversible treatment and disincentivises preventive care, resulting in disillusionment within the clinical workforce and contributing to occupational burnout.
    - Short-term and unreliable funding means that some staff are employed on fixed term contracts which decreases financial security and increase barriers to borrowing and home ownership.
    - Completing a Bachelor of Dental Surgery or equivalent qualification (for registration as a dentist) means practitioners are over-skilled for the requirements of public sector work and such limited service provision by dentists in the public sector results in “deskilling” over time. The suitability of the training programs to meet the needs of the community may warrant a review.
    - Dental practitioners are paid on average 30% less than their interstate counterparts:

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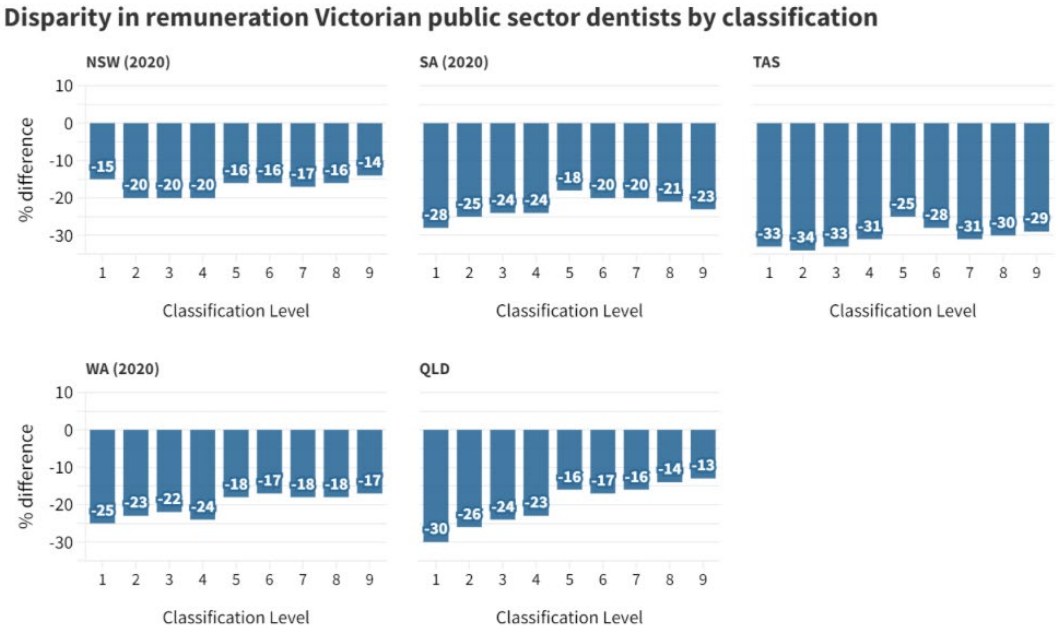

Data compiled in 2022 from each state's most recently published public sector Enterprise Bargaining Agreements highlights the significant disparity in entitlements for dentists compared with other states and territories. This trend in classification and renumeration disparity in Victoria compared with other states and territories is consistent for each dental practitioner division.[27]

[27] Stormon N, Tran C & Suen B. 2021. Australian Oral Health Workforce: The Oral Health Professions Workforce Survey 2020. Brisbane: The University of Queensland. The Australian Dental and Oral Health Therapists Association Ltd. And The Dental Hygienists Association of Australia Ltd.

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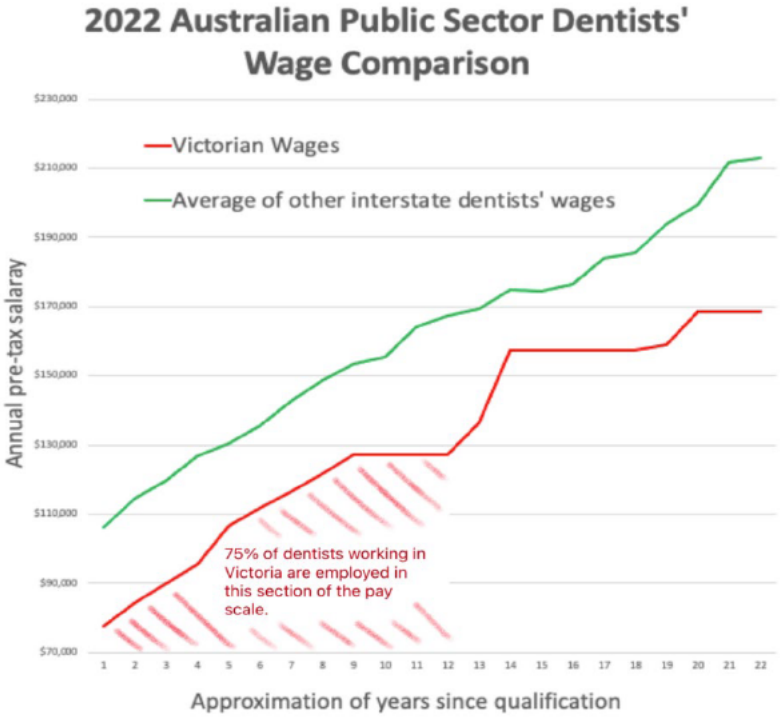

The 2023 Victorian Public Sector Wage Policy caps wage increases at 3% which clearly isn't possible to improve the equity of this situation for Victorian clinicians to reach pay parity with the rest of the Australian public dental workforce.

Research into the mental health of the Australian dental workforce shows that rates of psychological distress, professional burnout, suicidal ideation, and suicide attempts by Australian dental practitioners are above the average rates of the rest of the population.[28]

[28] Hopcraft, M. S., McGrath, R., Stormon, N., & Parker, G. (2023). Mental health, psychological distress and burnout in Australian dental practitioners. *Australian Dental Journal*. https://doi.org/10.1111/adj.12961; Hopcraft, M. S., Stormon, N., McGrath, R., & Parker, G. (2023). Factors associated with suicidal ideation and suicide attempts by Australian dental practitioners. *Community Dentistry and Oral Epidemiology*. https://doi.org/10.1111/cdoe.12849

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j. international best practice for, and consideration of the economic benefit of, access to dental services

"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 expenditures is not necessarily correlated to better or worse oral health status."[29]

WHO recommends that essential oral health interventions include, but are not limited to routine and preventive oral health care (including oral health examination, counselling on oral hygiene with fluoride toothpaste, fluoride varnish application, glass ionomer cement as a sealant and oral cancer screening in high-risk groups, linked with timely diagnostic work-up and comprehensive cancer treatment, in settings with a significant disease burden).

Investment in *prevention* is the key. Many countries have established effective policies and successful programs to reduce the prevalence and severity of oral diseases. Of these, water fluoridation is widely acknowledged as the most effective and cost-efficient means of preventing caries.[30] Currently, 90 per cent of Victorians drink fluoridated water, which is either naturally fluoridated or has fluoride added. Priority is given to areas with a community water source that supplies populations greater than 1000 people in size. But there is still a long way to go. An ongoing focus to provide water fluoridation to these and smaller communities is a cost-effective way of reducing oral health disparities.

Successful preventive strategies also include a renewed focus on integrating oral health care with primary health care, including prevention and oral health promotion in settings outside specialised oral health facilities. The isolation of dentistry from the mainstream health system is another key challenge brought to light by the COVID-19 pandemic. This separate approach to oral health care is an almost universal characteristic worldwide and is the result of historical and professional factors. Because independent private practitioners deliver a significant proportion of oral health care outside of the public health system, public health policymakers and key decision-makers often consider dentistry to be a marginal issue of low priority. Where oral health services are more integrated into the public health system, it is far easier to work

[29] World Health Organization. (2022, November 18). *Global oral, health status report: towards universal health coverage for oral health by 2030*. https://www.who.int/team/noncommunicable-diseases/global-status-report-on-oral-health-2022

[30] Griffin, S. O., Jones, K., & Tomar, S. L. (2001). An Economic Evaluation of Community Water Fluoridation. *Journal of Public Health Dentistry*, *61*(2), 78–86. https://doi.org/10.1111/j.1752-7325.2001.tb03370.x

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across professional boundaries to deliver more person-centred care as well as for patients to access and afford primary oral health care.[31] Importantly, countries that have more redistributive and universal welfare policies, including universal health coverage for oral healthcare, tend to have better population oral health.[32]

Japanese 8020 campaign

Japan introduced a universal health insurance scheme in 1961 that covered most dental treatments. To tackle the high prevalence of oral diseases in 1989 the Japanese Government introduced the "8020 Campaign" as a long-term national oral health-promoting strategy based 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. Japan has the highest percentage of older adults (aged 65 and above) in the world, and now the lowest tooth loss rate.[33] Results from their evaluations suggest that the oral health of the Japanese population has extensively improved since the introduction of the 8020 Campaign.[34]

[31] World Health Organization. (2022, November 18). *Global oral, health status report: towards universal health coverage for oral health by 2030*. https://www.who.int/team/noncommunicable-diseases/global-status-report-on-oral-health-2022

[32] Guarnizo-Herreño, C. C., Tsakos, G., Sheiham, A., & Watt, R. G. (2013). Oral health and welfare state regimes: a cross-national analysis of European countries. *European Journal of Oral Sciences*, *121*(3pt1), 169–175. https://doi.org/10.1111/eos.12049; Guarnizo-Herreño, C. C., Watt, R. G., Stafford, M., Sheiham, A., & Tsakos, G. (2017). Do welfare regimes matter for oral health? A multilevel analysis of European countries. *Health & Place*, *46*, 65–72. https://doi.org/10.1016/j.healthplace.2017.05.004; Sanders, A. E., Slade, G. D., John, M. T., Steele, J. G., Suominen-Taipale, A. L., Lahti, S., Nuttall, N. M., & Allen, P. F. (2009). A cross-national comparison of income gradients in oral health quality of life in four welfare states: application of the Korpi and Palme typology. *Journal of Epidemiology and Community Health (1979)*, *63*(7), 569–574. https://doi.org/10.1136/jech.2008.083238

[33] World Health Organization Regional Office for the Western Pacific. (2021, February 26). *Regional Action Plan on Healthy Ageing in the Western Pacific*. https://www.who.int/publications/i/item/9789290619352

[34] Ministry of Health, Labour, and Welfare. 1999 Dental Disease Survey; Ministry of Health, Labour, and Welfare: Tokyo, Japan, 1999; Yamanaka, K., Nakagaki, H., Morita, I., Suzaki, H., Hashimoto, M., & Sakai, T. (2008). Comparison of the health condition between the 8020 achievers and the 8020 non-achievers. *International Dental Journal*, *58*(3), 146–150. https://doi.org/10.1111/j.1875-595X.2008.tb00190.x

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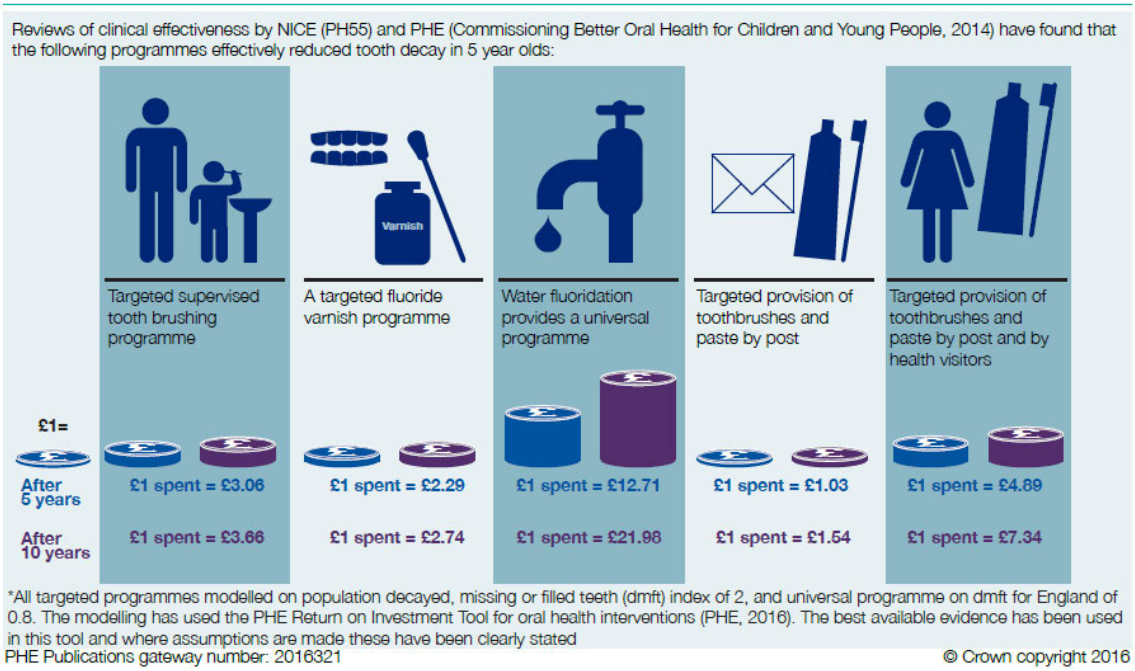
Public Health England

Return on investment of oral health improvement programmes for 0-5 year olds*



Reference: Public Health England. (2018, May 15). *Return on investment of oral health improvement programmes for 0-5 years olds.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560973/ROI_oral_health_interventions.pdf.

The above table compares the return on investment for a number of preventive oral health interventions. This type of analysis is *critical* to assure responsible use of public resources.

International best practice for consideration of the economic benefit of access to dental services includes:

1. **Cost-effective interventions**: Prioritising cost-effective interventions, such as preventive care and early intervention, can lead to better oral health outcomes and lower overall healthcare costs.
2. **Targeted funding**: Targeting funding to areas with the greatest need, such as low-income communities or rural areas with limited access to dental care, can help to improve access to care and reduce health disparities as the starting point for a pathway to universal coverage.

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3. **Collaborative models of care**: Collaborative models of care, such as those that involve all members of the dental care team (such as dental hygienists and therapists, prosthetists etc) that can help to improve access to care and reduce costs, particularly in areas where there is a shortage of dentists.
4. **Person-centred care**: Providing person-centred care that takes into account individual needs and preferences can lead to better outcomes and increased patient satisfaction, which can in turn lead to better overall health and economic benefits.

Overall, international best practice for access to dental services emphasises the importance of equity, prevention, and comprehensive care, and recognizes the economic benefits that can be achieved by investing in oral health.

k. any related matters.

Mutually respectful and egalitarian therapeutic relationships between people receiving care and people providing care can have an enormous impact on patient-reported experience measures, health outcomes, and the sustainability of health-related behaviour changes. The continuity of care in this context really matters in oral health, as anxiety and shame are very common experiences of people receiving oral health care. Continuity of care is the opposite of fragmented care, and this aspect of oral health should not be disregarded.[35]

Sharing of health information is one of the key enablers of interprofessional collaborative practice and access to and use of shared electronic medical records is the most straightforward way to ensure all members of the care team (including the person receiving care) can easily access relevant health information. Secondary use of this data is necessary to better understand the influences of health status and disease risk.

Appendices:

A – Table of Dental Report Recommendations 2012-present

B – The preventable costs of poor oral health

[35] Hofer, A., & McDonald, M. (2019). Continuity of care: Why it matters and what we can do. *Australian Journal of Primary Health*, *25*(3), 214–218. https://doi.org/10.1071/PY19041

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Endorsements:

Asylum Seeker Resource Centre

Australian Dental Association Victorian Branch (ADAVB)

Australian Dental & Oral Health Therapists Association

Australian Dental Health Foundation – Vic Branch

Australian Dental Prosthetists Association

Australian Network for Integration of Oral Health

Better Health Network

cohealth

Dental Hygienists Association of Australia

East Grampians Health Service

Health Issues Centre

IPC Health

North Richmond Community Health

Peninsula Health

The University of Melbourne Dental School

Victorian Healthcare Association (VHA)

Your Community Health

Victorian Oral Health Alliance (VOHA)
W: voha.org.au E: voha@adavb.org

Appendix A: Summary table of oral health related recommendations from previous governmental reports arranged according the 2023 Select Committee areas of inquiry into the Provision of and Access to Dental Services in Australia.

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.

Appendix A: Summary table of oral health related recommendations from previous governmental reports arranged according the 2023 Select Committee areas of inquiry into the Provision of and Access to Dental Services in Australia.

	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.

Appendix A: Summary table of oral health related recommendations from previous governmental reports arranged according the 2023 Select Committee areas of inquiry into the Provision of and Access to Dental Services in Australia.

	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.

Appendix A: Summary table of oral health related recommendations from previous governmental reports arranged according the 2023 Select Committee areas of inquiry into the Provision of and Access to Dental Services in Australia.

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;					

Appendix A: Summary table of oral health related recommendations from previous governmental reports arranged according the 2023 Select Committee areas of inquiry into the Provision of and Access to Dental Services in Australia.

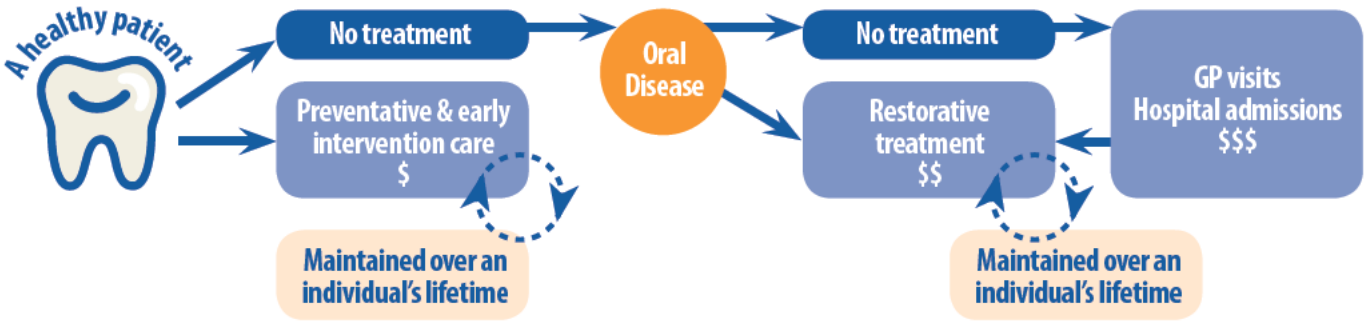
Pathways to improve oral health outcomes in Australia, including a path to universal access to dental services;	Aspiration 1 – It is recommended that Oral health be incorporated into General Health. Better integration of IT, data, links between health service provider networks. Aspiration 7: The workforce 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.	

Appendix B:

The preventable costs of poor oral health [1, 2, 3]

Avoidable Cost Category	Victoria	Australia
Lost productivity • Half day per year or more off work or study • Cutting down on usual activity	$ 139 million	$556 million
Costs to the health system • Potentially preventable GP visits • Impact on the Pharmaceutical Benefits Scheme **($ unknown)** • Potentially preventable hospitalisations **($3733 per patient)**	>$ 70 million	$262 million
Quality of life, wellbeing and general health • Avoiding eating certain foods • Difficulties with eating, sleeping, socialising and working without pain or embarrassment • Anxiety, depression, poor self-esteem and social stigma • Lost opportunities for employment, education and social relationships • Association with other diseases – heart disease, respiratory infections, diabetes complications, stroke	**$ unknown,** but impacts significantly on the community, especially those experiencing socioeconomic disadvantage	
Minimum annual cost	> $ 209 million	> $ 818 million

Regular access to dental care helps people to maintain good oral health, and can reduce the cost of care [2]



The broader cost of dental disease:

Decreased quality of life (difficulty eating, poor diet, poor appearance, low self-esteem)
Decreased productivity (including days lost at work and school)
Effect on general health

Image adapted from Fig 12 1 of (2)

References

1. Victoria's share of the cost burden is calculated as 25% of national costs (approx. 25% of Australians live in Victoria), except for potentially preventable hospitalisations, which are calculated as $3733 per episode of care, with around 17,144 episodes per year [2 3 4]
2. 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
3. State Government of Victoria. Victorian Health Information Surveillance System (VHISS), Ambulatory Care Sensitive Conditions 2019 (available at: https://hns.dhs.vic.gov.au/3netapps/vhisspublicsite/Report.aspx?LocationType=VIC&LocationID=1&LocationName=&Sex=&AgeGroupIDs=0&ReportYearIDs=29&BoDReportYearID=0&StandardYear=2011&ShowNote=1&ReportID=23&HealthIndicator=ACSC&IsBoDReport=0&ReportYearID=0&HealthIndicator=ACSC&IsBoDReport=0&ReportYearID=0)
4. Australian Institute of Health and Welfare. Oral health and dental care in Australia. Web Report. Canberra: 20 March 2019. Available at https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction

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