Australian Dental Association NSW Branch

Submission No. 040
(Dental Services)
Date: 15/03/2013

SUBMISSION TO THE HOUSE STANDING COMMITTEE ON HEALTH AND AGEING

Inquiry into Adult Dental Services in Australia

March 2013

Australian Dental Association NSW Branch

The Australian Dental Association (NSW Branch) (ADA NSW) represents dentists practising in the public and private sector in New South Wales and the Australian Capital Territory. The Branch has 4,000 members, including dental students, and represents over 80% of registered dentists (or close to 90% of practicing dentists) in NSW and the ACT.

Our vision is to add value to the community as the oral health authority in NSW and the ACT. Our members play an important role in the community as trusted health care professionals. The Branch promotes access to dental care that is safe, high quality, affordable and ethical. Working with our members, government and other stakeholders the Branch strives to promote leading models of care.

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Terms of reference 1: Demand for dental services across Australia and issues associated with waiting lists

The Australian Dental Association (NSW Branch) ("**ADA NSW**") is a founding member of the NSW Oral Health Alliance. The alliance is convened by the Council of Social Service of NSW (NCOSS) and currently includes sixteen member organisations, predominantly from the social and community services sector in New South Wales. The primary objectives of the NSW Oral Health Alliance are:

- to provide a forum for discussion of oral health issues; and
- to undertake coordinated activities to improve access to dental service for low income and disadvantaged people.

In March 2009 the NSW Oral Health Alliance published the results of a survey undertaken by NCOSS in August and September 2008 and overseen by the NSW Oral Health Alliance[1]. The survey was completed by 212 human service non-government organisations (NGOs) and 538 clients or consumers of NGOs. The Australian Dental Association (NSW Branch) provided financial assistance to NCOSS to carry out this project.

Based on the survey responses from 750 respondents, the Report points to three significant barriers to maintaining adequate oral health for low income and disadvantaged groups in the community: waiting times, cost and difficulty accessing dental services.

Overwhelmingly, **waiting times** for public dental services was the single biggest issue identified by human service non-government agencies and their clients.

Almost 60 per cent of the NGOs surveyed estimated that the average waiting time for their clients to access public dental services was six months or longer, with one in five indicating twelve months or longer[2]. There was also a strong sense that waiting times for public dental services in NSW exacerbate oral health conditions. More than seventy per cent of survey respondents who identified that they were currently on a waiting list stated a belief that their oral health or dental problem had become worse while waiting[3].

The same issues around waiting lists for public dental services in NSW were identified in a follow up publication of the NSW Oral Health Alliance in July 2010. *Issues in Oral Health for Low Income and Disadvantaged Groups in NSW*[4] noted that, although the quality of public dental treatment in NSW is generally high, the system is unable to cope with the high demand for services due to a lack of investment, inadequate public dental infrastructure, and public dental workforce shortages. As a result patients who are eligible for public services may have to wait months, or in some cases years, to receive treatment due to big waiting lists and the long wait times for treatment.

[1] Kristie Brown and Ruben Klaphake, 2009, Report of the NSW Oral Health Alliance, *Access to dental services amongst clients of non-government human service organisations*. Available at: http://www.ncoss.org.au/resources/090402-DentalSurveyReport.pdf
[2] *Ibid*, p.14
[3] *Ibid*, p.19
[4] NSW Oral Health Alliance, 2010, Issues in Oral Health for Low Income and Disadvantaged Groups in NSW. Available at http://www.ncoss.org.au/resources/issues-in-oral-health-kit.pdf

This systemic barrier to accessing dental services is one of the main causes of continuing inequities in oral health for low income and disadvantaged people in NSW (the other main barrier being the cost of dental treatment in the private sector).

Terms of reference 2: Mix and coverage of dental services supported by state and territory governments, and the Australian Government

To be eligible for treatment in NSW an adult patient must hold either one of the following valid Australian Government concession cards[5]:

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

The NSW Government says the range of oral health services provided through the NSW public health system broadly includes dental services to children and adults according to criteria that target emergency situations, those in most need, dental education and oral health promotional services[6].

In the following section we will limit our comments to the provision of dental services to adults and, in particular, the impact we believe the National Partnership Agreement (NPA) for adult public dental services will have in NSW.

First however, it is useful to outline existing funding for public dental services in NSW. In 2012-13 the NSW Government allocated $178 million for public sector dental services. NSW currently has the second lowest per capita public dental funding in the country at $24.50pp, only just ahead of the Australian Capital Territory. This compares to the national average of $39.30pp, which NSW falls well below[7].

The National Partnership Agreement for adult public dental services which has just been negotiated between the Commonwealth and a number of the states and territories (including NSW) will provide an additional $1.3 billion over four years to states and territories from 1 July 2014 to expand services for adults in the public dental system.

When announcing the National Dental Reform Package in August 2012 the Australian Government said the $1.3 billion dollar dental package for adults would provide dental services to 1.4 million adult patients on low incomes, including pensioners and concession card holders, and those with special needs; who will have better access to dental care in the public system.

It is difficult to believe this last statement can be true in NSW especially in relation to general and preventative dental services. Public dental services are so under-funded and so short on workforce that they struggle to provide eligible patients in this state with anything other than acute or

[5] Source: http://www0.health.nsw.gov.au/cohs/contacts.asp
[6] Source: http://www0.health.nsw.gov.au/cohs/health_services.asp#para_1
[7] Source: This information was sourced by ADA NSW in September and October 2012 by contacting individual state and territory dental services.

emergency care. Most of the available evidence suggests that there is little opportunity to receive general or preventative services in a timely and regular fashion in NSW.

The waiting list(s) that exist for general and preventative care are largely illusory in that patients are unable to access care until a minor dental problem becomes acute or an emergency. Even then patients are extremely limited in terms of treatment options available to them.

To illustrate this point, the extract below is taken from a submission by ADA NSW to the NSW Legislative Council Standing Committee on Social Issues, '*Inquiry into Dental Services*' in January 2006[8]. Although this is more than six years ago, the situation today remains largely unchanged. The issues and problems identified with respect to public dental services in NSW are the same or worse today, largely because funding for public dental services has barely kept pace with CPI for most of the past decade.

> *"According to the Department, initiatives to improve equity and access to oral health services include the Priority Oral Health Program (POHP). This program 'facilitates access to emergency oral health care within 24 hours, while patients reporting less urgent needs are prioritised following a standardized procedure and they are registered to have their oral health condition assessed'. It is clearly the case however that the POHP is a simple and blunt rationing tool adopted by Area Health Services in the face of insufficient funding. The claim that this system improves equity and access simply does not stand up to the evidence provided so far to this inquiry. For example, according to the submission of the Sydney South West Area Health Service (SSWAHS) emergency dental care predominates over routine care and the preservation of teeth in the public sector. Even more disturbing is the claim that this results in "continuing and increasing poor oral health" for eligible patients. In other words, according to the largest Area Health Service in New South Wales, the present system does not help overcome poor oral health in the community but in fact exacerbates existing problems.*
>
> *The Department has also claimed that the following categories of care (and recommended access times) are available in public dental clinics:*

PriorityCodes	***Category of Care***	***Recommended Access Times***
1 & 2	*Emergency (Trauma and serious medical condition)*	*<24 hours (Code 2 <3 days)*
3a & 3b	*Acute (Pain)*	*<5 to <10 days*
3c	*Loss of Social Function (Dentures)*	*<3 months*
4 - 6	*Routine Treatment*	*<12 months*

> *It is well and truly clear however that public dental facilities are so overwhelmed with meeting the demands of emergency patients (Codes 1 and 2) and those*

[8] Australian Dental Association (NSW Branch), 2006, Supplementary Submission (Part 1) to the NSW Legislative Council Standing Committee on Social Issues *Inquiry into Dental Services in NSW*, pp.11-12. Available at http://www.parliament.nsw.gov.au/Prod/parlment/committee.nsf/0/3E45B75659BCA20CCA25714600195BD5

suffering acute pain (Codes 3a and 3b) that little if any other treatment (Codes 3c, 4, 5 and 6) is ever undertaken in public dental facilities. For example, the submission of SSWAHS states that:

> *"Because there are insufficient resources to meet even the demand for emergency care there is very little general care provided in public oral care clinics and, therefore, public patients find themselves in a cycle of deteriorating oral health and repeated extractions."*

The submission of Dr John Webster (Senior Dental Officer, South Eastern Sydney Illawarra Area Health Service) provides a revealing but depressing illustration of how the current system manifestly fails not only public patients but public dental practitioners as well. Due to insufficient funding patients are forced to cycle through repeated patterns of treatment for emergency care and relief of pain. From a clinical point of view, this treatment only touches the tip in terms of patient needs and desirable patient outcomes. According to Dr Webster:

> *"This can be described as organised neglect. Consider what this does to the morale of Dental Officers working in the public system, knowing that while we are relieving pain for a number of patients each day, there are many more who are neglected by the system and we can do nothing for them."*

This is an appalling indictment on the present system. Not only does it contribute to poor patient outcomes, but it also exacerbates recruitment and retention problems in the public sector. It is clear that this is not an isolated point of view but is held by many (if not most) clinicians and managers working in public dental facilities spoken to by ADA NSW.

On the basis of 'waiting list blitz' funding announcing in the 2012-13 Budget[9] and the National Dental Reform Package (NDRP) in August 2012[10] we estimate that NSW will receive the following additional funding for public dental services between 2012-13 and 2017-18:

	2012-13 Budget NPA ($ millions)	**NDRF NPA** ($ millions)	**Total** ($ millions)
2012/13	$22.3	-	$22.3
2013/14	$50	-	$50
2014/15	$38.5	$64.4	$102.9
2015/16	-	$95	$95
2016/17	-	$125.5	$125.5
2017/18	-	$125.5	$125.5

[9] Commonwealth of Australia, 2012, Budget Paper No. 2, 2012-13, p.172
[10] Commonwealth of Australia, 2012, Mid-Year Economic and Fiscal Outlook 2012-13 at p.227

We acknowledge that additional funding of approximately $170 million has also been allocated for dental infrastructure and workforce initiatives to support expanded services for people living in outer metropolitan, regional, rural and remote areas across the whole of Australia over the next few years. More significantly however, $2.7 billion will be allocated for around 3.4 million Australian children who will be eligible for subsidised dental care over the next five years commencing on 1 January 2013[11].

Nevertheless, if we focus on funding for adult dental services, the total sums involved, while welcome, will not be sufficient to provide all eligible public patients in NSW with timely and appropriate dental services including general and preventative care.

By its own estimate the Government says the new adult program will provide services to 1.4 million public patients, across the whole country, over a four year period at a cost of $1.3 billion. By comparison, the Medicare Chronic Disease Dental Scheme (CDDS), which wound up in November 2012, provided more than 7 million services to 625,000 patients, with a value of $878 million in 2011-12[12]. Over 3.3 million dental services were provided to CDDS patients in NSW alone in 2011-12 (its last full year of operation)[13].

When the new adult dental program funding ramps up in 2016-17 and 2017-18, the most the Commonwealth will provide in additional funding for NSW public dental services is $125.5 million per annum. This falls well short of the $427 million in funding for dental services which made its way to patients in NSW in 2011-12 under the CDDS, most of whom the government now admits were eligible public patients[14].

In NSW, where uptake of the CDDS was highest, public dental services contacted patients on public dental waiting lists to advise them about the CDDS and encourage them to seek treatment under that scheme if the patient was eligible. We believe this had a significant impact upon waiting list numbers in NSW.

In June 2007, almost 160,000 patients were on public dental waiting lists in NSW. Today this figure has dropped to less than 118,000 – a drop of more than twenty five per cent[15]. In this time funding for NSW public dental services only increased in line with CPI at best. This significant reduction in waiting list numbers cannot be explained other than as a result of the CDDS which enabled eligible public patients to access care in the private sector, many for the first time ever.

We believe the decision to close the CDDS without providing a similar level of funding for a replacement program for adults will lead to considerable extra demand on public dental services in NSW. Ironically, the publicity surrounding the National Dental Reform Package may actually lead to

[11] *Ibid,* pp.227-229
[12] Department of Human Services Annual Report 2011-12, Chapter 7 available at http://www.humanservices.gov.au/corporate/publications-and-resources/annual-report/resources/1112/chapter-07/medicare
[13] Medicare Australia Statistics, Requested MBS category by group (9 Dentist, Dental Specialist and Dental Prosthetists) subgroup processed from July 2011 to June 2012 available at https://www.medicareaustralia.gov.au/cgi-bin/broker.exe?_PROGRAM=sas.mbs_group_standard_report.sas&_SERVICE=default&DRILL=on&_DEBUG=0&GROUP=9&VAR=services&STAT=count&RPT_FMT=by+state&PTYPE=finyear&START_DT=201107&END_DT=201206
[14] Medicare Australia Statistics, Requested MBS category by group (9 Dentist, Dental Specialist and Dental Prosthetists) subgroup processed from July 2011 to June 2012 available at https://www.medicareaustralia.gov.au/cgi-bin/broker.exe?_PROGRAM=sas.mbs_group_standard_report.sas&_SERVICE=default&DRILL=on&_DEBUG=0&GROUP=9&VAR=benefit&STAT=count&RPT_FMT=by+state&PTYPE=finyear&START_DT=201107&END_DT=201206
[15] Source: http://www0.health.nsw.gov.au/cohs/list_flow.asp#para_16

an increase in waiting list numbers and wait times for public dental services in this state. As well as having a significant negative impact on waiting times this increased demand may also have a negative impact on workforce dynamics within the NSW public dental sector, further exacerbating recruitment and retention problems in this small but important workforce.

ADA NSW understands that similar fears have also been voiced by both the NSW Government and oral health managers working within NSW Health.

Terms of reference 3: Availability and affordability of dental services for people with special dental health needs

As noted above, ADA NSW is a founding member of the NSW Oral Health Alliance. *Issues in Oral Health for Low Income and Disadvantaged Groups in NSW*[16] was published by the Alliance in July 2010.

The document provides a short and succinct overview of problems experienced by low income and disadvantaged groups most at risk of poor oral health in NSW including Aboriginal people, carers, children and young people, homeless people, older people, people with mental health issues, people with intellectual disabilities and people with other special needs including chronic physical conditions, substance use issues and blood borne disease.

For example, the document notes that people with intellectual disabilities face stark health inequalities which are also reflected in their oral health outcomes, such as:

- dental disease is the most common health problem faced by people with intellectual disability. It is estimated to be experienced by around 86% of people with intellectual disability;
- people with intellectual disability have a rate of dental disease up to seven times higher than the general population;
- people with an intellectual disability often need assistance with oral hygiene. However carers (both informal carers and formal carers in residential settings) often lack the understanding, time, and/or resources to assist the person maintain good oral health[17].

Access to appropriate dental treatment is a significant issue for people with an intellectual disability. This is due to a range of factors including:

- insufficient oral health professionals trained and skilled in working with people with intellectual disability;
- communication difficulties between the oral health professional and the person with an intellectual disability;
- insufficient time scheduled in routine appointments to adequately address the needs of people with intellectual disability;
- carers' low level of awareness of oral health problems and how to access dental services for people with intellectual disability;

[16] NSW Oral Health Alliance, 2010, *op. cit*.
[17] *Ibid.* p8.

- access to affordable transport to attend dental appointments;
- the cost of private dental services is prohibitive for most people with intellectual disabilities who are dependent on disability support pensions;
- long waiting times for public dental services[18].

Without access to timely, appropriate dental treatment, people with an intellectual disability and oral health problems may experience chronic pain and distress which may manifest in behaviours that people find challenging

ADA NSW would encourage all members of the House Standing Committee on Health and Ageing to read this document in light of the relevant information it can provide directly relevant to Terms of Reference 3.

Terms of reference 4: Availability and affordability of dental services for people living in metropolitan, regional, rural and remote locations

Once again, *Issues in Oral Health for Low Income and Disadvantaged Groups in NSW* provides a succinct overview of problems experienced by low income people and people living in rural and regional areas with respect to access and affordability of dental services.

For example, people living in rural areas experience poorer oral health outcomes than urban residents:

- rural and regional areas people are more likely to have tooth decay, more likely to have no natural teeth, have less frequent dental check-ups, and have fewer preventative treatments;
- children in remote and very remote areas experience approximately 38% more decay than children in major cities;
- elderly rural concession card holders are three times more likely to have no teeth than city dwelling non-card holders[19].

ADA NSW would strongly encourage all members of the Committee to read this document in light of the relevant information it can provide directly relevant to Terms of Reference 4.

Finally, a member of ADA NSW practicing in a small regional centre on the NSW North Coast made this comment recently in relation to the NSW Oral Health Fee for Service Scheme[20] (the voucher scheme) which operates across NSW:

> *I have been treating patients under the OHFFS voucher system for the first time this month. I understand the patients I have treated under this scheme are vetted to ensure*

[18] *Ibid, pp.8-9.*
[19] *Ibid,* p.8.
[20] The Oral Health Fee for Service Scheme (OHFFSS) provides episodic and general treatment, and allocation of dentures to eligible NSW residents through a procurement scheme with private oral health practitioners. The private oral health practitioners are required to be registered with their local Area Health Service. Access to the OHFFSS is based on the Priority Oral Health Program, which triages eligible NSW residents based on their clinical health needs.

I see the "best" patients. To say that I am astounded at the unmet oral health needs of these patients is an understatement. I believe publicity around any increased availability or improved range of services available in coming months will only exacerbate the waiting list problem in my area. I believe many of the patients around this area have given up on the public system entirely. The treatment they receive often just exacerbates their existing poor oral health. I believe the public in our area is disenfranchised and that this hides an enormous volume of work which goes untreated.

Terms of reference 5: Coordination of dental services between the two tiers of government and with privately funded dental services

ADA NSW shares concerns held by others relating to fragmented and often uncoordinated funding for dental programs, especially as this relates to the two tiers of government – state and federal. ADA NSW believes that the level of funding allocated under the National Partnership Agreement for adult public dental services is insufficient. Of equal concern to ADA NSW however is the apparent lack of certainty surrounding this funding both in the short term and longer term.

Our first concern relates to the impending federal election in September 2013. We believe most Australians would be disappointed if an elected government were to scrap this initiative without maintaining at the very least, the same level of funding for a dental program targeting low income adults and adults with special dental needs[21].

More broadly, the fragmented nature of funding for dental programs, as currently envisaged under the National Partnership Agreement for adult public dental services, creates additional problems around dental service provision. These problems relate largely to uncertainty around funding and a desire by each tier of government for the other to shoulder more of the funding burden.

Following the introduction of the CDDS in November 2007 and the election of a Labor government in December 2007 promising significant reform of dental programs for low income communities, successive state governments in NSW have made it known to ADA NSW that any increase in funding for public dental services would have to come from the Commonwealth. As a consequence, there has been little or no increase in public dental funding in NSW over this corresponding period.

Furthermore, the funding that has been announced under the National Partnership Agreement for adult public dental services is only committed up to the end of 2017-18. As noted, there is already a level of uncertainty around this funding given the impending election later this year. This uncertainty makes it very difficult for state and territory public dental services to efficiently and effectively plan dental programs around this funding, especially in the medium to long term. The knowledge that programs could be cut at any time, or discontinued in subsequent years (as happened to the Commonwealth Dental Health Program in January 1997), makes oral health managers reluctant to plan around appropriate workforce and infrastructure, other than in the very short term.

[21] As already pointed out, the additional funding provided under the National Partnership Agreement for adult public dental services, while welcome, will not be sufficient to provide all eligible public patients in NSW with timely and appropriate dental services including general and preventative care.

This is not conducive to sustainable and effective dental service provision. Therefore, there must be much clearer agreement and coordination between state and federal governments on their respective roles, priorities and funding responsibilities for publicly funded dental programs.

Finally, until such time as the Commonwealth appoints a Chief Dental Officer it will be extremely difficult for the Commonwealth to effectively plan and monitor dental programs it funds.

Further Information

For inquiries or further information please contact Mr Bernard Rupasinghe, Policy Officer on 02 8436 9900 or bernardr@adansw.com.au.

Report of the NSW Oral Health Alliance

Access to dental services amongst clients of non-government human service organisations

Produced by the Council of Social Service of NSW (NCOSS)

About the NSW Oral Health Alliance

The primary objectives of the NSW Oral Health Alliance (the alliance) are to provide a forum for discussion of oral health issues and to undertake coordinated activities to improve access to dental service for low income and disadvantaged people.

The alliance is convened by the Council of Social Service of NSW (NCOSS). Members include:

AIDS Council of NSW (ACON)
Association for the Promotion of Oral Health (APOH)
Australian Dental Association - NSW Branch (ADA NSW)
Brain Injury Association NSW (BIA)
CJD Support Network
Combined Pensioners and Superannuants Association (CPSA)
Council of Social Service of NSW (NCOSS)
Council on the Ageing NSW (COTA)
Haymarket Foundation
Hepatitis C Council of NSW
HomelessnessNSW
Positive Life NSW
Public Interest Advocacy Centre (PIAC)
Rural Dental Action Group (RDAG)
UnitingCare Burnside

Report prepared by Kristie Brown and Ruben Klaphake
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Executive Summary

Access to dental services amongst clients of non-government human service organisations (the report) presents the findings of a study undertaken by the NSW Oral Health Alliance examining access to dental services for adult clients of NSW human service Non Government Organisations (NGOs).

The report is based on data collected from three sources: a survey of NSW human service NGOs (n=212); a survey directed at the adult clients of these agencies (n=538); and a number of case studies collected by the NGO members of the NSW Oral Health Alliance (n=7). Whilst the study does not purport to be representative of the experiences of all NSW NGOs or their clients, the number and range of responses received and the consistency between the data collected and the findings of other research studies, supports the legitimacy of the issues raised throughout the report.

The key issues identified in the data as impacting on access to dental service were predominantly associated with waiting times for treatment from public dental services and the cost of private dental treatment. A number of other issues were also identified and mostly focused on public dental services. This included difficulties related to making appointments, a lack of locally available dental services and follow on problems with transport to available services. A range of issues relating to service delivery such as discrimination and complications using interpreter services were also raised.

The case studies presented throughout the report and survey data point to a public dental system under stress. Just under half of those people who had attended a public dental service in the last ten years received emergency treatment; one in four survey respondents indicated they had been on NSW public dental waiting lists for longer than two years, with three in five currently waiting longer than six months. Over 70% of survey respondents felt their oral health had deteriorated during the time they had been on a public dental waiting list.

For respondents who had not accessed any dental services in the previous ten years, the cost of private dentists was overwhelmingly given as the reason, with NGO respondents expressing the sentiment that "*For most, dentistry is a luxury they cannot afford".* The social costs of poor oral health, implicitly tied to difficulties accessing dental services, were linked to low self-esteem and difficulty seeking employment or education.

Solutions to the problems identified in this report remain complex. What is apparent, however, is that the NSW public dental system is inadequately resourced to meet the level and type of demand being placed on it. Consequently a considerable disparity exists between the oral health outcomes of those who are able to afford to pay for dental services and those who are not.

The report makes a number of recommendations, including the need for a substantial investment of funding into NSW public dental services. This funding would allow for investment in public dental workforce, infrastructure and service delivery capacity. This would ultimately decrease waiting times and improving access to public dental services for low income and disadvantaged people in NSW.

Recommendations

Throughout the report a number of recommendations have been made.

Recommendation 1:

a) The recommended maximum waiting times for treatment, according to priority code, are reviewed to ensure they are consistent with community expectations about appropriate timeframes for access to treatment by public dental services.
b) Data relating to waiting lists for public dental services, according to priority code, is collected centrally and publicly released for each Area Health Service. Where waiting list times exceed benchmarks, a reduction in waiting times should form part of the Key Performance Indicators (KPIs) for the Area Health Service.

Recommendation 2: The Centre for Oral Health Strategy (NSW Health) investigate, identify and, in coordination with Area Health Services, implement ways that sustain access to public dental services for treatment. This includes improving the care of ongoing dental health conditions, through flexible models of access.

Recommendation 3: Integrate oral health promotion and prevention activities through all public dental service processes, including assessment and treatment appointments.

Recommendation 4: A public dental waiting list reduction strategy for NSW is developed and outlines targeted activities to reduce public dental waiting lists across Area Health Services. This strategy should be adapted from planning that has already been carried out in anticipation of the rollout of the Commonwealth Dental Health Program (CDHP), and funding supplied by the NSW Government in the 2009/10 NSW budget (presuming plans are not in place for CDHP funding to be released by the Australian Government by May 2009).

Recommendation 5: As recommended in the final report of the Legislative Council's Inquiry into Dental Services, funding of public dental services in New South Wales should be reviewed and increased to be comparable with other States. Based on current estimates, this would require an additional $90million on top of the 2008/09 budget allocation, plus annual indexation.[1]

Recommendation 6: In consultation with the NGO sector NSW Health and Area Health Services develop and comprehensively disseminate:

a) Appropriate information on referral and access pathways to public dental treatment for clients of NGO services. Where possible, this should reflect flexible access pathways developed under Recommendation 2.
b) Oral health promotion materials targeting a range of client groups accessing NGOs.

[1] This costing is based on increasing per capita funding for NSW public dental services to the average per capita funding of the other States (does not include ACT and NT), based on figures contained in the table on p6.

Recommendation 7: Process and practices relating to communication with clients of public dental services should be improved, particularly in relation to advising of appointments and appointment cancellations. These processes should be appropriate to the range of client groups accessing public dental services, and compliance should be monitored and ensured.

Recommendation 8: In recognition of current infrastructure restraints of public dental services, expand the availability of dental treatment programs available to rural and regional public dental patients through appropriate use of private providers.

Recommendation 9: That transport to public dental services is considered as a component in any response to, or implementation of, recommendation 123 of the Garling Special Commission of inquiry[i], relating to non-emergency transport services.[2]

Recommendation 10: That the Australian Dental Association (NSW branch), as the professional association for NSW dentists, promote the consistent application of infection control guidelines and best practice models for non-discriminatory dental service access and treatment.

[2] The full recommendation includes "NSW Health is to ensure that there is provided, separately from the emergency transport service of NSW Ambulance, a non urgent transport service"

Introduction

Oral health is one of the greatest areas of health inequity in NSW. People from the lowest socioeconomic groups have fewer teeth, are more likely to have all of their teeth missing, have worse subjective oral health, and suffer greater social impact on their quality of life as a result of oral conditions[ii,iii]. Those in possession of a Government concession card have poorer health outcomes for most oral health indicators: they are more likely to visit a dentist for a problem; avoid or delay dental care due to cost; are significantly more likely to report their oral health as fair or poor, are significantly more likely to report they have experienced tooth ache in the last twelve months and have the highest tooth extraction rate[iv].

In rural and regional areas waiting times are twice as long as those in metro areas (3.9 weeks and 1.6 weeks respectively),[v] a significantly lower proportion of adults visit dental professionals over a twelve month period[vi] and a higher proportion of adults have all of their natural teeth missing[vii].

Within NSW, public dental services are provided to all pre school aged children and full time students under the age of 18, and to some eligible socioeconomically disadvantaged groups (eligibility is based on possession of a means-tested health care or pensioner concession card). This system is chronically underfunded, with the lowest per capita expenditure on public dental services of all states and territories[viii] and with approximately 147, 000 people currently on public dental waiting lists[ix].

State and Territory Oral Health Budgets 2008-09♦

	2008/2009 State & Territory Dental Budgets ($)♠	**Population as at June 2008**	**Per capita dental expenditure ($)**
Tasmania	$23,084,000	498,200	$46.33
Northern Territory	$9,480,000	219,900	$43.11
Queensland	$150,000,000	4,279,400	$35.05
South Australia	$56,000,000	1,601,800	$34.96
Western Australia	$63,380,000	2,163,200	$29.30
Victoria	$139,300,000	5,297,600	$26.29
Australian Capital Territory	$8,491,599	344,200	$24.67
New South Wales	$150,000,000	6,967,200	$21.53
National	**$599,735,599**	**21,374,000**	**$28.06**

SOURCE: Australian Dental Association, NSW Branch.

♦ This information was sourced from publicly available information or by contacting state and territory public dental services.

♠ Funding in Column 2 is funding allocated by state and territory governments and does not include funding from the Commonwealth Government under the Enhanced Primary Care (EPC) Medicare dental benefits, Commonwealth Dental Health Program (CDHP), or Medicare Teen Dental program.

A 2006 Legislative Council Standing Committee on Social Issues report on dental services found that socio-economically disadvantaged groups bear the brunt of underfunded public dental services:

> *The committee notes the level of treatment that the public system is able to provide to users contrasts with the wide range of general and elective treatments provided to people who can afford to pay for services provided by private practitioners. The reduced treatment available in public dental services is affecting the health of public dental patients, who can suffer in a range of ways from social embarrassment up to serious medical conditions and, in extreme cases, the death of patients who do not receive adequate and timely treatment.*[x]

This 'reduced treatment' means that NSW public dental patients suffer from poorer oral health[xi], are less likely to receive preventive services and experience higher levels of tooth loss[xii], the majority of which is preventable. Overall, a national survey of oral health found that "Virtually all aspects of oral disease measured in this study were more frequent and more severe among people who were eligible for public dental care and therefore were economically disadvantaged"[xiii].

Since the election of the Federal Rudd Government, the dental funding environment has been on unstable ground, with the introduction of the Medicare Teen Dental Plan, an ongoing stalemate affecting the status of the Medicare Enhanced Primary Care dental items and proposed Commonwealth Dental Health Program, and, most recently, suggestions that the Medicare rebate be increased to allow for the formation of 'Denticare', a universal dental health scheme.[xiv]

None of this should distract from the fact that the NSW Government are, currently and at least in the short to medium term, responsible for funding the NSW public dental system. The additional $40m announced in the 2006/07 Budget, whilst a welcome addition, has not and will not be enough to tackle the magnitude of the endemic inequity in oral health experienced by low-income and disadvantaged people.

This report draws on the experiences of NSW human service non-government organisations and their adult clients, providing an additional perspective to arguments on the need for further investment in programs that improve the oral health outcomes of low income and disadvantaged people in NSW. It is focused on adults, and does not include data relating to access to oral health services for children and young people.

Kylie

Kylie was sixteen years old when she started having trouble with her teeth. She presented at a public dental clinic with a swollen cheek and a painful mouth, and the dentist pulled the problem tooth out on the spot.

Gradually Kylie got more cavities but her public dental appointments were not timely enough to save her teeth. The waiting periods that she experienced from the time that she booked an appointment were so long that in the end she would present in severe pain and have them removed. One by one they were pulled out. She got so worried that when one of her front teeth got a tiny hole she rang to get an appointment at the public dental clinic as soon as she saw it. But by the time she got in to the dentist, the tooth had snapped and they had to pull it out.

At the public dental clinic, Kylie explained that “when I went in for treatment, it seemed like they didn’t really have a plan. They should have given me a checkup and seen what needed to be done to save some teeth. Instead I would have pain in three places in my mouth and the dentist would ask: “Well which one gives you the worst pain?” It was often difficult to tell and I’d get one tooth out and have to wait for an appointment to get the other ones taken care of.”

The length of waiting times for dental appointments and the dentists’ lack of capacity to help Kylie keep some of her teeth resulted in complete deterioration of Kylie’s teeth. Sometimes she waited for an appointment for two or three months in pain. When the pain became too strong to be helped by Panadeine Forte, she lost weight because she had difficulty eating around her sore teeth.

Kylie lost her self confidence as she lost more teeth and her remaining teeth became black and rotting. She started to cover her mouth when she talked and laughed, and she was no longer able to work in her customer service job.

Kylie was 25 years old when she had her last tooth removed and received dentures. This meant that she had to worry about the increase in oral health problems that are associated with dentures, up to fifty years before friends that were her age.

Survey Method

The project was carried out by the Council of Social Service of NSW, and overseen by the NSW Oral Health Alliance. The Australian Dental Association (ADA) NSW branch provided financial assistance to NCOSS to carry out the project.

Data collection included two surveys (one for NSW human service non-government agencies and one for the adult clients of these agencies) and the collection of qualitative case studies.

Both surveys were distributed through the membership of the NCOSS and other non-government peak agencies to their members, and to the clients accessing the services of these agencies. The surveys are available in Appendix A.

A total of 789 participants started the survey, with 750 surveys completed (95.1%). 212 surveys were completed by NGOs, and 538 surveys were completed by adult client/consumers. It is difficult to determine what proportion of human service non-government agencies or NGO clients these figures represent, as figures are not available for the total number of NGOs or the total number of clients of NGOs in NSW. Accordingly, data collected through the surveys should not be considered as a representative sample. However, the number of surveys received, the range of organisations and individuals that responded (more information is available below), and the consistency between the information collected and other related research suggests the data provides a reliable indication of the issues that would emerge within a more comprehensive study of these groups.

Before completing the survey tool, participants were provided with information outlining the purpose of the survey, who was collecting it, what would happen to the data, where a final copy of the report would be available and phone/email contact details if they had any concerns or questions. This information was provided to enable individuals and NGOs to give their informed consent to participating in the project.

Survey responses were collected during August/September 2008. During this time the survey was made available in either hard copy or online (via the SurveyMonkey web application). The hard copy and the online link to the survey was distributed via email. Paper surveys were returned via fax or email, and were then manually entered into SurveyMonkey. Client surveys were made available by NGOs to their clients, with many NGOs supporting their clients to return the surveys.

Data analysis was undertaken via download of the survey results from SurveyMonkey into an excel spreadsheet.

Funding provided by the ADA (NSW) supported Oral Health Alliance meeting costs, printing of the report, and other costs associated with undertaking and completing the report.

The survey instruments, data analysis, and project report were completed by Kristie Brown, NCOSS Senior Policy Officer, and overseen by the NSW Oral Health Alliance.

About the NGOs surveyed

- 212 survey responses from NGOs were received.

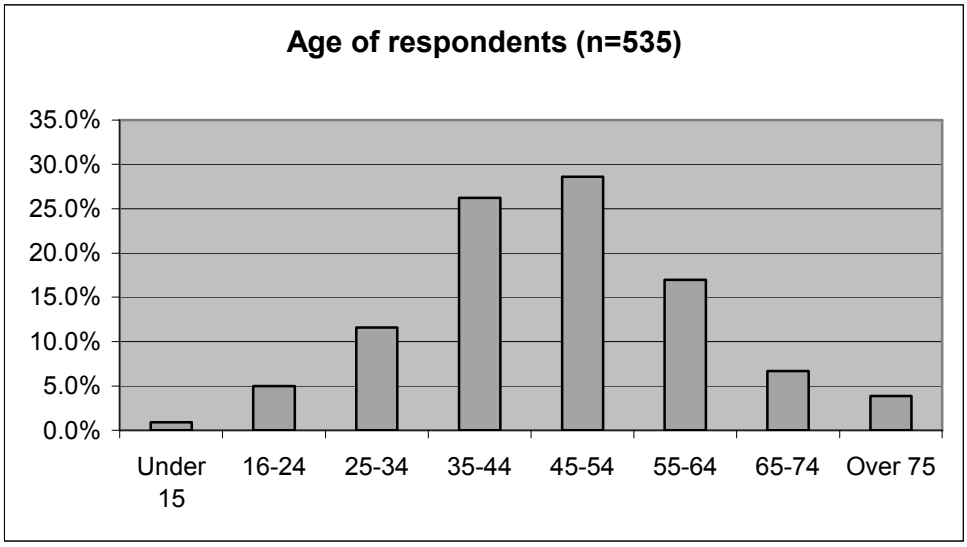
- When agencies were asked to describe the kind of service they provide, 32% (67 agencies) said that they provided case management and/or support (many of these agencies provided their services to young people, people with mental health issues, people with HIV and Hepatitis C and, and to a lesser degree, family support services.); 17% (35 agencies) provided homelessness or accommodation services. Other types of services included community centres, health services, employment/education services and outreach services (each making up less than 6%).

- The most prevalent client groups using the services of the NGOs who responded to the survey were; families with children (12%), young people (11%), people with low-incomes and/or receiving a Centrelink benefit (11%), and people with mental illness (9%). Other client groups cited included people experiencing homeless or in need of housing assistance (7%), people with a disability (5%), and older people (5%). Some agencies also cited women and children escaping domestic violence and Aboriginal and Torres Strait Islander people as specific client groups.

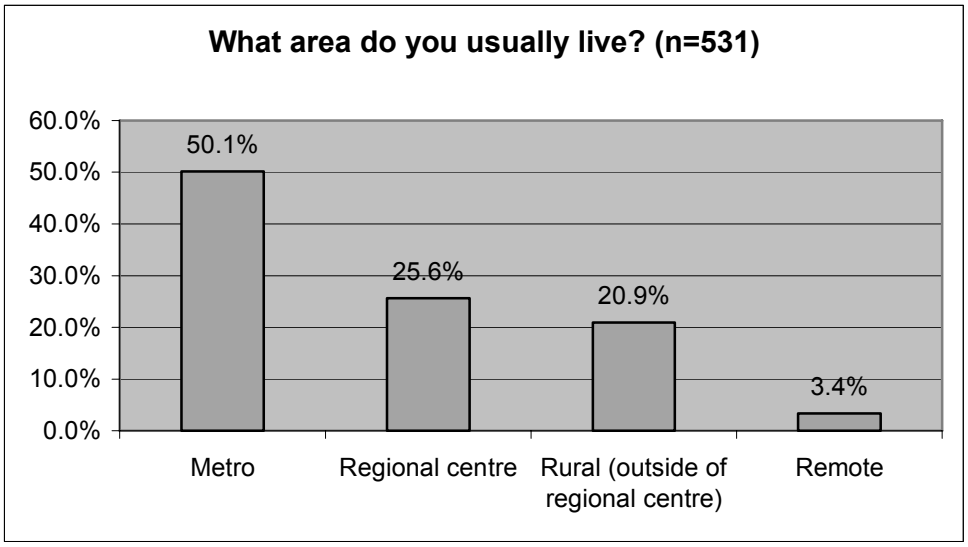
- About half (46.9%) of the NGO respondents were located in metro NSW, while the other half were located in regional/rural/remote NSW.

About the clients surveyed

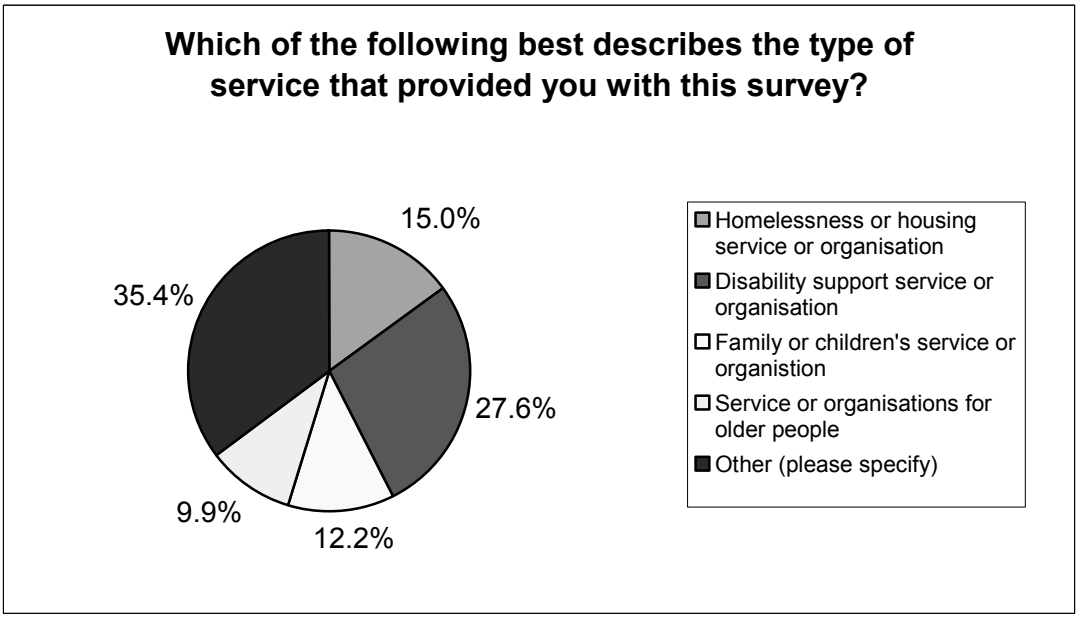
- 538 survey responses were received from clients of NGOs. These surveys were largely from adults, and do not represent the experiences of children or young people.



- Respondents' covered all age groups, roughly resembling a bell curve: 54.8% of respondents were aged 35-54 years, and 4.8% were aged under 15 or over 75.



- Half the respondents (50.1%) were living in metro NSW and half were living in regional/rural/remote NSW.



- 27.6% of respondents indicated that the service that provided them with this survey could be best described as a disability support service or organisation; 15% housing or homelessness service; just over 12% indicated the service was a family or children's service or organisation and 9.9% indicated it was a service for older people. 35.4% specified their own description of the service through which they received the survey.

About the case studies

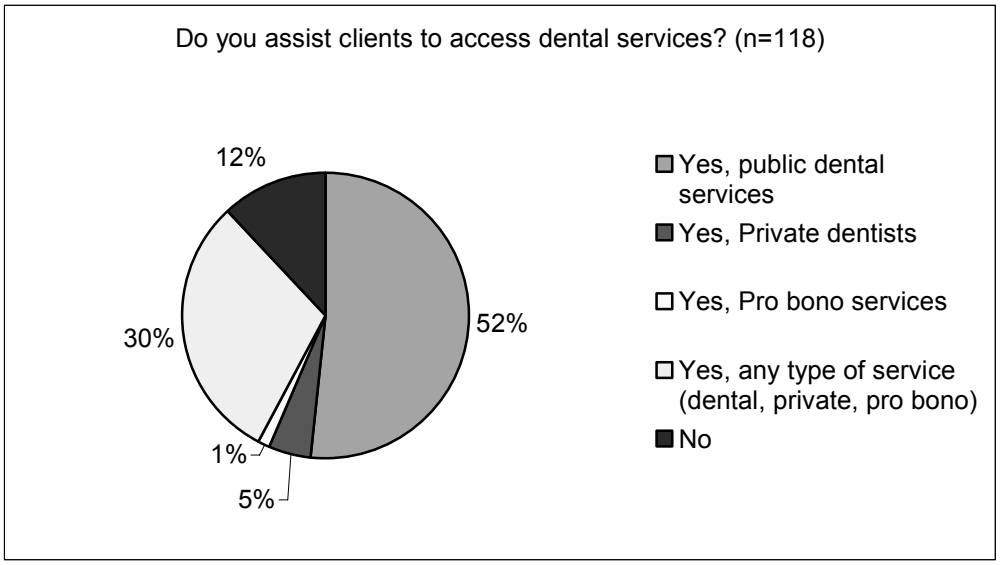
Case studies were collected by the members of the NSW Oral Health Alliance via interview with clients of their agencies, or their member agencies (where they are peak bodies). Each case study represents the experiences of an individual. The names of individuals have been altered. Case study participants provided their consent for their stories to be used in the report.

Survey Findings

What NGOs told us

Assisting Clients to Access Dental Services

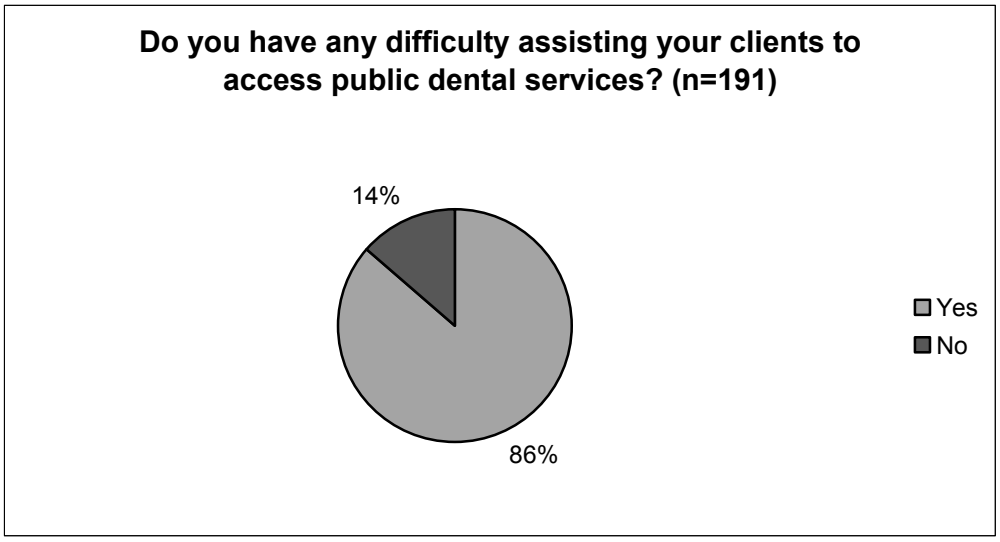
- Just over half of responding agencies asked their clients about oral health/dental health (such as during intake, assessment, case management or groups) (55.3%).



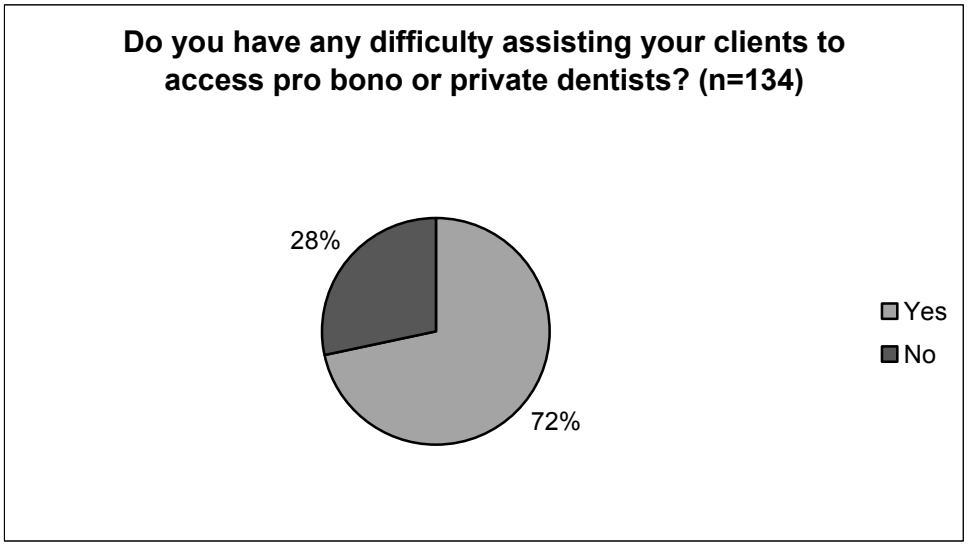
- The majority of agencies indicated that they assist their clients to access some type of dental service (88%). Most agencies reported that they only assisted their clients to access public dental services (52%).

- Agencies that did not assist clients to access dental services (n=26) commonly cited referral to another agency to assist with access or the provision of assistance not being relevant or possible for their service. A small number of agencies acknowledged they should or could assist clients, with one stating they didn't provide assistance because they "do not think of it".

Difficulties assisting clients to access dental services



- A majority of agencies indicated they experienced difficulty assisting their clients to access public dental services.
- The most common difficulty cited by agencies was waiting times (cited by 121 agencies). Waiting times are particularly an issue for agencies where clients do not maintain contact for significant periods of time, for example women and children at a refuge may move away before dental appointments can be met.

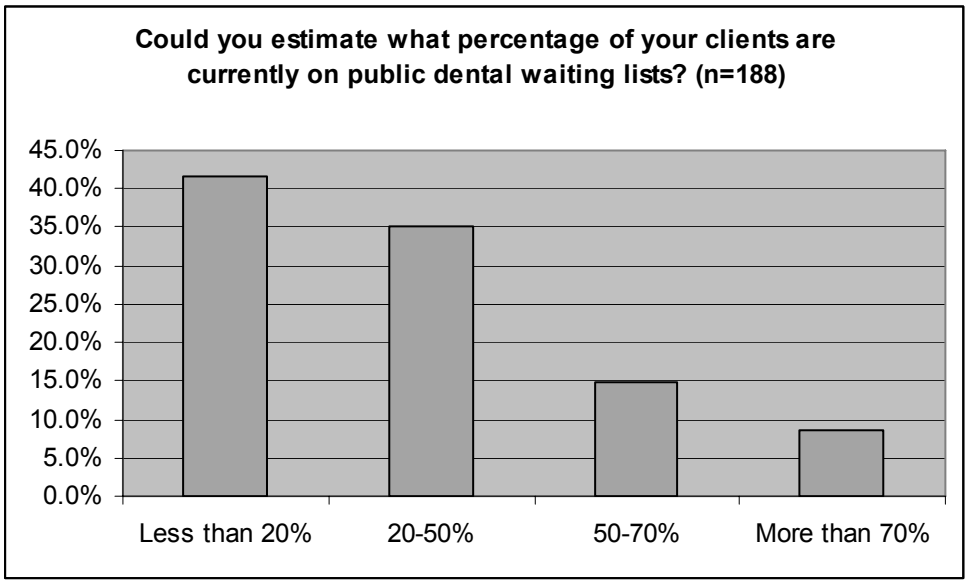


- A majority of agencies indicated they experienced difficulty assisting their clients to access pro bono[3] and private dental services.
- The most common difficulty cited for accessing private dentists was affordability

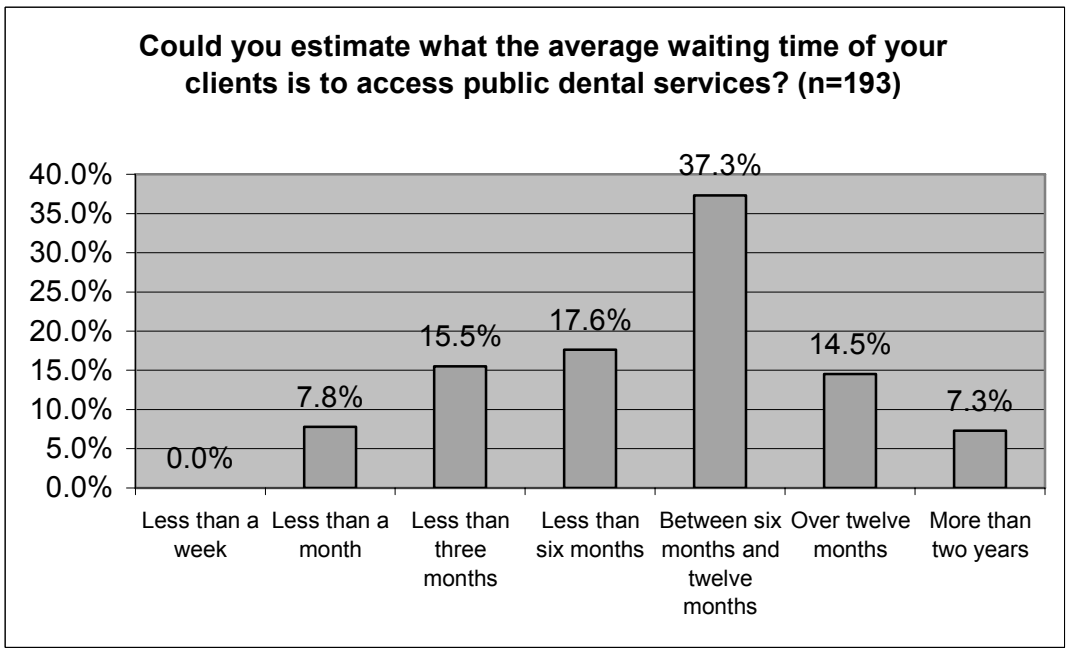
[3] Pro bono services are provided free of charge under private arrangements between a patient and their dentist. Pro bono services are separate to the Oral Health Fee for Service Scheme which enables care to be provided through a private practitioner (dentist or dental prosthetist) via an authorised Voucher system, managed by Area Health Services.

- The most common difficulty cited for accessing pro bono services was a lack of knowledge about how to access these services.

Client interaction with public dental services



- 60% of NGOs estimate at least one in five of their clients are on a public dental waiting list[4].

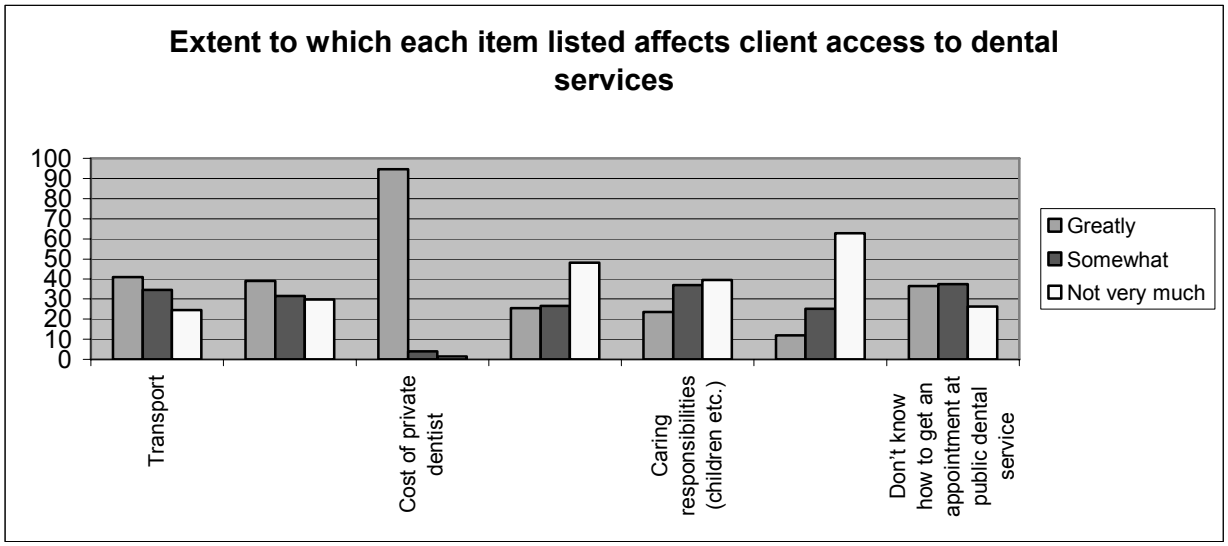


- Just under 60% of NGOs estimated that the average waiting time for their clients to access public dental services was six months or longer, with over one in five indicating twelve months or longer.[5]

[4] These figures should be treated with caution. When asked to provide any figures supporting their estimates many said that there was no data or they did not have access to quantitative figures. A number of respondents indicated that information was from informal or anecdotal sources.

[5] These figures should be treated with caution. When asked to provide any figures supporting the respondents' estimates of the average waiting time for their clients to access public dental service, about 10 respondents explicitly said estimates where based only on (verbal) feedback from clients. About three

Factors affecting client access to dental services



- Factors cited as greatly affecting client access to dental services included the cost of a private dentist (94.6%); Transport (41%); and no public dental service in the area (38.9%)

- When agencies where asked to describe other items affecting their client's access to public dental services:

    - 30% of the responses nominated 'wait lists' as an issue
    - 'Lack of services' constituted 25% of responses
    - Also of concern were issues with service delivery at public dental services (including discrimination against clients)
    - Two agencies raised the issue that their clients' lives where chaotic and/or lacked resources (for example, not owning a phone to call the 1300 number) and that this impeded their access to dental services

- Agencies who provided further comments outlined a range of issues, with 70% of responses relating to access (e.g. interpreters, location, availability, mobile dentists, dental-Medicare, waiting times and cost).

- Fourteen per cent of comments identified the need for improved education and health promotion (e.g. education about oral hygiene, about services and how to access them, and information for NGOs on dental services and issues).

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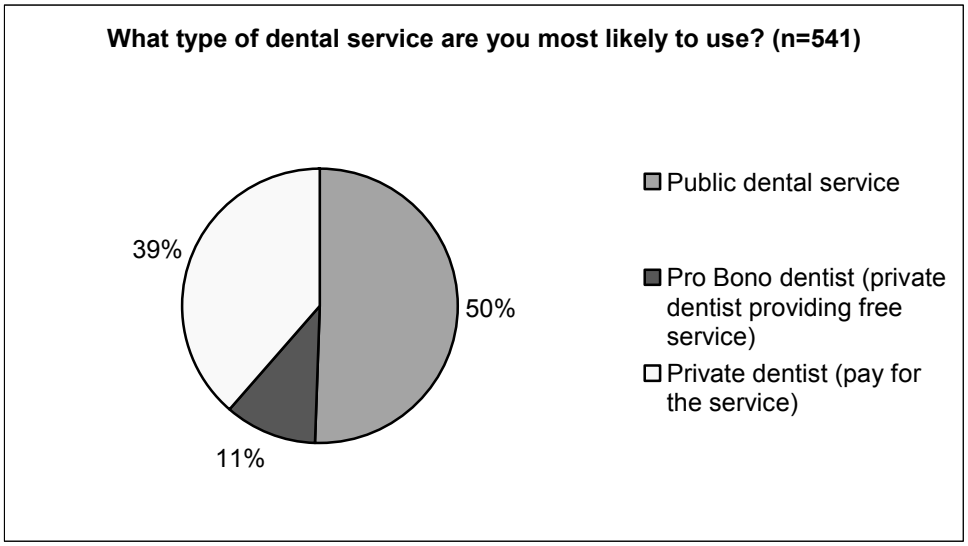
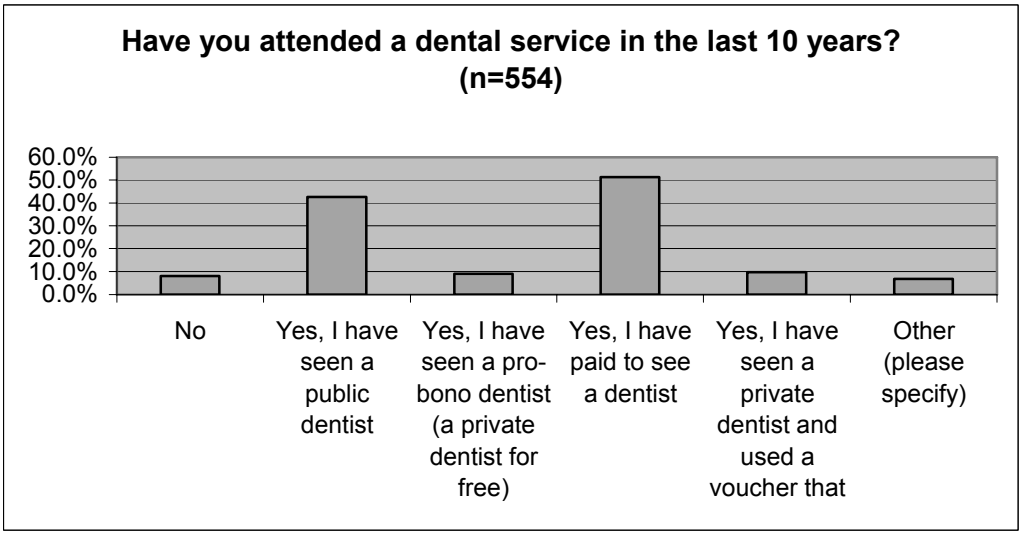
respondents made an example of a single client. Another three respondents used examples referring to more than one person. Some respondents explicitly indicated that they had no quantitative data available to support their estimates.

What clients told us

Using dental services



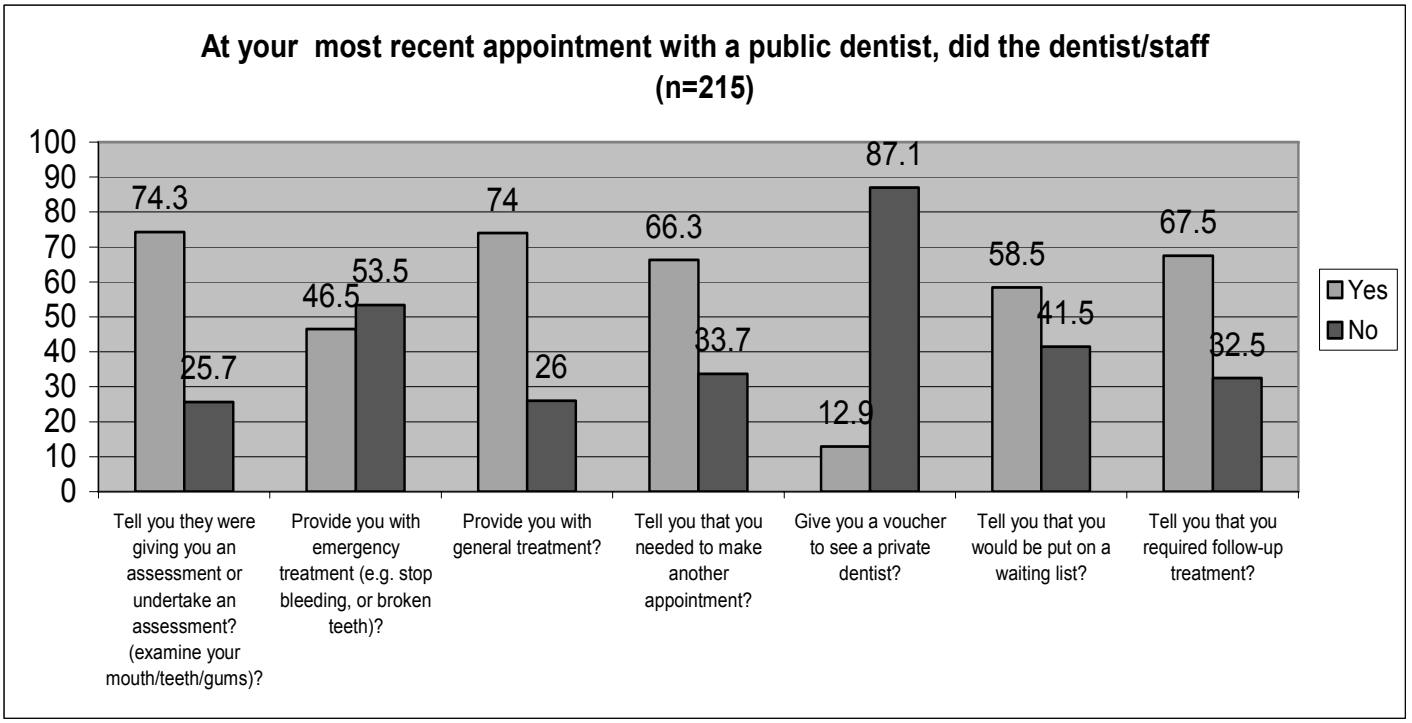
- Public dental services are the type of service most likely to be used by the respondents.



- Eighty-five per cent of respondents had attended a dental service in the last ten years. Of these, 51.3% indicated they had paid to see a dentist, and 42.6% indicated they had seen a public dentist.

- Those who had not accessed any dental service in that last ten years (n=45), overwhelmingly attributed this to the cost of seeing a private dentist (66.7%). The lack of a local public dentist and problems making appointments were also cited commonly as reasons (19% for both).

Using public dental services

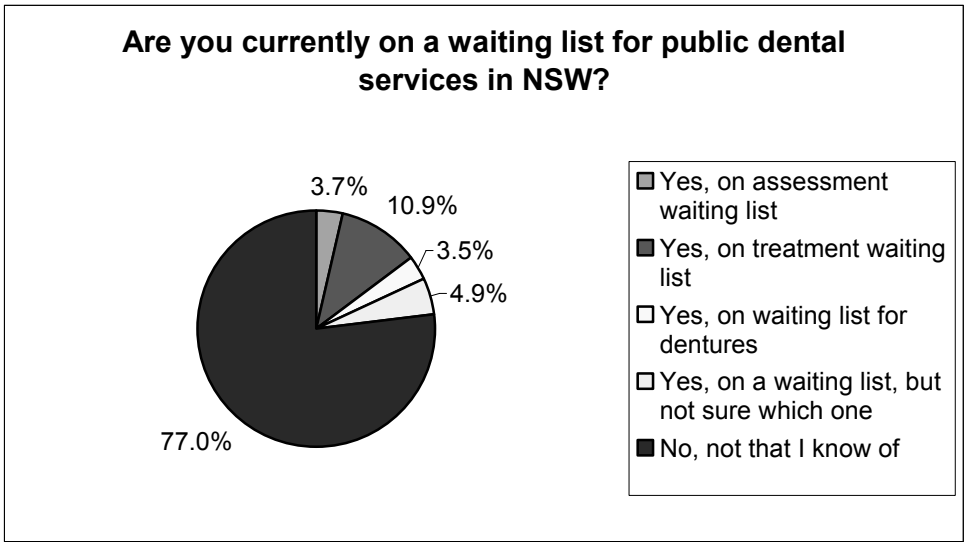


- Of those who indicated they had attended a public dental service in the last 10 years, 74.3% reported receiving an assessment, 74% reporedt receiving general treatment, 66.3% reported being told to make another appointment, 67.5% reported being told they would require follow-up treatment and 58.5% were told they would be put on a waiting list.

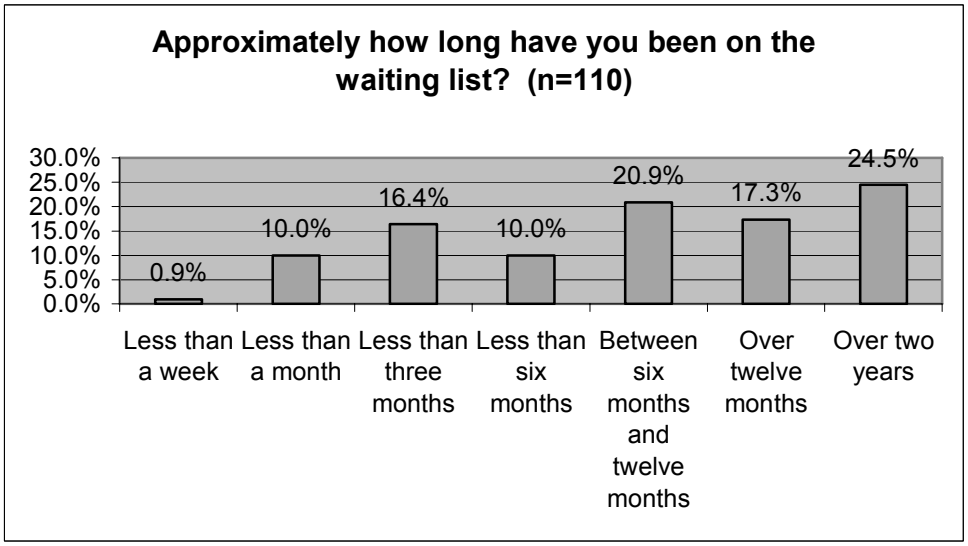
- When respondents were asked if there was anything they would like to say about their experience using public dental services, 31% of comments had a positive element to them. Comments included, for example, “satisfactory”, “very good”, “nice people”, “professional”, [service] “came to school”.

- However, 61% of comments were mainly negative, with ‘waiting times’ (30% of comments) and concerns about the ‘quality of treatment’ (31% of comments) topping the list. Concerns about the ‘quality of treatment’ included, for example, feeling that the job was rushed, that teeth were extracted rather than restored, and references to frightening or traumatic treatment. Another key theme in the comments related to perceptions of inadequate services being available (21% of comments), such as follow-up treatment being hard to get, no check-ups being available, and that the system only deals with emergency cases. Six per cent of responses made comment concerning difficulties with the making of appointments in the first place.

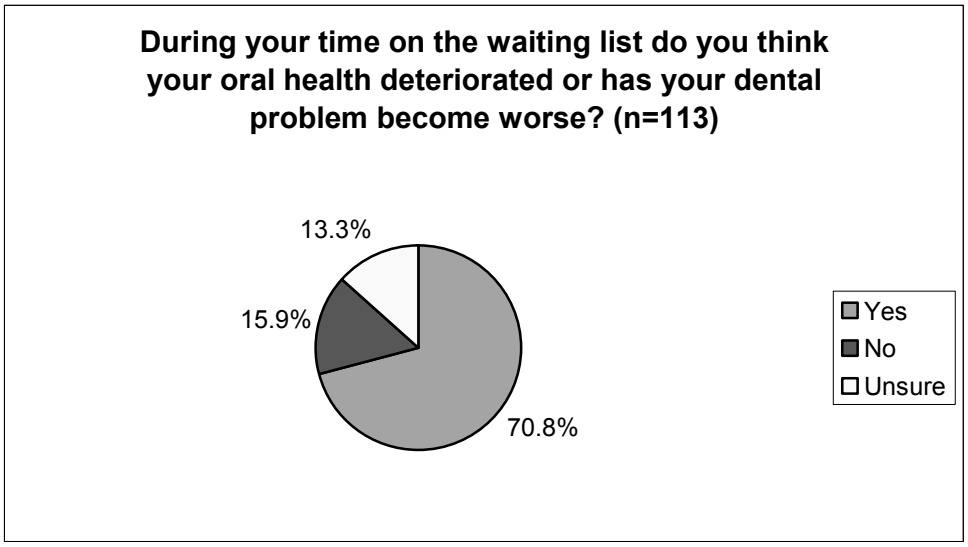
Waiting times for public dental services



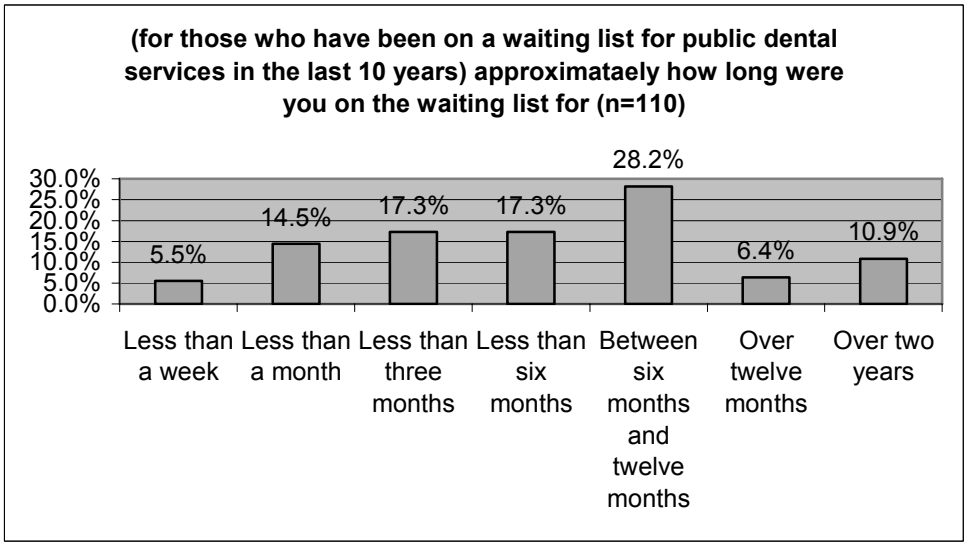
- Approximately 23% of respondents said they were currently on a waiting list for public dental services in NSW (n=112).



- Of those who were currently on a waiting list, 62.7% had been waiting for longer than six months (with one quarter of respondents waiting for longer than two years).

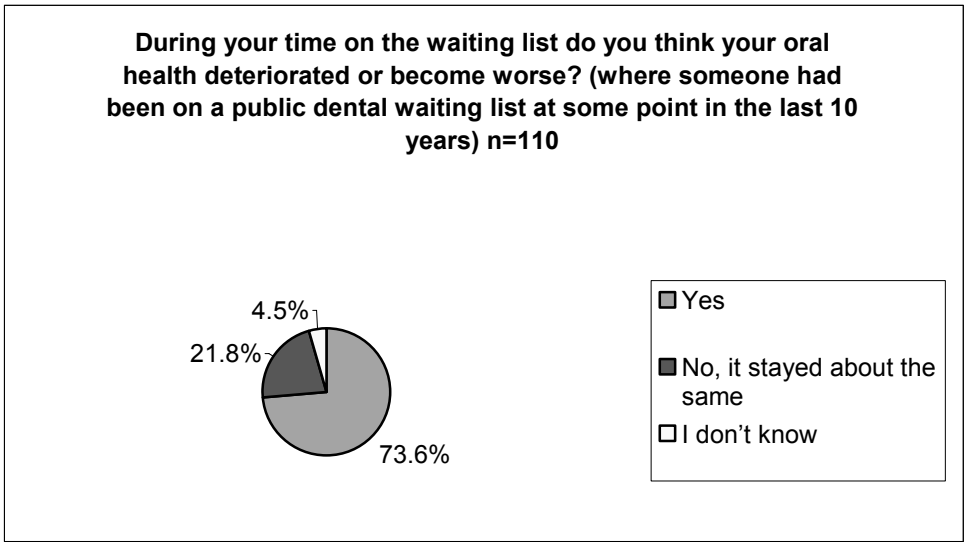


- 70.8% thought that their oral health or dental problem had become worse during their time on the waiting list



- Of those who had been on a waiting list in the last ten years, but were no longer on a waiting list, 45.5% had waited for longer than six months (with one-in-ten respondents having waited for longer than two years).

- Of those who had been on a waiting list in the last ten years, but were no longer on a waiting list, 15.8% (59 participants) indicated the reason they were no longer on the waiting list was as a result of reasons other than having had their appointment. Reasons cited included: that the waiting list was too long (34%); they saw a private dentist (20%); they were no longer eligible (10%).



- Of those who had been on a waiting list in the past, 73.6% said that their oral health or dental problem had become worse while they had waited.

- 368 participants provided 'other comments about access to public dental services in NSW'. 14% (50 responses) had positive elements within the comment, ranging from satisfactory to good or very good (some participants made positive comments about the voucher system and school dental system).

- Most of the other comments were negative. The main concern around access was that services are inadequate (171 responses, or 46%). This included issues about the location of services, that check-ups are not available, and that there are not enough staff. Waiting times were mentioned by 107 participants (29% of responses). This included some comments about having to wait even in an emergency. Other issues raised included a desire for dental to be covered by Medicare (38 responses, or 10%), bad customer service (28 responses, or 8%) including communications issues, and poor quality work (21 responses, or 6%).

Key Issues

This section presents an overview of key issues identified through the data as affecting access to dental services. These issues are predominantly associated with waiting times for public dental services and the cost of private dental services. A range of other issues are also identified in the last section under 'access to services'.

Waiting times

Catherine

Catherine is a young woman who lives in Campbelltown. In 2007 she began to feel pain in her jaw that was typical of unsurfaced wisdom teeth. Catherine attended a private dental assessment in October 2007 through a pro bono program. At this appointment the dentist told her that her wisdom teeth were impacted and she required extraction of her wisdom teeth and extensive work on her molars. Catherine's dental treatment could not be offered under the pro bono program, so she was referred to a public dentist for the work.

Catherine's local public dental clinic had a long waiting list and had to book her appointment for August 2008, ten months after she initially sought help for the pain in her jaw. Despite the referral for surgery from the private dentist, Catherine's initial public dental appointment had a diagnostic purpose only – to determine whether or not Catherine would require surgery on her wisdom teeth.

Catherine is still waiting for her extraction surgery and has not been informed of how long she will be waiting.

Catherine is experiencing periodic pain from the wisdom teeth that are growing in her jaw. The advanced nature of her wisdom teeth growth, together with the health risks brought about by her untreated molars, means that she is at high risk of infection at the site of her impacted wisdom teeth.

Waiting times for public dental services are identified throughout the data as a significant barrier to clients of Non Government Organisations achieving and maintaining good oral health.

One in four survey respondents indicated they had been on NSW public dental waiting lists for longer than two years, with three in five currently waiting longer than six months. These figures are consistent with estimates that the average waiting time for public dental services across Australia is 27 months[xv].

The majority of tooth loss is preventable: the longer people wait to see a dental professional, the more likely their oral health will deteriorate. The data and case studies collected indicate that worsening oral health as a result of waiting times to access services is a common feature of the NSW public dental system. Based on subjective assessment, over 70% of survey respondents felt their oral health had deteriorated during the time they had been on a public dental waiting list.

> *It's a very long wait, usually the problem is minor but when you finally get there it's become major.*

It should not be the case that public dental facilities are associated with high rates of tooth extraction, yet the experiences and perceptions of respondents as well as other research suggest that extractions are a common feature of the public dental system. Kylie,

Elizabeth, Steven and Adam (case studies) all had teeth extracted while just under half of those people who had attended a public dental service in the last 10 years received emergency treatment.

Like many other areas of health care (such as emergency department triage and elective surgery) benchmarks on access to care according to clinical need exist for public dental services in NSW. These are:

Priority Code	Factors Influencing Access	Summary of triage Criteria	Appoint Or Wait List	Recommended Maximum Waiting Time
1	Emergency	✓ Trauma including: ▫ loss of function, ▫ swelling, ▫ uncontrolled haemorrhage, ▫ supervening infection	Appoint/or OHFFSS voucher	24 hours
2	Medical condition requiring immediate attention	✓ Any medical condition where failure to give dental care would adversely affect commencement of urgent medical treatment	Appoint/or OHFFSS voucher	3 days
3a	Oral Health condition	✓ Pain	Appoint/or OHFFSS voucher	1 week
3b	Oral Health condition	✓ Pain	Appoint/or place on a list/or OHFFSS voucher	1 month
3c	Oral Health condition	✓ A child between 0-5 years	Appoint / OHFFSS Voucher	1 month
		✓ Urgent need of a denture ✓ Oral health condition in a child or adult requiring attention	Appoint/or place on a list / OHFFSS voucher	3 months
4	Medical	✓ Significant developmental or acquired disability OR ✓ Serious medical condition or Social, cultural, or economic risk factors ✓ Aboriginal descent	Place on list	6 months
		✓ Oral health condition in a child or adult requiring attention, OR ▫ significant developmental or acquired disability OR ▫ social, cultural, or economic risk factors		
5	Oral Health Need	✓ Extractions, periodontal disease, dental caries,	Place on list	12 months

Priority Code	Factors Influencing Access	Summary of triage Criteria	Appoint Or Wait List	Recommended Maximum Waiting Time
		impacted wisdom teeth, dentures. ✓ A child or adult requiring restorative treatment OR ▫ concerns regarding loose baby tooth/teeth		
6	General Request for Care	✓ Check up	Place on list	24 months

SOURCE: NSW Health Policy Directive "Priority Oral Health Program and List Management Protocols", September 2008, Document Number PD_2008 _056, p.13-14. Available: http://www.health.nsw.gov.au/policies/pd/2008/pdf/PD2008_056.pdf

The consumer and organisational attitudes expressed in data collected for this report suggest that the recommended maximum waiting times where there is an oral health need or general request for care (of 12 months and 2 years respectively) may be out of step with community expectations of timeframes for care.

Anecdotal evidence also exists that in some circumstances (including emergencies) there is a significant waiting period for dental treatment, potentially exceeding the recommended waiting times stated above. There is currently no data publicly released relating to whether or not these benchmarks are met. This issue should be further investigated through the collection and release of data on the length of public dental waiting lists across Area Health Services, including waiting times by triage category.

Recommendation 1:

a) The recommended maximum waiting times for treatment, according to priority code, are reviewed to ensure they are consistent with community expectations about appropriate timeframes for access to treatment by public dental services.
b) Data relating to waiting lists for public dental services, according to priority code, is collected centrally and publicly released for each Area Health Service. Where waiting list times exceed benchmarks, a reduction in waiting times should form part of the Key Performance Indicators (KPIs) for the Area Health Service.

The experiences of clients accessing public dental services suggest that rather than being 'one-off', waiting lists for dental treatment should become cyclical for clients seeking to access public dental services. After attending their first appointment, three out of five clients reported being told they needed to make another appointment, while a similar number were told they would be placed on a waiting list. Many of the case studies also illustrate the waiting list frustrations experienced by individuals seeking public dental treatment.

Clients are on long waiting lists for many years and when they do get to see the dentists they have a check up and then have to go back on a waiting list to get procedures done.

Teeth have gotten really bad while waiting. They waited two years for an assessment appointment to be told they had to get another appointment.

When you do access it you think you're going to get treatment and spend a whole day there going through three sets of queues and waiting, and all they do is assess you and put you on a list! A list! If you're lucky you will hear from them in six months or a year. You think you're going to get treated but at the end all you get is put on another list. When you finally do get treated you are happy with it and the service, but it's the gap between identifying the problem clinically (finally) and then having to start on a new list which is the killer. It gives you no confidence that you are even on a list at all, and it's easy to move in that year and miss your appointment, with rents so high. Make dental part of Medicare you boffins.

Waiting lists for treatment were the biggest difficulty NGO respondents faced in assisting their clients to access dental services. This posed particular problems because clients often have a range of complex needs, can be in periods of crisis, and may be in transient or unstable situations. Within this context, the requirements of gaining and keeping public dental appointments, such as contact information and residential address, can be difficult to maintain. Where clients access to dental services is facilitated by community organisations and the clients engagement with the agency ceases before the appointment/s have been completed, there is a sense of missed opportunity. Organisations commented that:

Clients are often not here long enough for an appointment to become available due to, particularly, mental health issues.

As we are a refuge, women and children have to wait for long periods of time and sometimes have already moved to a new area by time the appointment comes around.

As they are young homeless people they are transient so move by the time the appointment comes up.

Some organisations requested flexibility with the waiting list – assessment – waiting list – treatment cycle, believing this would ameliorate some of the issues their clients experience in seeking dental treatment. This included a suggestion that:

A service without appointments, run on a first come first serve basis would be ideal.

The data collected in this report suggests that aspects of the model of care being used to determine access to public dental services exacerbates the difficulties clients experience in seeking dental treatment, particularly people with complex needs or those whose lives are in a period of instability. A review of this model that sought to balance safety and quality issues, with the needs of different groups of consumers, could be used to identify appropriate changes so that public dental services are better able to facilitate access to services for vulnerable client groups. There are some examples of this sort of flexibility currently being applied in particular contexts, such as for people who are homeless accessing the Sydney Dental Hospital. A public dental service co-located with a homelessness service in Sydney, the Mission Australia Centre, is also an example of how flexible models of service delivery are being used to improve access to dental services and the oral health outcomes of targeted population groups.

Recommendation 2: The Centre for Oral Health Strategy (NSW Health) investigate, identify and, in coordination with Area Health Services, implement ways that sustain access to public dental services for treatment. This includes improving the care of ongoing dental health conditions, through flexible models of access.

Waiting times for public dental services were linked, throughout the survey data and case studies, to concerns about the quality of care the public dental system was able to provide. These concerns were often based on perceptions of financial and time pressures faced by the public dental workforce, and not the quality or dedication of the professionals that worked within public dental services. Concerns expressed about 'quality of treatment' included, for example, feeling that the job was rushed and that teeth were extracted rather than restored, that follow-up treatment and general check-ups are hard to get, and that the system only deals with emergency cases.

Only to be used in extreme emergency, but then you're in so much pain you can't bear to wait.

Waiting lists for public dental services, and the associated perception of eroding oral health amongst those waiting for assessment and then treatment, appear at odds with the NSW State Plan[xvi], NSW State Health Plan[xvii], and Oral Health Policy documents[xviii] which emphasise the importance and focus on oral health promotion and preventing poor oral health. A number of respondents requested a greater focus on the prevention of oral disease and decay, believe that the financial and social benefits of this approach were preferable to what they perceived as an emergency and extraction driven system:

Access to preventative rather than only emergency public dental services would not only save the public purse, but also enhance … quality of life.

I would love to see preventative dental health for adults through the public sector, oral health is important especially for many of our Aboriginal clients who suffer from diabetes.

Whilst there is some work occurring to provide oral health promotion and prevention programs, notably through the NSW Oral Health Promotion Network which is convened and supported by the Centre for Oral Health Strategy, these activities are not currently integrated into the core delivery of services through the public dental system. A greater focus on these components of oral health within all care and treatment provided is required.

Recommendation 3: Integrate oral health promotion and prevention activities through all public dental service processes, including assessment and treatment appointments.

Overall both the reality and the perception of long waiting lists for public dental services can act as a disincentive to seeking treatment. Survey responses indicated that of the group of people who were on public dental waiting lists but weren't any more, the reason cited was that the waiting list was too long (34%) or they saw a private dentist (20%).

I do need a check up and probably new dentures but I can't see the point if I have to wait so long.

This situation is ultimately counterproductive to the improvement of oral health of low income and disadvantaged people.

Whilst the overwhelming focus of the information collected was on waiting times for public dental service, there was some indication that waiting times for private dentists, particularly in rural and regional areas, were similarly problematic. For example, some respondents noted:

> *It can take months to get into a dentist even in a large town like Orange.*
>
> *[In Bourke] there is a wait of six weeks even to get an appointment with a private dentist (this is for attention to an aching tooth).*

By and large, Australia prides itself on a universal health care system that provides access to services based on clinical need and not capacity to pay. This does not extend to dental services. The waiting times and poorer oral health status of those who rely on the public dental system are markedly worse than those who do not. Waiting lists for public dental services present one of the key barriers to improving the oral health of these groups. Targeted and evidence-based activities must be developed to reduce public dental waiting lists in NSW. In anticipation of the rollout of funding through the Commonwealth Dental Health Program targeting a reduction in public dental waiting lists, The Centre for Oral Health Policy (COHS), NSW Health, developed a range of program and policy strategies to support this outcome. These strategies should be funded as a matter of priority.

> **Recommendation 4:** A public dental waiting list reduction strategy for NSW is developed and outlines targeted activities to reduce public dental waiting lists across Area Health Services. This strategy should be adapted from planning that has already been carried out in anticipation of the rollout of the Commonwealth Dental Health Program (CDHP), and funding supplied by the NSW Government in the 2009/10 NSW budget (presuming plans are not in place for CDHP funding to be released by the Australian Government by May 2009).

Elizabeth

Elizabeth is a single Age Pensioner. Elizabeth would previously make an appointment every two years at a public dental clinic at a large Sydney hospital to receive dental care, or whenever the clinic would send a reminder. In late 2006 she sought an appointment for a routine check. She was advised that she would have to wait twelve months. In the meantime, Elizabeth tried to find other ways of getting a check-up. However, there are no other free services in her area and she cannot afford a private dentist.

When she was finally given an appointment one year later, the dentist cleaned Elizabeth's teeth but in the process the enamel of one tooth was cracked. As a result, she had to have this tooth removed, but had to wait about six months for an appointment. Meanwhile, Elizabeth was left in a lot of pain that did not subside. Without any further assistance being provided by the dental clinic, she began taking painkillers in an effort to suppress the pain and went to see her GP. Elizabeth's GP prescribed antibiotics which she took for a number of weeks because her whole mouth was now infected. "I just had to keep swallowing painkillers and antibiotics due to the infection," Elizabeth said.

When it was time for her tooth extraction in the middle of 2008, the dentist extracted the problem tooth but her mouth was left partially numb after the extraction. To this day part of her lip is still numb.

This procedure has left Elizabeth in pain and has dinted her confidence, feeling anxious about going to the dentist.

"I was quite distressed, because nobody wants to be in constant pain," said Elizabeth. "Previously, I had pleasant experiences going to the dentist, but this has made me worried about who I am going to see and how long it would take for treatment."

Cost

Peter

Peter lives in Malabar, Sydney and is retired. He has used the public dental system in NSW for years but recently has taken to going to a private dentist.

About six years ago Peter had a partial plate made up for his top teeth. He picked it up the day before Christmas and it broke the next day. He then had to pay $90 to get it fixed by a private dental practice because the dental hospital was closed.

He explains that he'd rather have had his teeth capped than a partial plate but that's not an option in the public system. As his gums are shrinking (due to age) he has to get a new plate every couple of years.

About two years ago he had to have a tooth pulled out at the hospital. They left some of it behind, and he had to go back twice more before they got it all out.

In December 2007, he needed to get another tooth pulled out. The dental hospital couldn't see him that day, so they put him on the emergency list. He decided he'd borrow $500 (Centrelink loan) to go to a private dentist and get it sorted out. He hasn't been called by the dental hospital yet, even though he's rung to check that he's still on the list.

Now he gets the $500 (Centrelink) loan every year and goes to a private dentist. He also took $1400 out of his superannuation to buy a plate rather than stay on the waiting list.

Peter believes that the problem with the public dental system is that you have to wait too long to see someone, and even when you do get in, they only look at the emergency reason you're there, not your whole mouth. So you have to go back again and again.

Costs associated with dental care throughout the data were twofold: the unaffordability of private dental care and the human and social costs on the quality of life of people with poor oral health and those unable to access timely dental treatment.

The data collected through the surveys suggests that many people simply cannot afford private dental care. Respondents who had not accessed any dental services in the previous ten years overwhelmingly cited the cost of private dentistry as the reason.

> *Private dental services are extremely expensive. Even if one is working and has private health cover the cost is alarming, especially as one gets older the more work is needed.*
>
> *Most people can overcome the barriers [transport, caring responsibilities, etc.] but it is the cost of private that prevents them so they have no other choice than to wait.*

Costs associated with private dental care result in it being considered an 'unaffordable luxury' by many of the survey respondents:

> *Oral health care is considered an unaffordable luxury for many of the clients I serve.*
>
> *For most, dentistry is a luxury they cannot afford.*

Whilst the interplay between the cost of private dental services and difficulty accessing public dental services is complex, data collected for this report suggests that difficulties in accessing timely treatment from the public dental system is resulting in some clients taking out loans and seeking money from private sources to enable them to receive private dental treatment. 'Peter's' experience provides an illustration of this scenario, as do comments from other survey respondents:

> *I broke off a front tooth, was put on a waiting list for root canal therapy and a crown, then never heard back from the [public dental service]. Even phoning persistently I was refused cooperation in following the matter up. So I had to borrow the money and pay a private dentist (I still owe the money).*
>
> *I have tried to make an appointment in the past to see a public dentist but have not been able to because the waiting list was too long and I was in pain. I have since had to pay nearly two thousand dollars in dentist bills to have my problems fixed. I still need more work done but will need to wait until we can afford more treatment. I only go to the dentist now when I have a toothache as the costs are too high. If there was a cheaper check-up service I would use it.*

The above comments point to a perverse disincentive, with the costs of private dental care resulting in delays in accessing dental treatment. These delays can ultimately result in higher treatment costs. Public dental waiting lists present similar blockages, often replicating this scenario.

There was also a perception amongst some respondents of limitations in the types of treatment available from public dental services, forcing them to access private dental services (and try to meet the associated costs) or go without:

> *Public dental services do not do all types of dental work - only 'cheaper' work - so people still must pay if they require work to be done.*
>
> *[Public dental] offered no specialist treatment and often the solution was to get teeth pulled rather than provide other services that would cost more – i.e. root canal or fix a wobbly tooth.*

The data collected throughout this report indicates that the capacity for an individual to pay for a health service is affecting the nature of the service they are able to receive, to the extent that there are examples of individuals borrowing money to enable them to access the dental care they require. This situation would be considered unacceptable in many other areas of health care, and it remains unclear why an apparent two-tiered dental health system where capacity to pay affects services received is considered acceptable.

Rectifying this inequity will require investment in the expansion of public dental services across a range of areas, including workforce, dental infrastructure, oral health promotion and prevention programs, waiting list reduction strategies and investment in specialist programs (such as for people with intellectual disability, older people and a range of other groups). Whilst additional funding announced in the 2006/07 NSW budget for dental services is welcome, it does not meet recommendations made by the NSW Legislative Council Inquiry "that the funding of public dental services in New South Wales be reviewed and increased to improve public dental services and be comparable to other states."[xix] Data collected in this survey suggests that there is more to be done to improve public

dental services and improve the oral health outcomes of the people that rely on these services.

> **Recommendation 5:** As recommended in the final report of the Legislative Council's Inquiry into Dental Services, funding of public dental services in New South Wales should be reviewed and increased to be comparable with other States. Based on current estimates, this would require an additional $90million on top of the 2008/09 budget allocation, plus annual indexation.[6]

The social costs associated with poor oral health were repeatedly articulated by NGOs, who linked the poor oral health of their clients to low self-esteem and difficulty seeking employment or education.

> *We are a food and social service NGO. If people can't eat properly their nutrition and consequently their health declines. If they won't smile or go out of the house because of bad teeth, depression is the inevitable result.*
>
> *My client group is already disadvantaged in many other aspects, long term unemployed, social skills etc. but to have, on top of these issues, visible bad teeth affects their self esteem, their presence etc. They don't want to attend job interviews, smile or sometimes talk.*
>
> *Increasing self-confidence is very much part of case management with this particular client group and with terrible teeth it is not easy to re-enter the workforce, training or education. It would make such a difference to someone's life knowing that they could "smile" and not feel awkward and embarrassed. Poor dental health does have such an impact on a persons being.*

Good dental services are essential for physical health, but they are also essential to mental health and wellbeing. The social costs of poor oral health remain significant, and are disproportionately born by those who are unable to afford private dental care, exacerbating social isolation, marginalisation and economic and social disadvantage. Poor oral health results in difficulty in eating, impaired speech, loss of self-esteem, restriction of social and community participation, and can impede a person's ability to gain employment.

[6] This costing is based on increasing per capita funding for NSW public dental services to the average per capita funding of the other States (does not include ACT and NT), based on figures contained in the table on p6.

Margaret

Margaret is an Age Pensioner who rents her home privately. About two years ago she experienced a throbbing sensation in her mouth that sent her in search of treatment at the local hospital's free dental clinic.

"I've always looked after my teeth and I knew something was wrong, I went to the public clinic and they gave me an appointment to come back in 3 months. At that time I had x-rays and a good check. I was told I had an infection around one of my molars and taught how to clean the area with Savacol and a dental pick. When I went back six months later and had another x-ray the molar had a large cavity. I was told that the home maintenance I was doing was good for another two years and I wasn't encouraged to come back. "

"I've always been conscious of my teeth but when I hit pension age I realised I had to look after them. When I was working I could afford regular check up but not anymore. It took a lot for me to go to that hospital because of my pride. Now eighteen months later my tooth is disintegrating and not long ago I swallowed part of it while I was eating. I don't want to go back to the hospital, I'm frightened that I won't get the best treatment and I don't feel supported."

"Now I have to find the money to go to a private dentist. I'm renting and I get the pension, managing money is a continual battle and a struggle – it's wearying. But I'm a survivor and I'm now trying to work out how to get this done privately. I'll have to work it out with them and pay them off."

Access to services

Adam

Adam is a seven year old boy who is at risk of Creutzfeld-Jakob Disease (CJD) due to a family history of the genetic strain of this disease. CJD is the only disease that is both genetic and transmissible.

Adam was scheduled to have two molars removed at a public dental hospital. His mother, Sally, was informed that Adam would be the first surgery for the day. Under instruction from the dental hospital Adam did not eat after 8:00pm the evening before as a preparation for the surgery.

On the day of Adam's surgery the hospital staff seemed to be unaware of the infection control guidelines for CJD. Sally was frustrated by this as she had made significant efforts during the six months leading up to the surgery to provide Adam's dentist and dental team with all relevant information about CJD including the fact that molar extraction does not expose surgeons to tissue that would be infectious in a CJD patient.

Adam and Sally experienced considerable distress as a result of the staff's lack of knowledge of infectious disease protocols. It was very clear to Sally that there was a real sense of fear that was held from the nursing staff right through to the anaesthetist.

There was a five-hour delay in Adam's surgery, which was upsetting for Adam as he had been fasting since dinner-time the night before.

Adam was also upset when a nurse approached Sally and asked her about "this CJD problem your son has" in his presence. Adam, who is at risk of CJD but has not been diagnosed with it, asked Sally if he had CJD "like Grandpa had", as he had watched his grandfather die from the disease a few years ago.

Adam's surgery only went ahead after Sally telephoned a NSW Health contact provided by her support group who was extremely knowledgeable regarding CJD.

Beyond waiting time and cost a range of other key issues were cited in the data collected for the report, including difficulties relating to appointments (particularly with public dental services); lack of locally available dental services and the follow on problems with transport; and a range of issues relating to service delivery, particularly in public dental services, such as discrimination and complications using interpreter services.

Appointment related difficulties

The most common difficulty NGOs cited in assisting their clients to access pro-bono services was a lack of knowledge about how to access these services. However, where this appears to be the case for NGOs, responses from client surveys indicate that use of pro-bono services is moderately high, with 10% of respondents indicating this was the type of service they were most likely to access and 9% indicating that the last dental visit they had was on a pro bono basis. Unfortunately, further investigation of the use of and access issues associated with pro bono services is not possible from this data.

Similarly issues were raised throughout the data in relation to public dental services, with some clients indicating they did not know how to make an appointment. Whilst there were not a large number of these comments, they are nonetheless concerning. In reference to this issue, with NGO respondents commenting that:

At a local community level (for example Neighbourhood Centres) there is no promotional material available about dental hygiene etc. and NO information to advise people how to access public dental services. This information needs to be available at community level.

I'd like to see some kind of promotion to service providers that prompts them to ask about dental access, tells them where the nearest affordable dentist is and how to access that service.

Recommendation 6: In consultation with the NGO sector NSW Health and Area Health Services develop and comprehensively disseminate:

a) Appropriate information on referral and access pathways to public dental treatment for clients of NGO services. Where possible, this should reflect flexible access pathways developed under Recommendation 2.
b) Oral health promotion materials targeting a range of client groups accessing NGOs

Also of concern were the number of comments made relating to problems getting and keeping appointments, particularly in the consumer surveys. These problems included:

- Difficulty with the call centre;

I have tried to contact them to make appointments but was put on hold for nearly 20 minutes so I hung up.

Not having phones to ring a 1300 number themselves can prevent our clients from seeking help and assistance. Most of our clients have huge dental health issues, broken and damaged teeth, abscesses, no teeth (without dentures). They know they can only ring the public dentist 1300 number if they are in pain, so it is only a matter of time before they present with an abscess that is poisoning their system. Preventative dental health is non existent…

- Difficulties with the communication process for appointments

I was told I need to have one of my teeth removed as it was likely to cause serious problems due to infection. They told they would send out a letter regarding when this next appointment was and they never did. When I went back to [service] they informed me that they sent the letter and I missed the appointment and therefore will be passed to the bottom of the waiting list. Since then I have had to be put on two courses of antibiotics for the infection and am still waiting for it to be removed. It has been over six months.

- And cancelled appointments

I was on a waiting list but my face swelled up and I was rushed to [Hospital] where I had an operation to have four teeth pulled out. This was after three prior appointments being cancelled, because other cases were more important than mine.

I am not satisfied at all with the treatment I am receiving. My last appointment was the 2nd of April; the next appointment was made for the 4th of July. I received a phone call on that morning, one hour prior to the appointment, cancelling it. They made another appointment for me on the 21st of August. I was then called on the 11th of August, cancelling this appointment. A new appointment was made for me on the 1st of September. I am now waiting to see what happens with this one.

Recommendation 7: Process and practices relating to communication with clients of public dental services should be improved, particularly in relation to advising of appointments and appointment cancellations. These processes should be appropriate to the range of client groups accessing public dental services, and compliance should be monitored and ensured.

Lack of local services

Some survey respondents indicated there were significant distances required for travel to access public dental services:

[Public dental services are] non-existent in our town. Have to travel two hours to the nearest dentist.

Without transport, these distances become significant impediments to accessing dental care, both for public and private dental services:

It's impossible for me to access a public dentist. It's difficult enough to access a private one in country NSW. There is no public transport, other than the school bus, to take you to the private dentist in a big country centre.

It is difficult to access public dentists in our area as public transport is very poor and one must really have private transport- the patient needs to travel to other towns. Also there is a long waiting list

I believe there is a service now once a fortnight this is not good enough for a town of 10,000 and only 3 private dentists.

Family and caring responsibilities exacerbate these situations.

The dentist I attend is too far and, as I have little ones, it is such an inconvenience.

A number of research reports point to differences between metro and rural//regional areas in dental service infrastructure, workforce, and oral health outcomes. A study by the Australian Institute of Health and Welfare (AIHW) found that, across Australia "All measures of tooth loss, poorer oral health and unfavourable dental visiting patterns were more prevalent among non–capital-city residents than capital-city dwellers."[xx] Continuing this theme, research also illustrates differences in dental practice activity, with the number of patient visits per private dentist higher in rural/regional areas than metro (2,756 per year compared with 2,495 per year respectively) and longer average waiting times to see a private dentist in rural and regional areas (3.9 versus 1.6 weeks).[xxi] There are also nearly three times as many dentists available in major cities than there are remote areas (58.6 compared to 19.8 per 100 000 population.)[xxii]

In response to this issue, one NGO made the following recommendation:

> *I have heard of an aged care specific service in Brisbane which is a publicly funded bus that can accommodate the elderly in a bed and the beds are wheeled into the bus and surgery can be performed in the bus. This would be a worthwhile project in [this] region, particularly as it can go to rural and remote homes and be used for all levels of ability and disability*

The Oral Health Fee for Service Scheme (OHFFSS) currently provides vouchers to eligible public dental patients to access treatment from private dental services. This program is particularly used where public dental services are unable to provide treatment, either because of time imperatives (emergencies) or infrastructure or workforce capacity issues (there is no public dental service in the area). Until public dental infrastructure can be expanded to provide better access to public dental services in rural and regional areas, programs that provide treatment to public dental patients through private providers, such as the OHFFSS, should be expanded.

> **Recommendation 8:** In recognition of current infrastructure restraints of public dental services, expand the availability of dental treatment programs available to rural and regional public dental patients through appropriate use of private providers.

> **Recommendation 9:** That transport to public dental services is considered as a component in any response to, or implementation of, recommendation 123 of the Garling Special Commission of inquiry[xxiii], relating to non-emergency transport services.[7]

Service delivery issues

Discrimination was cited by some respondents as impacting on their access to and interaction with dental services, including public dental services. One respondent commented:

> *…I am well aware that many of our members are frequently discriminated against when attempting to access healthcare. This is usually because the dental clinicians do not understand or are not familiar with infection control guidelines and assume that EVERY procedure requires extra precautions, despite it involving low infectivity tissue.*

Discrimination acts as a disincentive to service access, which in the case of people with chronic or complex conditions can result on very poor health outcomes.

> *Previous bad experiences and long waiting times mean that many people with HIV accessing public dental services wait until they are in pain or there is an emergency before accessing assessment and treatment.*

It is worth noting that these comments relate both to public and private dental services, both the perception and experience of discrimination. Whilst it is difficult to assess the size and scope if this issue further, it is important that continued action is taken to prevent

[7] The full recommendation includes "NSW Health is to ensure that there is provided, separately from the emergency transport service of NSW Ambulance, a non urgent transport service"

discrimination in health service delivery, and ensure infection control guidelines are applied consistently across all public and private health services.

> **Recommendation 10:** That the Australian Dental Association (NSW branch), as the professional association for NSW dentists, promote the consistent application of infection control guidelines and best practice models for non-discriminatory dental service access and treatment.

A number of NGOs also cited difficulties in obtaining and using interpreters as affecting their clients' access to and interactions with dental services. One NGO commented:

> *I deal with CALD populations - dental services don't change practices for such clients(forcing carers if there to interpret which is inappropriate). Also staff and dentists don't use interpreter services when dealing with clients. No clarity is provided on diagnosis/ treatment/ future-care.*

Steven

Steven is 49 year old and lives in Sydney. He was diagnosed with HIV in 1984.
When Steven was able to afford private dental care his HIV doctor had difficulty finding a private dentist who would treat him because of his HIV infection. Combined with Steven's increasing immune suppression, this lack of access to dental services resulted in significant tooth decay and gum infection.

In 1995 Steven's health deteriorated. He was severely immune compromised and unable to work. He was placed on a Disability Support Pension and became eligible for treatment at Sydney Dental Hospital (SDH).

During this time Steven recalls lining up in the SDH waiting room and was often not seen by a dentist until late in the afternoon. Only basic dental services were provided during this period with a focus on pain prevention. He also received a number of extractions.

Steven was later informed that he was eligible for the '2.3' dental program (NSW Health fund this program to expedite assessment and treatment for people with HIV). Although the range of dental treatment was no greater, the waiting time for appointments improved.

In 2002 Steven sustained oral health trauma in an assault. His recovery from the assault was slowed by complications from a post surgery infection and his oral health deteriorated during this time. He experienced severe tooth decay (both above and below the gum line) and required multiple extractions. Steven could feel holes in his teeth with his tongue and regularly attended a public dental hospital for check-ups. He was told that no work was needed.

When the Medicare Dental Scheme was introduced for people with chronic health conditions, Steven was referred by his doctor to a private dentist for assessment and treatment. Over the last three years, most of his teeth have been repaired and he now believes that the condition of his oral health is better than ever before.

"Private dentists are light years ahead in technology, quality and treatment" Steven says.

"For the first time in 20 years, I have begun to go out again. I smile without covering my mouth or feeling self-conscious. It's made such a difference".

Conclusion

The data presented in this report points to a complex and broad array of difficulties faced by disadvantaged groups accessing dental services, particularly public dental services.

Put simply, the cost of private services prevents many clients from accessing this type of care, and the waiting times for public dental services impede the delivery of timely oral health care.

Solutions to this problem remain complex. The data used in this report suggests that the NSW public dental sector is inadequately resourced to meet the level and type of demand being placed on it.

The impact on the health and psychosocial aspects of peoples' lives are substantial and require a more significant financial prioritisation by the NSW Government, who hold responsibility for the delivery of these essential health services.

Without significant financial, political and policy investment in public dental services, a considerable disparity will continue to exists between the oral health outcomes for those who are able to afford to pay for dental services and those who are not.

End Notes

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Issues in Oral Health for Low Income and Disadvantaged Groups in NSW

An Advocacy Kit for Community & Welfare Non-Government Organisations (NGOs)

NSW Oral Health Alliance (OHA)

July 2010

Issues in Oral Health for Low Income and Disadvantaged Groups in NSW

About this Advocacy Kit

The NSW Oral Health Alliance has designed this advocacy kit for community and welfare non-government organisations (NGOs). It aims to raise awareness of oral health issues for low income and disadvantaged groups in NSW and promote action in the lead up to the NSW State Election 2011.

The NSW Oral Health Alliance encourages organisations to consider unfair access to dental services and the major disparities in oral health outcomes for their clients. We hope that you will incorporate oral health into your election campaign priorities and take up this often-neglected issue in your advocacy with government, media, and the broader community.

About the NSW Oral Health Alliance (NSW OHA)

The NSW Oral Health Alliance is a group of non-government organisations convened by the Council of Social Service of NSW (NCOSS). It provides a forum for the discussion of oral health issues and undertakes coordinated activities to improve access to dental service for low income and disadvantaged people.

Members of the Alliance as at June 2010 include:

- AIDS Council of NSW (ACON)
- Association for the Promotion of Oral Health (APOH)
- Australian Dental Association - NSW Branch (ADA NSW)
- Brain Injury Association NSW (BIA)
- CJD Support Network
- Combined Pensioners and Superannuants Association (CPSA)
- Council of Social Service of NSW (NCOSS)
- Haymarket Foundation
- Hepatitis NSW
- Homelessness NSW
- Positive Life NSW
- Public Interest Advocacy Centre (PIAC)
- Rural Dental Action Group (RDAG)
- UnitingCare Burnside

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IBN 1 875326 83 9 | Published July 2010

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Introduction

Why healthy teeth and gums matter

Oral diseases are one of the most common health problems in Australia - yet the majority of oral health problems are preventable. In NSW, disadvantaged and low income people have significantly worse oral health than the general population and they have the greatest difficulty accessing dental services.

Poor oral health can have a significant impact on a person's health and well-being. A recent report by the Brotherhood of St Laurence that found of clients with oral health problems:

- 90% experienced pain or discomfort
- 80% had difficulty eating
- 86% were affected in their ability to go about daily activities
- 90% experienced embarrassment due to their teeth, contributing to poor self image, reducing their social interactions and limiting employment prospects.

As well as the individual impact, poor oral health also results in considerable social and economic costs to our community.

How this kit is structured

This kit aims to raise awareness of oral health issues for low income and disadvantaged groups in NSW and promote action in the lead up to the NSW State Election 2011.

It is structured in the following sections:

- **The Facts** – overview of low income and disadvantaged groups most at risk of poor oral health.
- **Key Issues** - outlines the main reasons why there is such an unfair disparity in oral health
- **Our Recommendations** – the NSW Oral Health Alliance's four priority recommendations to Government to improve equity in oral health.
- **Your Actions** - provides suggestions about how your organisation can take action to raise awareness of oral health issues and put pressure on Government to make teeth matter!
- **Case studies** – stories from clients of NGOs about their experiences with dental services and the impact of poor oral health
- **Resources and further information** – links to key policy and research documents, and information about how to access public dental services.

About the case studies

Each case study represents the experiences of an individual accessing dental services. In some instances, names have been changed to maintain privacy.

The case studies were collected by members of the NSW Oral Health Alliance via interviews with their clients, or the clients of their member agencies. Some case studies used in this Kit have been adapted from the 2009 Alliance report, Access to dental services amongst clients of non-government human service organisation.

The Alliance encourages you to talk with your clients' about their oral health experiences. If your client would like to share their story with us or is willing to be a media spokesperson, we would love to hear from you.


value
toothpaste
Quality Guaranteed

The Facts

A number of groups have significantly worse oral health outcomes than the rest of the NSW population. These include Aboriginal people, carers, children and young people, homeless people, low income people, older people, people with intellectual disability, people with mental health issues, people with special needs, refugees, and rural and remote people.

Aboriginal people*

- Aboriginal people have significantly worse health outcomes than the general population.[1] They are more likely to be at risk of poor oral health due to a range of factors, including:
  - poor water quality and the lack of fluoridation in some in rural and remote communities
  - poor diet and nutrition
  - poor general health
  - higher rates of chronic diseases, such as obesity, diabetes, and heart disease
  - higher rates of smoking and alcohol consumption
- Aboriginal Health Care Card Holders accessing public dental services have significantly higher levels of gum disease, tooth decay, and greater numbers of missing teeth than non-Indigenous patients.[2]
- Aboriginal adults have a higher prevalence of severe gum disease, have higher levels of untreated decay, and have more missing teeth than non- Aboriginal adults. They are also more likely to report avoiding certain foods because of dental problems, to rank their oral health as fair or poor, and report experience of toothache.[3]
- Compared to their non-Aboriginal counterparts, Aboriginal children experience:
  - Around twice as many decayed, missing, and filled teeth.[4]
  - More than twice the amount of untreated decay.[5]
  - Almost one-and-a-half times the rate of hospitalisation for tooth decay.[6]
- Less than 5% of remote Aboriginal pre-school children reported brushing their teeth on a regular basis.[7]
- Aboriginal people have greater difficulty accessing dental services due to:
  - High cost of dental treatment - around 40% of Aboriginal people delay or avoid dental care due to the cost,[8] and more than twice as many Aboriginal people report that they would have a lot of difficulty in paying a $100 dental bill (33.5%) compared with non- Aboriginal people (14.1%).
  - Lack of appropriate trained oral health workforce to meet the specific needs of Aboriginal people.
  - Lack of dental services, including both public and private oral health professionals and public dental infrastructure, in rural and remote communities.
  - Cost and availability of transport to attend dental services.

Carers **

- Carers play a central role in the delivery of oral hygiene and the maintenance of oral health of the people for whom they care.[9]
- There is a lack of data about the oral health of carers in NSW and Australia.
- As carers have higher rates of risk indicators such as poor general health, chronic disease and poverty, it is reasonable to assume that they have worse oral health than the general population.

* Aboriginal people' is used in the document to refer to Aboriginal and Torres Strait Islander people.

** A carer is any individual who provides care and support to a family member or friend who has a disability, mental illness, drug and alcohol dependencies, chronic condition terminal illness or who is frail. Across NSW, there is estimated to be approximately 750, 000 carers.

- Carers often overlook their own personal health care, including oral health, as their primary concern is the well-being of the person they care for.
- Financial cost of dental services is a significant barrier for carers to maintain their oral health. Carers have an average income 25% lower than non-carers, and around 44% of primary carers live in low-income households compared to 17% of non-carers.[10] Carers will often allocate a significant proportion of their personal income towards the people that they care for, and have little resources remaining to meet their own healthcare needs.
- Accessing dental services can be difficult for carers, particularly for those with full-time caring responsibilities. There is a lack of adequate respite services for carers to attend to their own health needs, such as attending dental appointments.

Children and young people

- Good oral health in infancy and early childhood contributes to better general health in adulthood.
- The oral health of primary school children has deteriorated by 20% in the last decade.[11]
- More than half of NSW children have evidence of tooth decay. Tooth decay is the single most common chronic childhood disease.[12]
- There is a four-fold increase in tooth decay between 12 and 21 years of age. Almost half of all teenagers have some signs of gum disease.[13]
- Children in low socioeconomic groups experience nearly twice the tooth decay as those in high socio-economic groups.[14]
- Aboriginal and Torres Strait Islander children experience on average twice as many decayed, missing and filled teeth than their non-Aboriginal counterparts, and have more than twice the amount of untreated decay.[15]
- Young children of mothers from non- English speaking countries have over two-thirds more decayed, missing and filled teeth, and more untreated decayed teeth, than those whose mother was born in an English speaking country.[16]
- Children in remote and very remote areas experience approximately 38% more decay than children living in major cities.[17]
- Children and young people in out-of-home care have difficulty accessing specialist dental services despite initial assessments that show evidence of gross decay.[18]
- More than one-third of children do not visit a dentist each year,[19] and the majority of young adults have an unfavourable dental visiting pattern.[20]

Children and young people

Catherine's story

Catherine is a young woman who lives in Campbelltown. In 2007, she began to feel pain in her jaw that was typical of un-surfaced wisdom teeth. Catherine attended a private dental assessment in October through a pro bono program. At this appointment the dentist told her that her wisdom teeth were impacted and needed to be extracted, along with extensive work on her molars. Catherine's dental treatment was not offered under the pro bono program, so she was referred to a public dentist for the work.

Catherine's local public dental clinic had a long waiting list. She got an appointment in August 2008, ten months after she initially sought help for the pain in her jaw. At the appointment the public dental clinic required Catherine to have another diagnostic assessment, despite the referral for surgery from the private dentist.

Following the assessment, Catherine was put on another waiting list for surgery. She is still waiting for to have her wisdom teeth extracted and has not been informed of how long she will have to wait.

Catherine is experiencing periodic pain from the wisdom teeth that are growing in her jaw. The advanced nature of her wisdom teeth growth, together with the health risks brought about by her untreated molars, means that she is at high risk of infection at the site of her impacted wisdom teeth.

Children and young people

Kylie's story

Kylie was sixteen years old when she started having trouble with her teeth. She presented at a public dental clinic with a swollen cheek and a painful mouth, and the dentist pulled the problem tooth out on the spot.

Gradually Kylie got more cavities but her public dental appointments were not timely enough to save her teeth. The waiting periods that she experienced from the time that she booked an appointment were so long that in the end she would present in severe pain and have them removed. One by one they were pulled out. She got so worried that when one of her front teeth got a tiny hole she rang to get an appointment at the public dental clinic as soon as she saw it. But by the time she got in to the dentist, the tooth had snapped and they had to pull it out.

At the public dental clinic, Kylie explained that "when I went in for treatment, it seemed like they didn't really have a plan. They should have given me a checkup and seen what needed to be done to save some teeth. Instead I would have pain in three places in my mouth and the dentist would ask: "Well which one gives you the worst pain?" It was often difficult to tell and I'd get one tooth out and have to wait for an appointment to get the other ones taken care of."

The length of waiting times for dental appointments and the dentists' lack of capacity to help Kylie keep some of her teeth resulted in complete deterioration of Kylie's teeth. Sometimes she waited for an appointment for two or three months in pain. When the pain became too strong to be helped by Panadeine Forte, she lost weight because she had difficulty eating around her sore teeth.

Kylie lost her self confidence as she lost more teeth and her remaining teeth became black and rotting. She started to cover her mouth when she talked and laughed, and she was no longer able to work in her customer service job.

Kylie was 25 years old when she had her last tooth removed and received dentures. This meant that she had to worry about the increase in oral health problems that are associated with dentures, up to fifty years before friends that were her age.

Homeless people

- Homeless people are much more likely to have tooth decay and much less likely to have visited a dentist in the last 12 months than the general population.[21]
- The Haymarket Foundation Clinic estimates that up to 80% of clients may have serious dental problems.
- Homeless people are at greater risk of poor oral health due to poverty, poor self care including lack of oral hygiene, substance abuse, mental illness, and co-occurring disorders.[22]
- Homeless people find it difficult to afford and access mainstream dental services. Free dental services have long waiting lists, and their transient lifestyle can make it difficult for them to keep appointments.

Low income people

- There is a strong social gradient in oral health – the poorer you are, the worse your oral health:
  - Government concession card holders are more than twice as likely to report poor or fair oral health (30%), compared to non-card holders (13%).[23]
  - Adult concession card holders have 1.4 times the tooth decay of non-cardholders.[24] Children in low socio-economic groups experience nearly twice the tooth decay as those in high socio-economic groups.[25]
  - People living in the most disadvantaged areas are twice as likely to have complete tooth loss or inadequate natural dentition compared to people from high socio-economic areas.

Low income people

Peter's story

Peter lives in Malabar, Sydney and is retired. He has used the public dental system in NSW for years but recently has taken to going to a private dentist.

About six years ago Peter had a partial plate made up for his top teeth. He picked it up the day before Christmas and it broke the next day. He then had to pay $90 to get it fixed by a private dental practice because the dental hospital was closed.

He explains that he'd rather have had his teeth capped than a partial plate but that's not an option in the public system. As his gums are shrinking (due to age) he has to get a new plate every couple of years.

About two years ago he had to have a tooth pulled out at the hospital. They left some of it behind, and he had to go back twice more before they got it all out.

In December 2007, he needed to get another tooth pulled out. The dental hospital couldn't see him that day, so they put him on the emergency list. He decided he'd borrow $500 (Centrelink loan) to go to a private dentist and get it sorted out. He hasn't been called by the dental hospital yet, even though he's rung to check that he's still on the list.

Now he gets the $500 (Centrelink) loan every year and goes to a private dentist. He also took $1400 out of his superannuation to buy a plate rather than stay on the waiting list.

Peter believes that the problem with the public dental system is that you have to wait too long to see someone, and even when you do get in, they only look at the emergency reason you're there, not your whole mouth. So you have to go back again and again.

- People livening in areas of greatest socio-economic disadvantage have difficulty accessing services due to economic restraints, reduced mobility, and a lack of services:
  - Nearly half of people on low incomes* avoid or delay dental care due to cost.[26]
  - Almost half as many dental practitioners per head of population work in disadvantaged areas compared with the least disadvantaged areas.[27]
  - Around half of welfare participants cannot access dental treatment when needed or an annual check-up for children.[28]

Older people

- Poor oral health can have a major impact on the health and social functioning of older people and can contribute to malnutrition.[29]
- Older people are at increased risk of tooth decay and chronic degenerative problems as they are retaining their natural teeth for longer.
- Periodontal diseases and oral cancers are more prevalent among older people.[30]
- Older people are more likely to be at risk of poor oral health due to multiple chronic disease; disabilities that make brushing and flossing their teeth difficult; using medications causing dry mouth; and barriers to accessing oral health care.
- Access to dental services is a critical issue for older adults because they require more clinical preventive supports than younger age groups.[31]
- Older people make up nearly 40% of all adults eligible for public dental care.[32]
- Current programs to assist older people to remain in their own homes, such as Home and Community Care (HACC), do not provide assistance with oral hygiene.
- People in nursing homes and residential aged care facilities are more likely to have poor oral health due to a lack of support with daily oral hygiene, lack of regular assessment of their oral health needs, and lack of referral for treatment. They also have greater difficulty accessing dental care due to poor coordination between the dental and aged care sectors, transport barriers, and the small scale of public dental outreach programs.[33]

* Incomes less than $20,000 or holders of Government healthcare cards

Older people

Elizabeth's story

Elizabeth is a single Age Pensioner. Elizabeth would previously make an appointment every two years at a public dental clinic at a large Sydney hospital to receive dental care, or whenever the clinic would send a reminder. In late 2006 she sought an appointment for a routine check. She was advised that she would have to wait twelve months. In the meantime, Elizabeth tried to find other ways of getting a check-up. However, there are no other free services in her area and she cannot afford a private dentist.

When she was finally given an appointment one year later, the dentist cleaned Elizabeth's teeth but in the process the enamel of one tooth was cracked. As a result, she had to have this tooth removed, but had to wait about six months for an appointment. Meanwhile, Elizabeth was left in a lot of pain that did not subside. Without any further assistance being provided by the dental clinic, she began taking painkillers in an effort to suppress the pain and went to see her GP. Elizabeth's GP prescribed antibiotics which she took for a number of weeks because her whole mouth was now infected. "I just had to keep swallowing painkillers and antibiotics due to the infection," Elizabeth said.

When it was time for her tooth extraction in the middle of 2008, the dentist extracted the problem tooth but her mouth was left partially numb after the extraction. To this day part of her lip is still numb.

This procedure has left Elizabeth in pain and has dinted her confidence, feeling anxious about going to the dentist.

"I was quite distressed, because nobody wants to be in constant pain," said Elizabeth. "Previously, I had pleasant experiences going to the dentist, but this has made me worried about who I am going to see and how long it would take for treatment."

Older people

Margaret's story

Margaret is an Age Pensioner who rents her home privately. About two years ago she experienced a throbbing sensation in her mouth that sent her in search of treatment at the local hospital's free dental clinic.

"I've always looked after my teeth and I knew something was wrong, I went to the public clinic and they gave me an appointment to come back in 3 months. At that time I had x-rays and a good check. I was told I had an infection around one of my molars and taught how to clean the area with Savacol and a dental pick. When I went back six months later and had another x-ray the molar had a large cavity. I was told that the home maintenance I was doing was good for another two years and I wasn't encouraged to come back. "

"I've always been conscious of my teeth but when I hit pension age I realised I had to look after them. When I was working I could afford regular check up but not anymore. It took a lot for me to go to that hospital because of my pride. Now eighteen months later my tooth is disintegrating and not long ago I swallowed part of it while I was eating. I don't want to go back to the hospital, I'm frightened that I won't get the best treatment and I don't feel supported."

"Now I have to find the money to go to a private dentist. I'm renting and I get the pension, managing money is a continual battle and a struggle – it's wearying. But I'm a survivor and I'm now trying to work out how to get this done privately. I'll have to work it out with them and pay them off."

People in rural and remote areas

- People living in rural areas experience poorer oral health outcomes than urban residents:
  - In rural and regional areas people are more likely to have tooth decay, more likely to have no natural teeth, have less frequent dental check-ups, and have fewer preventative treatments.[34]
  - Children in remote and very remote areas experience approximately 38% more decay than children in major cities.[35]
  - Elderly rural concession card holders are three times more likely to have no teeth than city-dwelling non-card holders.[36]
- There are a range of factors that contribute to the poorer oral health outcomes of people in rural and remote areas, including:[37]
  - Greater socioeconomic disadvantage
  - Less exposure to fluoridated drinking water,
  - Greater exposure to injury risks
  - Geographic isolation
  - Poorer general health among Aboriginal people.
  - Lower levels of access to health services. People in rural and remote areas have longer average wait times to see a private dentist (3.9 versus 1.6 weeks), and receive significantly less hours of dentistry compared to the rest of the population.[38]
- Access to dental services is a significant issue for people living in rural and regional areas due to:
  - Lack of private and public oral health care professionals.
  - Insufficient public dental infrastructure.
  - Transport to attend dental services.
  - Financial cost of services.

People with mental health issues

- The National Oral Health Plan identified mental health clients as one of the major disadvantaged groups facing significant issues around declining oral health and poor access to dental services.
- Studies have suggested that mental health clients have poor oral hygiene practices.[39] This is due to low levels of self-care, a lack of understanding of oral health care, and mistrust of dental professionals.
- People with mental health issues have higher rates of co-morbid risk factors, such as poor diet, alcohol and drug use, and smoking that mean they are at increased risk of oral disease.[40]
- Common medications for mental illness cause dry mouth, which increases the risk of developing dental caries (cavities), gum disease, and oral infection. Long-term anti-psychotic medication use can cause excessive teeth grinding or clenching that can lead to severe dental damage.
- People with mental health issues face significant barriers to accessing appropriate oral health services, including:
  - Fear, anxiety and dental phobia that influence the acceptance of dental care[41,42]
  - Inadequate knowledge and skills of dental teams for managing patients with mental health problems[43]
  - Stigma and the attitude of some oral health professionals has been identified as a barrier to dental care[44]
  - Cost of dental services
  - Professional carers lack oral health knowledge and skills. This includes knowing how to assist clients with oral hygiene, identifying potential oral health issues, and awareness of available services.[45]

People with intellectual disability

- People with intellectual disability, "...face stark health inequalities"[46] which are also reflected in their oral health outcomes.
- Dental disease is the most common health problem faced by people with intellectual disability. It is estimated to be experienced by around 86% of people with intellectual disability.[47]
- People with intellectual disability have a rate of dental disease up to seven times higher than the general population.[48]
- People with an intellectual disability often need assistance with oral hygiene. Carers (both informal carers and formal carers in residential settings) often lack the understanding, time, and/or resources to assist the person maintain good oral health.
- Access to appropriate dental treatment is a significant issue for people with an intellectual disability. This is due to a range of factors including:
  - Insufficient oral health professionals trained and skilled in working with people with intellectual disability.
  - Communication difficulties between the oral health professional and the person with an intellectual disability.
  - Insufficient time scheduled in routine appointments to adequately address the needs of people with intellectual disability.
  - Carers' low level of awareness of oral health problems and how to access dental services for people with intellectual disability.

- Access to affordable transport to attend dental appointments
- High cost of private dental services that is prohibitive for most people with intellectual disabilities who are dependent on disability support pensions
- Long waiting times for public dental services

- Without access to timely appropriate dental treatment, people with an intellectual disability and oral health problems may experience chronic pain and distress. This may manifest in behaviours that people find challenging.

People with special needs

(chronic physical conditions, substance use issues, blood borne disease)

- People with special needs experience substantially higher levels of oral disease, with considerably less access to treatment.[49]
- A disabling condition may place people at increased risk both of oral disease itself, and/or during treatment for that disease
- Smoking and use of methadone and other opioids can also lead to a worsening of gum conditions.
- Some medications for chronic conditions can cause a dry mouth and contribute to dental problems. Some people, including those on Interferon, have a lower resistance to gum infection than others.
- People with Hepatitis C may experience additional teeth and mouth problems. These can include dry mouth, tooth sensitivity and decay, gum infections and mouth ulcerations.
- Residential settings, such as supported accommodation, can act as a barrier to accessing either private or public dental care.
- The oral health workforce lacks the skills and capacity to provide appropriate care to meet the needs of people with special needs.

People with Special Needs

Adam's story

Adam is a seven year old boy at risk of Creutzfeld-Jakob Disease (CJD) due to a family genetic history of the disease. CJD is a disease that is both genetic and transmissible.

Adam was scheduled to have two molars removed at a public dental hospital. In the six months leading up to the surgery, Adam's mother Sally, made significant efforts to provide Adam's dentist and dental team with all the relevant information about CJD, including risks of infection.

When Adam and Sally arrived at the Dental Hospital on the day of the surgery, Sally was frustrated to find that the hospital staff appeared to be unaware of the infection control guidelines for CJD.

Adam and Sally experienced considerable distress as a result of the staff's lack of knowledge of infectious disease protocols. Sally believed that there was a real sense of fear from the nursing staff right through to the anaesthetist, despite the fact that molar extraction does not expose surgeons to tissue that would be infectious.

A nurse approached Sally and asked her about, "this CJD problem your son has", in front of Adam. This was particularly upsetting for Adam. While he is at risk of CJD, he has not been diagnosed with it. He asked Sally if he had CJD, "…like Grandpa had?" as Adam had watched his grandfather die from the disease a few years earlier.

Although the dental hospital had informed Sally that Adam would be the first scheduled appointment on the day, there was a five-hour delay in his surgery. This was very distressing for Adam as he had been fasting since dinner-time the night before in preparation for the surgery.

Adam's surgery only went ahead after Sally telephoned a NSW Health contact provided by her support group who was extremely knowledgeable regarding CJD.

People with Special Needs

Steven's story

Steven is 49 years old and lives in Sydney. He was diagnosed with HIV in 1984.

When Steven was able to afford private dental care his HIV doctor had difficulty finding a private dentist who would treat him because of his HIV infection. Combined with Steven's increasing immune suppression, this lack of access to dental services resulted in significant tooth decay and gum infection.

When Steven's health deteriorated in 1995, he was severely immune compromised and was unable to work. Steven was placed on a Disability Support Pension and became eligible for treatment at Sydney Dental Hospital (SDH).

During this time, Steven recalls lining up in the SDH waiting room and was often not seen by a dentist until late in the afternoon. He only received basic dental services with a focus on pain prevention. He also received a number of extractions.

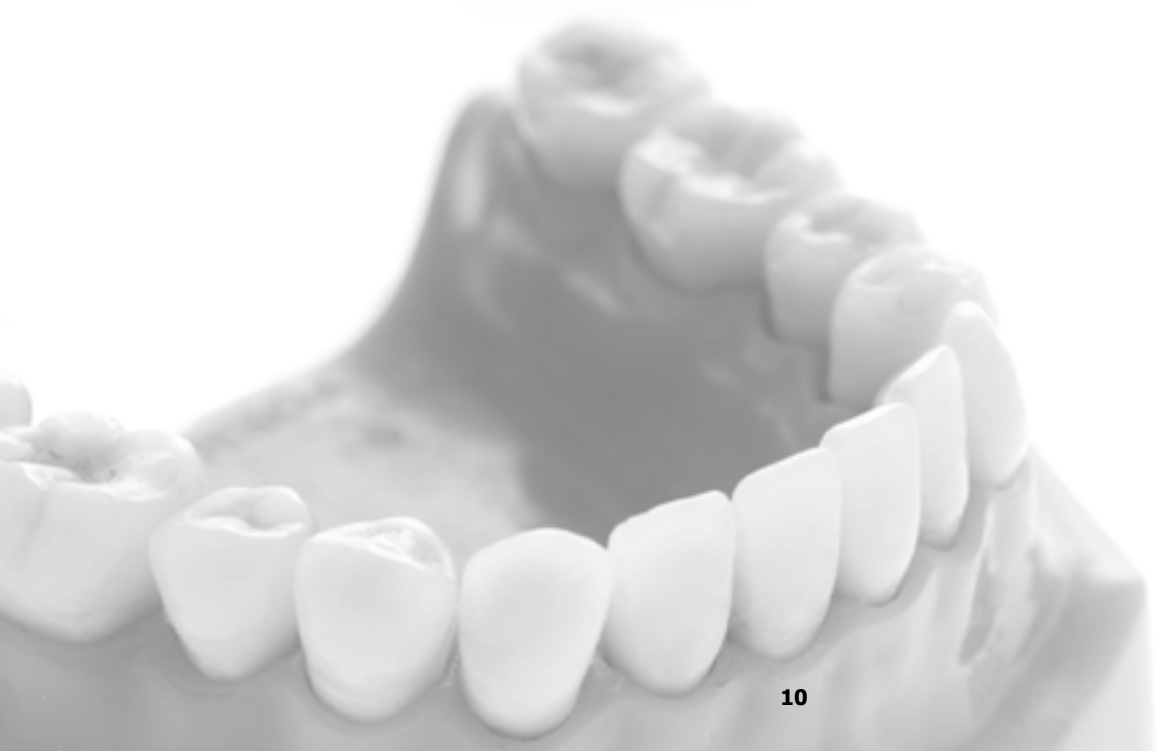
Steven was later informed that he was eligible for the '2.3' dental program, which expedites assessment and treatment for people with HIV. This reduced his waiting time for appointments, although he still did not receive more comprehensive dental treatment.

In 2002, Steven sustained oral health trauma in an assault. His recovery was slowed by complications from post-surgery infection, and his oral health subsequently deteriorated. He experienced severe tooth decay and required multiple extractions. Steven could feel holes in his teeth with his tongue and regularly attended a public dental hospital for check-ups. He was told that no work was needed.

When the Medicare Dental Scheme was introduced for people with chronic health conditions, Steven was referred by his doctor to a private dentist for assessment and treatment. Over the last three years, most of his teeth have been repaired and he now believes that the condition of his oral health is better than ever before.

"Private dentists are light years ahead in technology, quality and treatment" Steven says.

"For the first time in 20 years, I have begun to go out again. I smile without covering my mouth or feeling self-conscious. It's made such a difference".



Refugees

- The National Oral Health Plan identified that the oral health needs of recently arrived refugees are among the highest in the country.[50]
- A study by the Sydney Dental Hospital found that almost double the number of refugees surveyed had 5 or more untreated decayed teeth (29%), compared to Australian-born emergency dental care recipients (14%).[51]
- Generally, people from non-English speaking countries have poorer oral health outcomes than Australian-born residents, including more tooth decay, higher usage of emergency dental care; more extractions, lower rates of preventative services, and greater difficulty paying dental bills.[52]
- Refugees have a high risk of poor oral health due to factors including: torture related injuries, a lack of access to health care in periods of conflict, a lack of water fluoridation in their countries of origin, and poor diet or nutrition while in exile.
- Once in Australia, the availability of low cost, high sugar foods can exacerbate existing oral health problems.
- Barriers to effective oral health care for refugees include: language and cultural factors, financial pressures, transport difficulties, and the ongoing effects of torture and psychological trauma.[53]

Refugees

Ibrahim's story

Ibrahim came to Australia hoping to be recognised as a refugee. He fled his country out of fears for his safety from religious persecution.

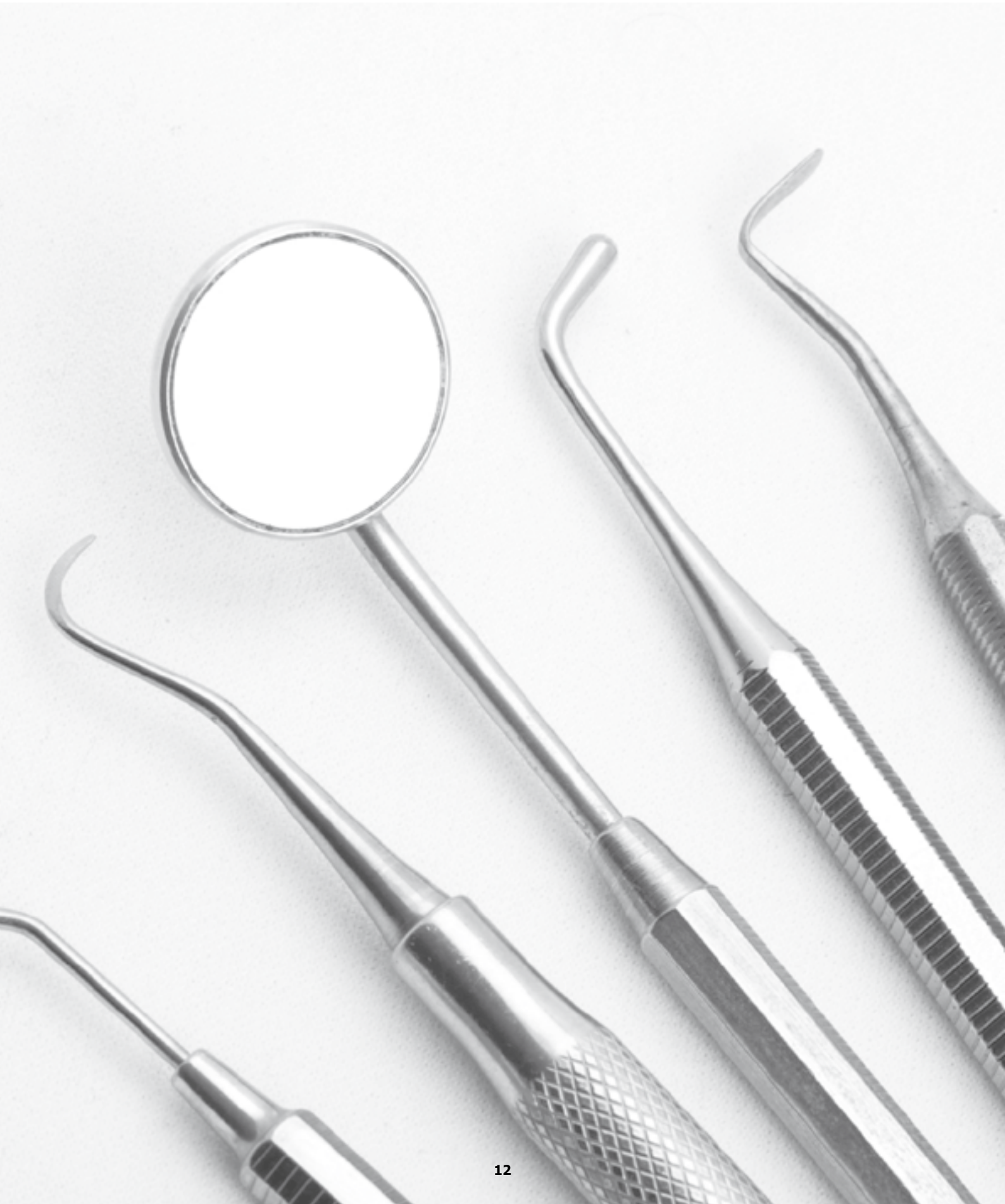
Living in Sydney as an asylum seeker was very tough for Ibrahim. He spoke limited English and found adjusting to life in a big city very challenging. Although he was legally entitled to work, recurring flashbacks and nightmares about the torture he endured in his old country made it difficult for Ibrahim to hold down a job. Under the Asylum Seeker Assistance (ASA) Scheme, Ibrahim received a small amount to cover basic living expenses, such as food and rent.

In late 2009, Ibrahim began to experience severe tooth ache. Despite being in constant pain, he did not go to a dentist because he could not afford the cost of private treatment and was ineligible for public dental services.

Ibrahim's Red Cross caseworker was able to find a place for him in a dental clinic run for asylum seekers and staffed by volunteer dentists. On the day of the clinic, Ibrahim was very nervous as it was the first time he'd been to the dentist in more than 20 years. However, at his appointment the dentist explained the procedure using an interpreter so that Ibrahim could understand what he was doing.

The clinic also showed Ibrahim how to brush and floss his teeth properly to reduce the risk of developing future oral health problems. Ibrahim later told his caseworker that he was very grateful to the volunteers at the clinic. His tooth felt better and he was no longer in any pain.

Ibrahim knows that attending the dentist for a regular check up is just as important to help prevent further dental problems. However, he still cannot afford to see a private dentist and remains ineligible for general public dental services.



Key Issues

Why is the oral health of low income and disadvantaged groups so bad?

Systemic barriers to accessing dental services are the main cause of continuing inequities in oral health for low income and disadvantaged people in NSW.

The majority of oral health care is provided by private dentists. However, fees for private dental services can be expensive, and there is a lack of private dentists in some areas, particularly in rural and remote areas.

Public dental services are provided by the NSW Government, with some Commonwealth funding for specific programs, such as the Teen Dental Program. However, unlike universal access to GP services under Medicare, only people with Government concession cards are eligible for public dental services.

The National Health and Hospital Reform Commission recommended the introduction of a scheme to provide universal access to basic oral health care (Denticare) as a key priority. However, there was no reform to oral health in the recent COAG National Health and Hospital Network Agreement and the States will continue to have funding responsibility for public dental services.

What is wrong with the public dental system in NSW?

For those people who are eligible for public services, they may have to wait months, or in some cases years, to receive treatment due to big waiting lists and the long wait times for treatment.

While the quality of public dental treatment in the NSW is generally high, the system is unable to cope with the high demand for services due to a lack of investment, inadequate public dental infrastructure, and workforce shortages.

The desperate state of the public system is highlighted by:

- Around 132,800 people are currently on waiting lists for general dental services in NSW, of which more than half are likely to have been waiting at least six months.[55]
- Only 13% of all dentists in NSW work in the public sector,[56] and yet 57% of the population are eligible for public oral health services.[57]
- NSW has the lowest per capita funding for public dental services of any State or Territory, at $23.20 per person.[58] There was no real funding growth for oral health in the 2010-11 State Budget.

Other contributing factors

Multiple disadvantage experienced by many low income and disadvantaged people may also compound their lack of access to dental treatment in both private or public settings. This can include:

- financial hardship which limits the type of treatment that can be afforded and the frequency of dental visits
- a lack of transport that can restrict the persons ability to physically get to and from dental services
- mental health issues that can impact on the persons ability to remember or attend appointments
- housing instability or transience which can impede treatment continuity or limit follow-up or reminder services.

Our Recommendations

The NSW Government must accept its responsibility for public dental services in the absence of national reform, and commit to reducing oral health inequalities in NSW.

Immediate priority must be given to reform of the public oral health workforce and investment in public dental infrastructure, particularly in rural and remote areas.

The NSW Oral Health Alliance is calling for the NSW Government to:

1. Increase funding for public dental services

Bring per capita funding for public dental services in NSW into line with Queensland. This will require approx. $102.5m in additional funding.

2. Expand the dental workforce

Invest in comprehensive public oral health workforce development initiatives, including the development of a workforce strategy.

3. Enhance public dental infrastructure

Invest in public dental infrastructure and develop flexible service delivery models

4. Address the oral health inequities

Fund targeted initiatives for those most in need, including older people, people with intellectual disability, refugees, Aboriginal people, and people in rural and remote communities.

Your Actions

By raising awareness of oral health issues in the community and in the media we can put pressure on the government to take teeth seriously!

Your organisation can take action by informing your clients, your members, other agencies, and your local community about oral health issues and encouraging them to take action too.

You can also lobby politicians to develop fairer oral health policies.

What you can do

1. Contact your local MP

Send a letter, email, or request a meeting with your local MP to express your concerns about oral health.

- **State MP:** www.parliament.nsw.gov.au/prod/parlment/members.nsf/V3ListCurrentMembers
- **Federal MP:** apps.aec.gov.au/esearch/

2. Write to the NSW Health Minister and Shadow Health Minister

Tell the Minister and Shadow Minister why oral health is an issue for your client group and demand action to reduce the inequities in oral health.

- NSW Health Minister Carmel Tebbutt
  email: dp.office@tebbutt.minister.nsw.gov.au
- NSW Shadow Health Minister Jillian Skinner
  email: northshore@parliament.nsw.gov.au

3. Send a media release

Write a media release for your local newspaper or radio station. You could highlight your clients' experiences of the public dental system or promote your organisation's advocacy work around oral health.

What you can do (continued)

4. Write a letter to the Editor

Send an opinion piece or writer a letter to the Editor of the major newspapers.

- The Sydney Morning Herald
  email: letters@smh.com.au
  post: GPO Box 3771, Sydney NSW 2001
- The Daily Telegraph
  email: news@dailytelegraph.com.au
  post: 2 Holt St, Surry Hills NSW 2010

5. Educate your staff and clients

Hold a workshop with your staff about oral health risks for your clients and how to incorporate oral health into regular care and support.

Run an information session for your clients about the importance of good oral health.

Distribute information about eligibility and access to public dental services to your staff and clients (see **Resources and Further Information** at the end of this Kit).

6. Encourage client self-advocacy

Encourage your clients to tell their oral health stories. They could share their experiences through creative writing, giving media interviews, or discussion in peer circles.

7. Gather evidence

Carry out a survey or undertake research on oral health issues for your client group. Document case studies about your clients' experiences.

8. Spread the word

Feature an article in your organisations newsletter or on your website about oral health issues for your clients or access to public dental services.

Hold a meeting or forum with your members.

Use your existing networks or form new partnerships with other organisations in your field to advocate for better oral health policy.

If you need some additional information or resources or would like some assistance with organising an activity, please contact the NSW OHA:

email: solange@ncoss.org.au

Resources & Further Information

How to access public dental services

Free dental care is available at NSW Public Dental Clinics for:

- All children under 18 years of age.
- Adult Centrelink concession card holders (Health Care Card, Seniors Health Card, Pensioner Concession Card)

For further information about public dental services or to make an appointment, ring the Public Dental Call Centre in your local area.

NSW Public Dental Call Centres

Area	Phone number
Greater Southern Area Health Service:	1800 450 046
Greater Western Area Health Service:	1300 552 626 (Far West & Macquarie)
	1300 552 208 (Mid West)
Hunter New England Area Health Service	1300 651 625
North Coast Area Health Service	1300 651 625
Northern Sydney Central Coast Area Health Service	1300 789 404
Southern Eastern Sydney Illawarra Area Health Service	1300 369 651 (Illawarra)
	1300 134 226 (South East Sydney)
Sydney South West Area Health Service	02 9293 3333 (Eastern region)
	1300 559 393 (Western region)
Sydney West Area Health Service	1300 739 949
	02 9845 6766

Key policy and research documents

- Healthy mouths healthy lives: Australia's National Oral Health Plan 2004-2013
- National Advisory Committee on Oral Health, South Australian Department of Health on behalf of the Australian Health Ministers Conference, Adelaide, 2004 www.sadental.sa.gov.au/Portals/57ad7180-c5e7-49f5-b282-c6475cdb7ee7/Oral Health Care.pdf
- NSW Oral Health Strategic Directions 2005-2010
- NSW Department of Health, Sydney, 2008 www.health.nsw.gov.au/pubs/2008/pdf/oh_direction.pdf
- NSW Oral Health Promotion: Framework for Action 2010
- NSW Department of Health, Sydney, 2006 www.health.nsw.gov.au/pubs/subs/sub_oral.html

- Access to dental services amongst clients of non-government human service organisations
- NSW Oral Health Alliance, Sydney, 2009 www.ncoss.org.au/component/option,com_docman/task,doc_download/gid,480/Itemid,78/
- Public dental care and the Teeth First trial - A history of decay
- Brotherhood of St Laurence, Melbourne, 2010 www.bsl.org.au/pdfs/Bond_Public_dental_care_and_the_Teeth_First_trial_2010.pdf
- NCOSS Vote 1 Fairness in NSW: Oral Health, Council of Social Service of NSW (NCOSS), Sydney, 2010 www.ncoss.org.au/content/view/3207/195/
- Dental Services in NSW, Report 37, March 2006
- NSW Legislative Council Standing Committee on Social Issues, Sydney, 2006 www.parliament.nsw.gov.au/Prod/parlment/committee.nsf/0/4fa2d0149b588095ca25714200077d20/$FILE/FINAL-%20COMPILED%2030%20MARCH.pdf

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