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Contents

1. ONE PAGE EXECUTIVE SUMMARY

This document outlines a tension between increasing demand for advanced dental services by an ageing and medically complex population, against the absence of an adequate funding mechanism.

Almost half the population cannot afford private dental treatment, but having only 10% of the dental workforce, the public dental service is unable to properly treat these mostly eligible patients. Inability of the public dental services to cope with current demand is outlined, as is evidence that simply increasing public dental funding does not improve outcomes.

A focus on 'basic' and 'emergency' services in public dentistry contrasts with arrangements in medicine, where public hospitals provide high quality care to patients unable to be seen in the private sector.

The high cost of private dental services is explained by the absence of effective competition, while maldistribution of dental workforce away from areas of high clinical need is explained by the absence of a dental market in communities without the money to afford private dentistry. Also, inability of public dental services to attract more clinicians is accounted for by low salaries compared with private practice, as well as a limited scope for practice in the public sector.

Harmonization of arrangements in dentistry with those in Medicine is suggested as critical to overcome these problems, as well as further difficulties that are discussed relating to dental workforce development including academic funding, internships, conjoint specialist appointments and specialist registrar appointments. The key initiative proposed to be of greatest importance, is inclusion of dental services in Medicare.

It is clear that dental Medicare would make it possible for most people to access dental care in private dental practices, thus providing immediate relief of public dental waiting lists. Apart from this obvious improvement in access, there are other important effects that dental Medicare would have.

The greatly relieved public dental services would be free to focus on provision of high quality care for people too medically fragile for treatment in private practice, including those with special needs. In this way, the public system would shift from one of 'poor dentistry for poor people', to one of high quality care for those who need it.

By creating a market for dental service in low income suburbs, dental Medicare would also help redistribute the available dental workforce out of wealthy areas, into areas of high clinical need.

Also, through the creation of bulk-billing dental surgeries, dental Medicare would generate competition amongst private dentists that would start to contain private dental costs, and hence reduce total National dental expenditure.

The creation of National standards for dental diagnosis and treatment planning is also proposed as an important initiative to improve the quality of care, as well as to ensure that Government spending in dentistry is clinically appropriate. Monitoring that these standards are actually applied, would be possible through Medicare.

Finally, the point is made that dental Medicare has been successfully trialled through the Medicare Chronic Disease Dental Scheme, which between 2007 and 2012 provided comprehensive dental care for over one million Australians. Evidence for the advantages and difficulties of dental Medicare is thus available for future Governments to properly design an effective dental Medicare program for Australia.

2. TERM OF REFERENCE 1: DEMAND FOR DENTAL SERVICES ACROSS AUSTRALIA AND ISSUES ASSOCIATED WITH WAITING LISTS

2.1. Australian Adult Dental Service Needs Cannot Be Satisfied Without Inclusion Of Dentistry In Medicare

2.1.2. The ageing population has increasing demand for complex dental care but reducing capacity to pay for private services

In the comparatively recent past, most people had lost their teeth by old age, so that the cost of dental treatment for the aged was comparatively low. The currently ageing population, however, is such that most older people have most of their teeth, while many of these teeth have fillings and other advanced restorations that require life-long maintenance.

With increasing age, comes increasing medical complexity, so that not only does the aging population require more dental treatment than in earlier times, but the treatment must be delivered in increasingly difficult clinical circumstances, demanding higher levels of clinical skill and longer treatment times.

Unfortunately, also with increasing age comes reducing income, so that the capacity to pay for private dental services reduces at a time when the cost of maintaining oral health increases. The outcome is, that demand for adult dental services can be expected to grow for the foreseeable future, but that there will be reducing capacity to pay for private dental services.

2.1.3. Almost half the population cannot afford dental services

There are numerous reports that demonstrate that a significant proportion of the population is unable to afford private dental service. The proportion of the population affected varies from report and across populations sampled, but approaches 50% in some areas.

2.1.4. The public dental services will never attract significantly more than 10% of the Nation's available dental workforce

State governments have responded to inability of the population to afford private dental service by provision of public dental services on a means-tested basis. Dependent on jurisdiction, in the order of 50% of the population is eligible for public dental treatment. However, with only 10% of the dental workforce, it is clearly impossible for the public dental service to deliver comprehensive dental care for more than 10% of the population.

One reason why public dental services are unable to attract more dental workforce, is that salaries are generally significantly higher in private compared with public dental practice. Also, the range of practice is often very restricted in the public dental service (see 3.2.3), so that clinicians do not enjoy opportunity to practice their profession across the full breadth of their clinical skill. In consequence, the public dental service is widely perceived as unattractive by dental clinicians, relative to private dental practice.

2.1.5. Public dental services are trapped in a state of chronic failure by impossible demands

From 2.1.4, it is clear that public dental services with just 10% of the workforce cannot deliver care to 50% of the population.

State and Federal Governments expect the impossible of public dental services, when asking them to deliver comprehensive care to all eligible patients. This why public dental waiting lists are long, hovering about 500,000 across the Nation, and also why waiting times for public dental treatment are also unacceptably long.

Adding to the impossible task asked of the public dental services, is that most dental disease is concentrated in that part of the population with the lowest income. Current arrangements clearly trap public dental services in a state of chronic failure.

2.2. Inclusion of dental services under Medicare would provide service to people otherwise unable to afford dental treatment, and unable to receive appropriate care in the overwhelmed public dental system

Were Medicare to fund dental treatment in a similar way to medical service, then most people currently unable to access timely dental treatment in the public dental service, could receive near immediate treatment by private dentists.

This would greatly reduce demand for public dental services, and provide opportunity for the public dental service to improve the quality of treatment delivered (3.1, 3.2).

3. TERM OF REFERENCE 2: THE MIX AND COVERAGE OF DENTAL SERVICES SUPPORTED BY STATE AND TERRITORY GOVERNMENTS, AND THE AUSTRALIAN GOVERNMENT

3.1. The Focus of Public Dental Services is Currently On Basic and Emergency Service

3.1.1. Delay in access to care drives public patients towards dental emergencies

The imbalance between demand for public dental service and capacity to supply timely treatment outlined in 2.1 above, creates a circumstance where few public dental patients are able to receive treatment in a timely manner.

The significance of this is that preventive treatment is rarely delivered, and early problems such as early decay, or early periodontal disease, are not treated in time to save teeth. Without early intervention, public dental patients more frequently present for emergency treatment and extraction of badly infected teeth.

3.1.2. Emergency and basic dental service is predominant in the overwhelmed public dental service

The high demand for emergency treatment by public dental patients, created by an inability to deliver preventive or otherwise timely care (3.1.1), forces the public dental service to focus on emergency treatment.

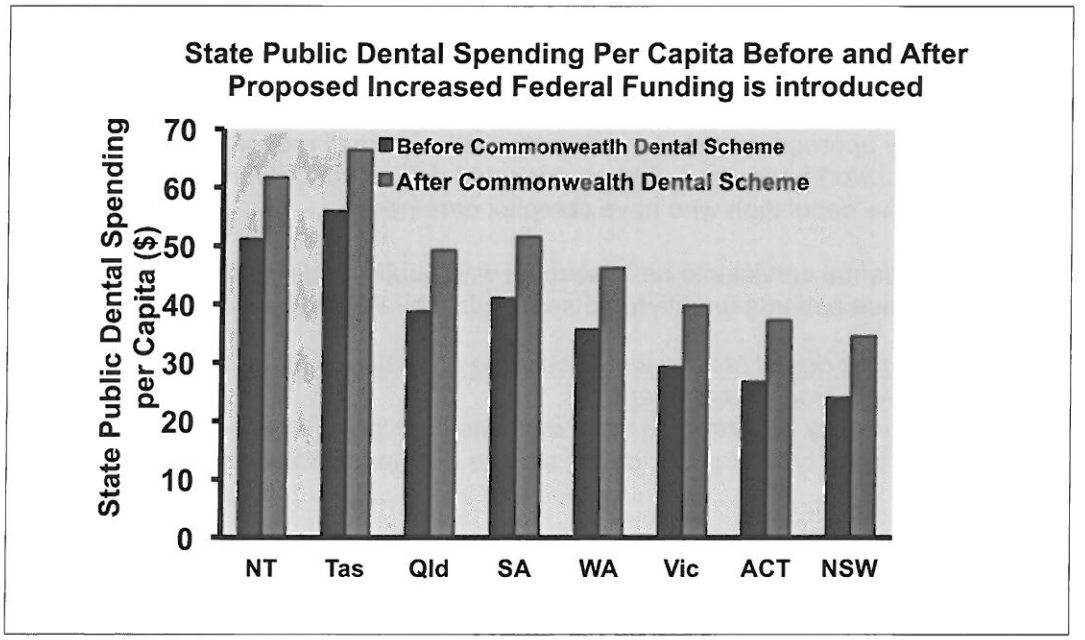
Further, because of time and resource limitations, advanced treatments such as root canal therapy, crowns, or periodontal surgery, needed to save badly diseased teeth, is simply not available for most public dental patients who could otherwise benefit from such care.

3.1.3. Increased funding of state public dental services has little effect on waiting lists, waiting times, or the quality of care

It is unfortunate that simply increasing the amount of funding to public dental services does not appreciably reduce waiting lists or waiting times, or even improve the quality of care. This is because irrespective of funding, public dental services are only able to attract in the order of 10% of clinicians (2.1.4), and evidence for this is seen in the table and graph shown on the next page.

Table and graph showing total public dental spending across jurisdictions, as well as per-capita spending, both before and after the Government's proposed increased public dental expenditure.

State	Current Spending ($)	Current Per Capita Spending ($)	Additional $ Per Year	Final Proposed $ Per Year	% Increase	Proposed Per Capita Spending ($)
NT	10,580,000	51.19	2,173,734	12,753,734	20.55	61.70
Tas	27,323,000	55.89	5,141,453	32,464,453	18.82	66.40
Qld	156,950,000	38.72	42,627,054	199,577,054	27.16	49.24
SA	63,816,622	41.05	16,349,800	80,166,422	25.62	51.56
WA	73,125,000	35.66	21,568,023	94,693,023	29.49	46.17
Vic	148,900,000	29.24	53,546,201	202,446,201	35.96	39.76
ACT	8,773,000	26.68	3,457,782	12,230,782	39.41	37.20
NSW	163,500,000	23.95	71,802,619	235,302,619	43.92	34.46
Total	652967622	37.80	216,666,667	869,634,289	33.18	48.31



From the table and graph shown above, it is clear that there is highly variable funding for public dental services across State and Territory jurisdictions, and that even after the currently planned increased Federal funding from 2014 onwards, the two most populous states (NSW, VIC) will spend less per citizen on public dental service than most other jurisdictions already do.

The fact that waiting lists, waiting times, and quality of care are not appreciably better in NT or TAS, spending around twice per citizen compared with NSW, shows that increased spending in the public dental service has little impact.

3.2. An Enhanced, Achievable and Sustainable Role for Public Dental Services is Possible if Dentistry is Included in Medicare

3.2.1. Quality of care in public dental services is out of keeping with the high quality advanced care in public medical hospitals and community health services
The focus on 'emergency' and 'basic only' dentistry in the public dental services contrasts strongly with the quality of service delivered in public medical hospitals.

Public medical hospitals deliver services that are either too unpredictable or too expensive for private hospitals or medical practices to deliver. While public dental services deliver 'poor dentistry for poor people', public medical services deliver high quality care that cannot be provided in an economically viable way or with adequate safety by the private sector.

3.2.2. Inclusion of dental services in Medicare would increase quality of care in public dental services, realigning public dental with public medical services
Were dental services included in Medicare, most current demand for public dental services would disappear, and the public service would be liberated from it's currently impossible task (2.1.5).

Public dental clinicians would instead be able to focus attention on those patients who have complex needs, and who cannot be treated in an economically viable way, or with adequate safety, in the private sector.

Importantly, public dental clinicians would have an appropriate amount of time to offer suitably advanced and clinically appropriate care for this comparatively small proportion of patients. With 10% of the dental workforce, the public sector could deliver comprehensive care to approximately 10% of the population who have complex care needs.

This would thus realign public dental services to be in keeping with public medical services, providing advanced care for those patients unable to be seen safely by the private sector.

3.2.3. A Medicare enhanced public dental service would become attractive to the best clinicians and improve dental workforce development
High quality dental clinicians currently not attracted to an overwhelmed 'basic only' public dental service (2.1.4), would find the type of public dental service outlined in 3.2.2 above highly attractive.

Further, the high quality care environment that dental Medicare would create in the public sector (3.2.2) would greatly enrich training opportunities for the dental workforce, which acquires clinical skills by working in the public sector. In this way, the quality of the developing workforce would be improved by dental Medicare.

4. TERM OF REFERENCE 3: AVAILABILITY AND AFFORDABILITY OF DENTAL SERVICES FOR PEOPLE WITH SPECIAL DENTAL HEALTH NEEDS

4.1. People With Special Needs Have Difficulty Accessing Appropriate Care

4.1.1. People with special needs often have limited income and ability to negotiate the health care system
People who suffer chronic mental or physical disability often have difficulty negotiating the health care system. There are barriers to access ranging from the complexity of identifying eligibility, difficulty in completing applications, attending appointments, and physically accessing sometimes distant public clinics.

4.1.2. People with special needs are often unable to afford private dental services
People with chronic mental or physical disability or disease usually have very low incomes, and so are unable to afford private dental services.

Further, many private dental surgeries are ill equipped to cope with the special needs that disabled patients have. In addition, while individual dental procedures required by these patients may be comparatively simple and offer little income to private dentists, the time required to treat medically fragile patients is very much greater than for patients who are otherwise well. For this reason, it is often financially non-viable for private dental clinicians to treat patients with special needs.

4.1.4. Public dental services are unable to direct sufficient resources towards people with special needs to satisfy demand
The current demand for public dental services by large numbers of otherwise healthy people (2.1.5), reduces access to public dental service by people with special needs.

In consequence, patients with special needs including the aged, residential care patients and people with a wide range of mental and physical disabilities, are unable access appropriate timely dental care.

4.2. Inclusion of Dentistry in Medicare Would Liberate the Public Dental Services to Deliver High Quality Care to People with Special Needs
Were dental services included in Medicare, the public dental services could focus attention on patients with special needs, and deliver high quality care to these currently neglected citizens (3.2).

5. TERM OF REFERENCE 4: AVAILABILITY AND AFFORDABILITY OF DENTAL SERVICES FOR PEOPLE LIVING IN METROPOLITAN, REGIONAL, RURAL AND REMOTE LOCATIONS

5.1. Failed Funding Has Led to Anti-Competitive Effects and Failed Workforce Distribution

5.1.1. A lack of competition inflates the cost of private dental services
Dental services are inherently expensive to deliver, due to high cost of equipment, infection control and workforce, especially considering that efficient and safe dental service usually requires the support of a single dentist by up to three assistants.

Nonetheless, it also appears to be the case that a lack of competition on price contributes to the high cost of private dental services.

5.1.2. The maldistribution of available workforce across metropolitan and rural areas
There is an acknowledged shortage of dental workforce in rural areas. Almost as severe, however, is a lack of dental workforce in outer metropolitan areas, where community need for dental service is often high related to low average incomes of residents.

For example, while the number of dentists per 100,000 population in rural NSW is only about 28, compared with 88 in the Eastern Suburbs of Sydney, there are only 32 dentists per 100,000 population in the South Western Suburbs of Sydney, so that highly populous South Western Sydney has comparable access to dentists to that of rural NSW.

The maldistribution of workforce between these two highly populous parts of Sydney reflect the fact that despite high clinical need, there is simply not enough money in South Western Sydney to support more private dental practices. In the absence of demand, private dental practices cannot be established or maintained.

5.2. Improved Competition and Workforce Distribution with Dental Medicare

5.2.1. The competitive effect of Medicare contains health costs in Australia
In Medicine, bulk-billing medical practices exert significant competitive force on medical practices charging a gap for service. This is because, from the perspective of the patient, they can either access apparently 'free treatment' in a bulk-billing practice, or alternatively choose to 'pay the gap' to be seen by a clinician they may prefer.

In this way, so long as Medicare rebates are consistent with viable private practice, bulk-billing will continue to exert strong downward force on the cost of private medical service in Australia.

5.2.2 Inclusion of Dentistry in Medicare would introduce competition and reduce the cost of private dental services
In dentistry, however, there is no such competitive force, because dental services are not included in Medicare. Instead, private dental charges are high, and highly variable, while the high demand for dental service helps maintain high dental fees in an essentially uncompetitive market.

Were dentistry included in Medicare, bulk-billing dental practices would start to exert downward force on the cost of private dental services, reducing total National dental costs. It is important to appreciate that a means-tested dental Medicare program would not capture enough of the market to exert downward pressure on price.

5.2.3. Inclusion of Dentistry in Medicare would create a market for private dental services in outer Metropolitan areas and help redistribute available dental workforce
By providing a mechanism for funding private dental service in outer Metropolitan areas, dental Medicare would create the market necessary to establish and maintain private dental surgeries in areas where there are currently few private dentists available (5.1.2).

Recent dental graduates as well as more senior clinicians wishing to establish their own private practice, but unwilling to squeeze into an over-serviced 'wealthy area', would tend to open surgeries in outer metropolitan areas that are currently underserviced, based on the income that Medicare would guarantee.

5.3. Special Government Initiatives Will Be Required to Address Needs of Rural and Remote Communities Independent of Dental Medicare
Although inclusion of dentistry in Medicare would be helpful in redistributing the available dental workforce, special initiatives would likely be required for remote and some rural areas.

Fly-in fly-out strategies have been successful for some remote areas, and discrete Government funding for this would be needed. Similarly, rotation to community health centres and hospitals some rural areas by public clinicians, or private clinicians on a contractual basis, may be required and appropriately funded.

5.4. Dental Medicare Has Been Trialed in the Medicare Chronic Disease Dental Scheme
The Medicare Chronic Disease Dental Scheme (MCDDS) was established in late 2007, and until late 2012 delivered comprehensive dental care to people with chronic disease such as diabetes, valvular heart disease, and immune compromise.

The scheme was highly successful and popular, with over one million people treated at a cost approaching $2B. Notably, the cost per patient reduced over time, as patients moved from expensive initial care to low cost maintenance therapy. Nonetheless, there were some difficulties relating to possible over-servicing in crown and bridgework, as well as in ensuring appropriate treatment delivery. It is unfortunate that the current Government elected to close this scheme, rather than to address the difficulties that emerged by improved regulation and administration.

The experience of the MCDDS is thus available to guide introduction of universal dental Medicare by a future Government, in that dental Medicare can clearly be successful in delivering dental services, and can have good acceptance by both patients and clinicians, but does require appropriate regulation.

6. TERM OF REFERENCE 5: THE COORDINATION OF DENTAL SERVICES BETWEEN THE TWO TIERS OF GOVERNMENT AND WITH PRIVATELY FUNDED DENTAL SERVICES

6.1. A Lack of Federal-State Coordination

6.1.1. Exclusion from the wider Health System undermines appropriate Federal - State coordination
Uncertainty as to the precise responsibilities and roles of Federal and State governments emerges naturally from exclusion of dentistry from the wider health system.

Until recently, the Federal Government argued strongly that it had no role in delivering or funding dental services, while there has been significant argument within Federal Parliament, and between State and Federal Governments, as to the precise role and responsibility that each of these levels of government should have with regard to dental services.

The most recent Federal initiative of providing additional funding to support State public dental services seems inconsistent with usual arrangements, this particularly in light of the highly variable level of state funding across the Nation (3.1.3 and the Table and Graph provided above). A federal initiative that is not uniform across the Nation seems difficult to justify.

6.1.2. There is unacceptable variability in diagnosis and treatment planning for dental disease across private and public sectors
A long standing difficulty, occasionally highlighted by the media, is that different dentists deliver widely differing diagnoses and treatment plans for the same patient.

While there will always be reasonable scope for difference in clinical opinion, the extent of currently diverse approach to diagnosis and treatment planning is unacceptable. As a dental patient, it is equally undesirable to have 'too little dentistry', or 'too much dentistry'. Instead, most dental patients would wish to be assured that they are getting 'the right dentistry' when attending a dental clinician. Notably, excessive or inappropriate dental treatment has great potential to damage teeth by unnecessarily removing tooth structure.

It could be reasonably argued, that in Australia, the poor lose their teeth because they cannot get enough dentistry, while the rich lose their teeth because they get too much.

6.2. Suggested approaches to improved Federal - State Coordination

6.2.1 The need for a Federal Chief Dental Officer
The Federal Government currently has no clear source of independent informed advice on dental health, and it is suggested that creation of the position of Chief Dental Officer, together with appropriate support for collection of relevant data would be of benefit for future governments.

6.2.2. The need to establish National clinical guidelines for dental diagnosis and treatment planning
As outlined in 5.4 above, there were some difficulties in ensuring appropriate dental service in the MCDDS, while this reflects a long standing difficulty in highly variable dental diagnosis and treatment planning (6.1.2).

Establishment of clear clinical guidelines for dental diagnosis and treatment planning, based on current best practice informed by available evidence, would overcome these problems (5.4, 6.1.2). This should be done as part of the introduction of dental Medicare, to ensure that government funding is only for clinically appropriate dental service, as well as to provide a mechanism for monitoring application of these guidelines by clinicians.

This would have the effect of greatly improving the quality of both private and public dental services.

6.2.3. Harmonization of State and Federal funding arrangements for dentistry
Uncertainty regarding the proper roles of State and Federal Governments in dental health (6.1.1), would appear most simply addressed by harmonization of arrangements for dentistry with those that are well established for medicine.

On this basis, the Federal Government would be responsible for supporting private dental services through Medicare, and State governments would provide public dental services. With regard to workforce development, Federal Government would support university training, and State Governments would support internships, conjoint appointments and registrar appointments (7.2).

7. TERM OF REFERENCE 6: WORKFORCE ISSUES RELEVANT TO THE PROVISION OF DENTAL SERVICES

7.1. Review of Current Policies

7.1.1. Currently available data is insufficiently detailed to properly evaluate workforce needs, which would change dependent on funding and service models applied
While some data is available on community dental disease load and workforce across Australia, the detail of data available in insufficient for comprehensive workforce planning.

For example, there is no information on: the number of people or teeth requiring endodontic treatment; the number of people with pre-malignant oral mucosal lesions; the number of people or teeth with radicular cysts; the number of people with impacted teeth and the types of impactions involved; or the number of teeth requiring crowns for long-term restoration.

Further complicating analysis, is that much of the population is unable to afford or access dental care (2.1.3), so that actual community need is not reflected by demand for private dental services, and certainly not by capacity of the public system to supply service (2.1.5).

In addition, were 'dental teams' established in which one dentist works together with two to three oral health therapists, the cost structure for dental service delivery in both private and public sectors would be further changed.

For these reasons, accurate correlation of true community need for dental workforce with funding and workforce availability is very much dependent on the precise funding and service models developed by Government, and cannot be properly predicted from available data.

7.1.2. New dental faculties in rural locations may not be sustainable
Despite these uncertainties, and in large part in response to calls for improved rural dental workforce, a number of new dental faculties have been established in mostly rural locations across Australia.

These new dental schools are often not supported by Medical schools, so that provision of basic medical sciences education is difficult. There is also an international shortage of dental academics, so that the small available dental academic workforce is increasingly distributed across more faculties and larger distances.

This new and developing configuration may not be sustainable, particularly as established dental faculties struggle with inadequate resources. It seems reasonable to consider if the newly established schools create a two-tiered education system for the developing dental

workforce, and if it is acceptable for there to be a lower level of training for rural clinicians from rural dental faculties.

7.1.3. Intake of overseas trained dentists may not be justified
Also in response to a need to increase dental workforce, there has been significant growth in the number of overseas trained dentists sitting for the 'Australian Dental Council Examinations' to achieve registration in this country. It has been said that these examinations now comprise the 'largest dental school in Australia', and the wisdom is of this is uncertain in circumstances where true workforce and community needs are ill determined (7.1.1).

7.1.4. The current balance between 'dentist' and 'oral health therapist' graduates may be inappropriate
Currently, oral health therapists with dental therapy and dental hygienist skills comprise a comparatively small proportion of the dental workforce, and a similarly small proportion of the dental student population.

However, there seems significant advantage in development of integrated dental teams, with two to three oral health therapists working together with a single dentist, and if Australia is to take advantage of this service model, the proportion of training places for these two types of dental clinician will need to change.

In particular, the quality of training for dentists would need to increase over that currently accepted for general practice, while oral health therapists would similarly need to be trained to cope with an appropriately wide range of dental procedures.

7.1.5. Current funding for dental faculties is insufficient and drives development of full fee paying courses to ultimately inflate the cost of dental services
Dental students are unusual in that they deliver irreversible surgical procedures to patients while still at the undergraduate level. Often one to one student supervision is necessary to ensure patient safety, so that dental faculties incur very high student tuition costs greatly exceeding those of other faculties.

The University funding model, however, does not recognize the unique expenses of dental education, so that dental faculties are chronically under-funded.

In an effort to achieve financial viability, several established dental faculties are forced to resort to creation of full fee paying student positions, with the effect that it will become increasingly common for dental graduates to incur debts in the order of $300,000 by graduation.

New graduates with high levels of debt, will have no choice but to demand high incomes, and this expense must be passed on to the patient in private practice, or to the Government in the public service.

7.1.6. The dental academic workforce is ageing and not being renewed at a sustainable rate
While a number of new dental faculties have been created, the dental academic workforce is ageing. Income for dental academics is appreciably lower than that of private dental practitioners, while there are high teaching and administrative loads that make academic work in a dental faculty unattractive relative to many other faculties. There is a low rate of renewal in the dental academic workforce, so that the long-term dental academic workforce may not be sustainable.

7.2. Initiatives to Improve Dental Workforce Development

7.2.1. Establishment of dental internships
The Federal Government has recently established a small number of dental internships. This is a positive initiative, but must be accompanied by establishment clear and effective clinical training course, guaranteeing appropriate specialist clinical rotations, and providing support in a way that improves the quality of service in the public sector.

Unless the number of intern training positions is increased, and uniform high standards for structured clinical training established, this important program will not be successful.

7.2.2. Establishment of specialist registrar and con-joint specialist academic appointments by State governments in public dental hospitals
Specialist training in dentistry is unlike that in medicine, in that dental specialists attend a three year post-graduate university course in context of a teaching hospital. There are few paid registrar positions, but instead there are high University fees.

This creates unhelpful barriers to development of the dental specialist workforce, as comparatively few general practice dentists are prepared to sacrifice income and pay full University fees for three years of training.

If registrar positions paying both a salary and university fees were established in dentistry, then the specialist dental workforce would grow, while senior registrars would be available to rotate to rural areas and deliver service in areas currently not receiving specialist dental care.

A further difficulty in development of the specialist workforce, is the absence of con-joint dental specialist positions with universities, funded by state health departments in public hospitals as is the case in Medicine. Con-joint specialists provide the core reservoir of specialist clinical skill for medical schools, and provide specialist service for the public hospitals in addition to specialist teaching for universities. Conjoint specialist dental appointments would strengthen public dental services and also greatly support dental faculties.

7.2.3. Establishment of appropriate funding levels for dental faculties and dental academic workforce development
Improved funding is required for dental faculties, that takes appropriate account of the high cost of dental education (7.1.5), and also provides improved incentive to build the dental academic workforce (7.1.6).