CHAPTER 5

OPTIONS FOR THE FUTURE

5.1 It is evident to the Committee that Australia's system of dental care is in need of reform. The evidence presented to the Inquiry indicated a significant, continuing level of disadvantage for many Australians in their dental health and treatment.

5.2 While the cost of services is the most important barrier to good dental health for many people, the deficiencies in the current system are inter-related and complex. There is no single answer to these problems. Even the injection of more funding, by itself, would not be a complete solution.

5.3 A wide range of suggestions was put to the Committee for the future development of dental care in this country. Many of them have some merit, though not all may be viable at the current time. These options for reform in the delivery of public dental services are considered in this Chapter.

A Commonwealth funded dental health program

5.4 Evidence presented to the Committee described a profound deterioration in the standard of public dental care available nationally since the cessation of the Commonwealth Dental Health Program (CDHP).

5.5 To redress the situation there was support for the Commonwealth to fund dental services provided by the States and Territories, including through the reintroduction of the CDHP.[1] However, most submissions did not recommend the reintroduction of the CDHP in its previous format, but referred to the need for a more permanent funding arrangement between the Commonwealth and the States and Territories. For example, the South Australian Council for Social Service (SACOSS) submitted that the:

> Commonwealth and States need to agree to a Commonwealth State Dental Health Program with the Commonwealth contributing funding through specific purpose payments and the States increasing their current contributions to dental health services.[2]

The Council on the Ageing (COTA) made a similar recommendation and suggested that funding should be provided through the Health Care Agreements.[3]

5.6 The Consumers' Health Forum of Australia (CHF) suggested a range of possibilities for the delivery of Commonwealth funding:

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1 For example, Submissions No.44, p.2; No.54, p.2; and No.6, p.1.

2 Submission No.107, p.7. See also Submissions No.19, p.2 and No.125, pp.12-14.

3 Submission No.97, p.15.

> The success of the Commonwealth Dental Health Scheme suggests that direct Commonwealth involvement in funding dental health services may be worth considering again as a way to target programs to disadvantaged groups. Alternatively, states could be provided with funding by the Commonwealth which is earmarked for public dental health. Strong safeguards and conditions would have to be attached to such funding to ensure that it is not syphoned off to other programs. A further option could be the establishment of a cost matched program of funding, by which the Commonwealth committed funding on a dollar to dollar basis against funding provided by the states. This would have the advantage of encouraging some relative consistency across the states.[4]

5.7 There was widespread support by both community and dental organisations for a system in which the Commonwealth directly funded dental programs delivered by the States and Territories. The communique, agreed to at the national seminar on the 'Role of the Commonwealth in the Provision of Dental Services for the Disadvantaged' held in Melbourne on 16 January 1998 and attended by representatives from dental health, community service and other relevant groups, concluded with the recommendation:

> That the Commonwealth make specific purpose payments to fund dental health programs to the States and Territories based on the following principles:
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> - That the States and Territories continue to fund existing dental health programs.
> - That the Commonwealth assist the States and Territories to raise services to agreed national standards.
> - That the Commonwealth contribute to the funding of specific new programs.[5]

5.8 As discussed in the previous Chapter, the position of the Commonwealth is that it has no legal responsibility for the funding of dental services delivered by States and Territories.

Coverage through Medicare or 'Denticare'

5.9 Many of the submissions received by the Committee highlighted the apparent incongruity of differentiating between oral and general health and advocated the integration of the two, particularly in terms of rebates and subsidies available to patients. This led, inevitably, to suggestions that basic dental care be covered in the Medicare schedule, that a separate Denticare system be established, or if this is unacceptable to government, that some limited scheme be designed to cover members

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4 Submission No.125, p.2.

5 'Role of the Commonwealth in the Provision of Dental Services for the Disadvantaged' *National Seminar Communique,* 16 January 1998, p.5.

of particularly disadvantaged groups. [6] This argument was illustrated by the following comment:

> There is an irony that the Medicare system pays for general medical practitioner visits but provides no cover even for the simplest dental care, despite the advice of bodies such as the World Health Organisation who see dental services as an important part of primary health care. Medicare pays for antibiotics prescribed by a medical practitioner for a dental abscess but not for a dentist to treat the tooth properly.[7]

5.10 Dr Peter Foltyn of St Vincent's Hospital presented a case for the inclusion of dental treatment for medically compromised patients to be covered by Medicare:

> Should a medically compromised patient require dental services occasioned by their medical condition it should be possible for that service to be requested by a medical practitioner, hospital or referring Dental Department who have assessed that patient's needs as part of their medical treatment. Fees could be established and listed in the Medicare Schedule. It is not intended that this would be a dental scheme initiated by dentists rather an adjuvant medical service provided by registered dentists.[8]

5.11 Dr Mark Schifter of the Westmead Hospital Dental Clinical School made a similar suggestion that certain medical conditions have clear but limited Medical item numbers, offering a rebate, for the undertaking of dental procedures. Dr Schifter noted that such a scheme is already in operation in regard to the provision of orthodontic/dental services for cleft palate patients.[9]

5.12 It was recognised that the inclusion of even a minimal form of dental care within the Medicare Scheme or creation of a separate Denticare scheme would be costly. In response to Committee questioning, Dr John Loy, from the Commonwealth Department of Health and Family Services (DHFS), estimated that incorporation of dental care into Medicare would cost roughly $1 billion. He added that 'we have not done any more precise figuring than that, but that seems to me to be the sort of back of the envelope calculation that gives you the order of magnitude'.[10] The Committee accepts Dr Loy's argument that this is a rough estimate only and acknowledges that the costs involved in such a scheme would vary considerably depending on whether it was based on universal eligibility and what specific services were to be included.

5.13 While there was general acknowledgment that this might not be an option favoured by the Commonwealth because of the costs involved, the National Seniors Association (NSA) put the case that:

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6 For example, Submissions No. 50, p.1; No. 125, p.12; No.107, p.8; No. 105, p.4; No. 83, p.4; No. 85, p.8; No. 100, p.3; No. 98, p.2 and No. 97, p.16.

7 Submission No.68, p.1.

8 Submission No.59, p.7.

9 Submission No.74, p.2.

10 *Committee Hansard,* 6.3.98, p.3.

> …the cost of the program would be offset by improvements in general public health and the avoidance of unnecessary suffering on the part of those people who are on long waiting lists or go without dental services they require. The program could be partly funded through an increase to the Medicare levy. Although there is general resistance to increased taxes and government charges, NSA believes the establishment of such a program would be politically popular and the increased levy would be accepted if access to the program was universal.[11]

Additional funding arrangements

5.14 Additional funding-related options including the use of vouchers, co-payments and means testing were also raised with the Committee.

Vouchers

5.15 One means of ensuring that members of disadvantaged groups have access to adequate care, despite its costs, is to institute a system of vouchers which could be used to ‘buy’ dental services. Under such a scheme the costs of care in a given period (eg. annually) which is beyond that covered by the voucher, would have to be met by the individual. Dental Health Services Victoria (DHSV) noted that voucher-based dental schemes have been used for patients referred to the private sector for publicly funded dental care. A voucher scheme would allow consumers to choose their preferred public or private provider.

5.16 DHSV proposed a tightly controlled voucher system in which eligible patients would generally be those already using the public system and where only basic dental care would be included.[12] Such a scheme would have the benefit of utilising the resources of both the private and public dental systems to meet the needs of disadvantaged groups at a time when it is clear that the public system, as currently configured, cannot meet those needs. The communique from the national dental health seminar in January 1998 recommended that the use of voucher schemes should be tested. It was also put to the Committee that a voucher system could be useful for Health Card holders in rural and remote areas where they could be treated by their local practitioners.[13]

5.17 On the negative side, it was argued by Dr Judith Lewis that while vouchers may be useful for some adults, they may be inappropriate for minors where most require minimal preventative services and a few require complex treatment such as orthodontic treatment.[14]

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11 Submission No.83, p.4.

12 Submission No.67, p.41.

13 Submission No.47, p.1.

14 Submission No.109, p.2.

Co-payments

5.18 In some States and Territories such as Victoria, Western Australia and the ACT, patient co-payments have been introduced for some public dental treatment. The Committee was informed that these co-payments have the effect of ensuring that free services are not used trivially by those who have access to them as well as boosting the funding for dental services by providing a source of revenue other than government funding[15]. The Australian Dental Association (ADA) supports the principle that there should be patient co-payment for oral health services.[16]

5.19 The Committee received differing evidence as to the acceptance of co-payments. Concern was expressed that co-payments may actually be another barrier preventing the economically disadvantaged from accessing dental care. Professor John Spencer of the Australian Institute of Health and Welfare (AIHW) stated that 'when one already has the eligibility criterion of being low income, to introduce a co-payment seems to cut across the very people who are least able to afford to pay it'.[17] However, the Health Department of Western Australia submitted that 'the W.A. experience is that modest co-payments are well accepted by patients'.[18]

5.20 ACT Community Care noted that, with the introduction of co-payments, 'there is a concern that some people are making a decision that they cannot afford to pay fees for their dental care'.[19] Ms Jill Davis, ACT Community Care Dental Health Program, described the operation in the ACT:

> There are fees in the child and youth program and fees in the adult program. …we have had a reduction in the numbers using both programs. We expect that some of that is a result of fees, although there are exemptions for certain groups of people. We are hoping to investigate this through some research a bit later in the year, but we believe it is some kind of a barrier to some people. On the other hand, there are quite a few people who appreciate paying the fee; so there are people who are valuing the service more because they are making a small contribution.[20]

5.21 Co-payments were introduced in Victoria following the loss of CDHP funding and apply to basic emergency and general non-emergency care. Commenting on Victoria's experience to date, Dr Martin Dooland of DHSV noted that there had been some initial suppression of emergency care, though this had returned to original levels, and evidence of a suppression of demand for general, non-emergency care.

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15 Submission No.130, p.5.

16 Submission No.51, p.1.

17 *Committee Hansard,* 23.3.98, p.101.

18 Submission No.130, p.2.

19 Submission No.77, p.3.

20 *Committee Hansard,* 6.3.98, p.81.

5.22 Dr Dooland suggested that benefits, not just in terms of revenue, have accrued through the reduction of an unreasonable use of emergency services, freeing up dentist time to treat patients from waiting lists. Consequently, DHSV is 'comfortable' with the co-payments in the emergency area. In relation to the co-payments for general, non-emergency care, DHSV acknowledges that there may be some 'unexpected undesirable consequences' and that at least a refinement of the co-payment system is needed. Dr Dooland expects that, with time, some modification of the co-payments system could lead to revenue benefits by reducing the disincentives to attend for care.[21]

5.23 The Committee also received evidence that 'most experienced public health dentists feel that a co-fee contributes to the patient's involvement in their dentistry', and through such involvement may 'reduce inappropriate treatment and thus improve the quality of care'.[22]

5.24 In a paper written in February 1997, Professor Spencer rationalised the use of client contributions for specific services as a means of backfilling reduced funding following the cessation of the CDHP. Although this was 'regretable and best avoided', Professor Spencer argued on equity grounds that client contributions from adults should be contemplated in a wider package of revenue raising measures that minimise the individual contribution and spread the burden. In the paper, he proposed that:

> The relative size of client contributions is crucial to influencing demand. As the desire is to move people out of non-acute emergency care to general dental care, co-payments for non-acute emergency care should be at a higher percentage of fees than for general dental care…In the area of emergency care only trauma, bleeding and infections that risk complications…would be exempt from any co-payment.[23]

Means testing

5.25 It was put to the Committee that there was a need for stricter eligibility criteria for access to public dental care. The Health Department of Western Australia suggested that such a move would narrow the focus of the program to people who really need it. The Department noted that the CDHP had wider eligibility criteria than programs previously in use in that State and had given some people who were paying for private care access to public care.[24] Dr Lewis similarly argued that:

> The use of the Health Care Card and the Pension Card to define the client base for public dental services funded by the States results in inadequate services for card holders, many of whom are in dire need while others who could afford to access private dental care minimise their "income" and claim

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21 *Committee Hansard,* 23.03.98, pp.122-23, 137; and Submission No.67, Additional Information, p.2.

22 Submission No.132, p.2.

23 Submission No.61, Attachment, *Policy Options for Public Funded Dental Care*, p.8-10.

24 Submission No.130, p.5.

> the benefit. Public sector dental staff regularly hear about their patients taking trips overseas and/or attending a private school. Public dental services are so underfunded that the "safety net" cannot function for those who need it if eligible patients are not selected more carefully. For example, children are listed on the custodial parent's Card and the ability of the non-custodial parent to pay for treatment is not taken into account.[25]

5.26 Professor Spencer was of the opinion that:

> It would be convenient to discover that large numbers of persons have disputable eligibility. However, apart from holders of the Commonwealth Seniors Card, who are few in number…those adults eligible for public-funded dental care have a reasonable prima facie claim for public support.[26]

5.27 Mr Ken Patterson, the ACT Community and Health Services Complaints Commissioner, suggested that means tested subsidies could be made available to people on low incomes who attended private dentists of their own choice and required expensive treatment. Mr Patterson believed that more people would make use of this because many avoid using public dental services which are seen as a form of charity. He also noted that this would be an expensive system because more people would use it and because private dentists would provide optimum services and it would be difficult to control those costs.[27]

Oral health promotion

5.28 The Victorian Dental Therapists' Association encapsulated the view of many who gave evidence to the Committee when it stated that:

> …any public health program ought to have at its core, the promotion of health, not just its restoration.[28]

This view reflects the evidence from most service providers who emphasised that the preferred situation is one where dental care is restorative and preventative rather than emergency-based.

5.29 The promotion of oral health was widely seen as a necessary component of reforms to Australia's dental system, as evidenced in its inclusion in the communique from the national dental health seminar.[29] Ms Leonie Short, of the Public Health Association of Australia (PHA), gave evidence that:

> …a public health focus must be taken in order to utilise scarce resources in the most efficient and effective manner. For this we need to move from that

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25 Submission No.109, p.2.

26 Submission No.61, Attachment, *Policy Options for Public Funded Dental Care,* p.5.

27 Submission No.100, p.3.

28 Submission No.76, p.4.

29 *National Seminar Communique,* p.4.

> individual to a population focus, …We also need to move from an illness focus to actually looking at health, and we need to see oral health as part of general health…We need to mobilise [the Ottawa charter of health promotion] so that oral diseases can be prevented and minimised in the most cost-effective manner.[30]

5.30 The Queensland Government commented that 'investment in raising awareness levels of oral health would, conceivably over time, lead to a greater understanding and acceptance of the need for healthier behaviours, which could be expected to reduce the incidence of oral diseases. Such a program would need to link in with the States capacity to deliver and support effective oral health promotion programs.'[31]

Recommendation 1: That the Commonwealth, in consultation with the States and Territories and other key stakeholders in the public and private dental sectors, support the development of programs to improve the promotion of oral health throughout Australia.

Effective use of oral health professionals

5.31 Several suggestions were advanced for ways in which more effective utilisation could be made of dental and other oral health professionals in improving the level of oral health care available, particularly to disadvantaged groups.

Vocational training

5.32 One proposal, which received a high level of support during the inquiry, was for the development of a National Vocational Training Program for Dentistry. A working party with members from the Committee of Dental Deans, the Australian Dental Association, the Australian Dental Council and the dental branch of State Health Departments has been developing this proposal. The specifics of the proposed vocational scheme were contained in submissions from Professor Iven Klineberg, Dean of the Faculty of Dentistry at the University of Sydney, and DHSV.[32]

5.33 The intention of the proposed scheme is to advance the community service commitment of dental graduates, and to enhance the dental workforce in urban and rural communities to assist in the management of oral health needs. Basically, the program would require all newly qualified dentists to complete, under supervision, a 12 month period of vocational training in placements determined for them. The graduates would treat public patients and could be assigned to work in public dental services, private practices, in rural or remote locations, in States and Territories without dental schools and with a variety of client groups. In addition to the beneficial practical experience for dentists, the scheme was seen as an opportunity to counteract

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30 *Committee Hansard,* 6.3.98, p.48.

31 Submission No.128, p.15.

32 Submissions No.52, pp.1-11 and No.67, pp.39-40.

the shortfall of dentists servicing rural and remote areas by placing dentists in such areas for at least six months and, hopefully, encouraging more of them to locate there permanently. Dentists on the postgraduate program would be a valuable resource to address the needs of public patients.

5.34 Professor Klineberg noted that post-graduation vocational training programs operate in the United Kingdom and many European countries. In the UK vocational training is a requirement before new graduates may enter private practice within the national health service. This training has provided 'enormous' benefits to both the new graduates and the health system in general.[33]

5.35 Support for a vocational training scheme was received from a wide cross-section of those giving evidence, including State Governments and Dental Health Services, the ADA, and various welfare groups.[34] Professor Klineberg advised that Commonwealth and State funding would be needed to support this initiative and provided a detailed estimate of the funds required as $20 million.[35]

5.36 The Committee sees benefits in such a vocational scheme, particularly to service the needs of people in rural and remote Australia. It notes, though, that as the scheme requires graduates to be supervised, difficulties may arise in remote areas where professionals are not available to provide the required supervision, thus limiting the remote areas in which a graduate could work.

Recommendation 2: That the Commonwealth Government support the introduction of a vocational training program for new dental graduates, especially to assist in the delivery of oral health services to people in rural or remote areas.

Expanded use of dental auxiliaries

5.37 It was put to the Committee that 'expanding the role of allied health personnel could make more effective use of dental therapists, dental hygienists and dental technicians'.[36] Ms Short of the PHA proposed that:

> …we have dental therapists… and dental hygienists who could be employed very efficiently and effectively to work with older people in their homes, in hostels and nursing homes. That could be a wonderful strategy – doing some prevention and promotion with those older people. Again, I would go more to ethnic communities and those sorts of groups. We cannot keep justifying therapists working solely with children any more.[37]

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33 Submission No.52, p.2 and *Committee Hansard,* 6.3.98, pp.28-29.

34 For example, Submissions No.47, p.1; No.51, p.11; No.53, p.7; No.67, pp.39-40; No.85, p.8; No.120, p.7; No.127, pp. 23-24; and No. 128, p.13.

35 Submission No.52, p.7.

36 Submission No.53, p. 7.

37 *Committee Hansard,* 6.3.98, p.51.

5.38 The Victorian Dental Therapists Association referred to the contribution made by School Dental Services and its use of dental therapists as key providers of care which have been critical to improving the general health status of Australian children. The Association submitted that the model which uses dental therapists and dentists to provide care 'has been demonstrated to decrease the cost of providing care by a minimum of 30%'.[38]

5.39 Legislation in most States both limits the employment of dental therapists to the public sector and its provider agencies, and the client group of dental therapists to children and adolescents. The Association urged the wider use of dental therapists in the care of populations other than school aged children and adolescents and a review of the legislative restrictions on the effective and efficient employment of dental auxiliary professionals to allow for 'more innovation in the delivery of care, and better use of existing dental care resources'.[39]

5.40 Support for more effective utilisation of dental therapists was given in other submissions. Dr Judith Lewis argued that:

> The current workforce retention rate of dental therapists is very low and refresher courses, extended duties and more employment opportunities could utilise these valuable health professionals. The controversy concerning therapists working with adults could be averted if the age restrictions were gradually increased as the generation benefiting from lifetime water fluoridation matures.[40]

5.41 COTA supported the development of courses to train people in ancillary dental health services, particularly dental hygienists 'who can play an important role in providing preventive services and do not involve the costs of a dentist's services'.[41] When questioned as to whether there should be an expansion of the circumstances in which dental auxiliaries are used, Dr Robert Butler of the ADA responded that:

> The Australian Dental Association has supported an increased utilisation of dental hygienists in the public sector in particular. We believe that they are the auxiliary of choice in today's age with their preventive focus and that they reflect the dental needs of the community. We have tried to urge that more of them be employed.[42]

5.42 The Committee also received evidence that overseas trained dentists should be able to operate as dental hygienists and dental therapists without supervision or other restriction and should be permitted to perform, under the supervision of a registered dentist, all dental tasks (other than performing dental surgery under a general

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38 Submission No.76, p.3.

39 Submission No.76, pp.3-4.

40 Submission No.109, p.1.

41 Submission No.97, p.14.

42 *Committee Hansard,* 6.3.98, p.26.

anaesthetic) and to work as dentists in hospitals and other institutions where public dental services are delivered.[43]

Recommendation 3: That the use of dental auxiliaries such as therapists and hygienists be expanded, particularly to cater for the needs of specific disadvantaged groups and that, to this end, the States and Territories be encouraged to review legislation restricting the employment of such auxiliaries.

Training of carers and health workers

5.43 The lack of adequate training in oral health for health professionals and carers has been referred to in Chapter 2. This lack of adequately trained staff can place many disadvantaged people, especially those in nursing homes, at greater risk of rapidly declining oral health than should reasonably be expected.

5.44 The Victorian Government acknowledged that one of the barriers to dependant older people obtaining oral health is the lack of dental health knowledge and skill of carers, and proposed:

> The development of educational programs for carers of dependant older people and other health and welfare professionals who visit homebound people, to increase their awareness of the importance of oral health and their ability to refer to appropriate dental health providers for treatment. This would include developing broader strategies such as the introduction of accredited oral health education curricula for people training as attendant carers.[44]

Support for a training strategy on oral health for aged care workers was also received from other organisations, including Aged Care Australia (ACA) and the South Australian Dental Service (SADS).[45]

5.45 The need for health professionals to have some knowledge of oral health is not, however, restricted to those caring for the aged. The National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that:

> Any planning of health programs for Aboriginal people must incorporate dental health as part of overall primary health care, instead of considering dental health as a separate program…Aboriginal Health Workers should be supported nationally to acquire dental knowledge, at the very least in oral health promotion, and even to the extent of being able to perform some basic dental procedures…Aboriginal Health Workers are often the first point of contact for a client seeking health care, assessing the client and presenting this information to the treating health practitioner, particularly in some rural and remote services, as well as performing basic clinical skills.

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43 Submission No.118, p.2.

44 Submission No.127, p.22.

45 Submissions No.49, p.3 and No. 86, p.24.

> Many Aboriginal Health Workers have little or no dental knowledge, and they are the ones who remain in the communities while dentists generally come and go.[46]

Recommendation 4: That support be given to a national oral health training strategy for health workers and carers, specifically including those working in the fields of aged care and Aboriginal health.

Further measures to improve access to dental care and general oral health

5.46 A number of other measures to improve access to public dental care and general oral health were also raised with the Committee. These included:

- Holding an inquiry into the costs of dental care[47], for instance through a referral to the Australian Competition and Consumer Commission.[48]
- Encouraging the private insurance industry to develop more innovative models which might make private cover for dental services more affordable.[49] Tax relief options were also suggested, with the warning, however, that they could assist those people who were working and/or able to afford health insurance rather than the most disadvantaged people.[50]
- Measures to support dental professionals and encourage improvements in the standard of care, such as: peer review, professional support, establishment of recognised best practice, accreditation and continuing education.[51]
- Expanding the school dental programs to cater for secondary school students.[52] It was also suggested that treatment should be free to all students at government schools and that more orthodontists should be included in the school dental service.
- Encouraging indigenous people to train as dentists and dental auxiliary staff and encouraging dental undergraduates to gain work experience in Aboriginal communities.[53]
- Using schemes to improve services in rural and remote areas such as: a rural incentive scheme where above award payments are paid to dentists in those areas, using the Rural Health Support, Education and Training Program to

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46 Submission No.78, pp.8-9.

47 Submission No.97, p.16.

48 Submission No.98, p.2.

49 Submission No.125, p.11.

50 Submission No.38, pp.7-8.

51 For example, Submissions No.120, p.7; No.114, p.3; and No.111, p.3.

52 Submissions No.110, p.1 and No.92, p.4.

53 For example, Submissions No.78, p.9; No.87, p.9 and *National Seminar Communique,* p.4.

develop collaborative approaches to improve the availability of dental professionals, and broadening the Patient Assisted Travel criteria to allow access for Aboriginal people in remote areas to emergency and other care.[54]

- Extending the fluoridation of Australia's water supply. The ADA emphasised that water fluoridation is recognised as the most cost effective and equitable means of reducing dental caries in the community, yet only 66 per cent of the population enjoy the advantage of this proven anti-decay measure.[55]

5.47 The Committee notes that State Dental Service Departments or professional dental associations could implement some of these suggestions without the specific involvement of the Commonwealth.

5.48 The Committee considers that action is needed to address oral health problems both in the short term by targeting areas of specific disadvantage and in the longer term through coordinated policy planning and development.

Action in the short term – targeting areas of specific disadvantage

5.49 In evidence, the Banyule Community Health Service stated that:

> …a civilised society is obligated to provide good quality services to the underprivileged. For those receiving the services, improved dental health means an improved quality of life. For funding bodies, improved dental health means lower costs in the long term.[56]

5.50 The Committee concurs with these sentiments and has heard convincing argument that those Australians who are disadvantaged under current dental care arrangements are in such need that urgent action is required to alleviate their suffering.

5.51 There was widespread support in submissions, in addition to the many organisations and individuals supporting the communique from the January 1998 national dental health seminar in Melbourne, for the introduction of specific programs to target the needs of particular low income and disadvantaged groups.[57] The disadvantaged groups proposed to be the subjects of highly targeted programs were:

- Pre-school children;
- 18-25 year olds;
- the elderly, including those who are homebound and institutionalised;
- rural and remote communities; and
- indigenous Australians.

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54 For example, Submissions No.128, p.13; No. 129, p.5 and No. 78, p.9.

55 Submission No.51, pp.4-5, 10. See also Submissions No.129, p.4 and No.78, p.8.

56 Submission No.65, p.2.

57 For example, Submissions No.41, pp.4-6; No.49, p.3; No.50, p.1; No.51, p.8; No.63, p.4; No.67, pp.27-38; No.76, Attachment p.4; No.80, p.2; No.85, p.7; No.86, p.23; and No.96, p.5.

5.52 Other groups which were also identified as having special dental needs and difficulty accessing mainstream services included: the homeless and particularly 'at risk' youth, people with mental illness, the medically compromised, the intellectually disabled, non-English speaking adults, and humanitarian program entrants.[58]

5.53 The Committee noted the statement from the ADA as to the role of private dentists in contributing to schemes designed to counter disadvantages in oral health:

> The private system has a part to play in any Government funded scheme as a supplement to the public infrastructure and has particular advantages in that it has a well-distributed infrastructure which can service the needs of rural communities and those metropolitan areas where they are not well serviced by the dental public health system.[59]

5.54 The Committee considers that the Commonwealth Government needs to work in partnership with the States and Territories in devising means to ensure that all Australians have a high standard of oral health. As a first step, the Committee supports the thrust of proposals by DHSV, and supported by others, for a range of highly targeted pilot programs to address the priority health needs of specific disadvantaged groups.[60] It is envisaged that these programs would be funded by the Commonwealth but run in partnership with the States and Territories. Monitoring and evaluation of the programs, with appropriate outcome indicators being established, will enable informed decisions to be made regarding the most effective strategies to be contained in a national oral health policy.

5.55 For each disadvantaged group, DHSV has outlined the current situation, program rationale, program standards and proposed the main aspects of each pilot project. The pilot projects are targeted primarily at Health Card holders (or their children) within each group and are discussed below. Dr Dooland emphasised in evidence that government should not be subsidising dental care for people who are not low income earners and that higher income earners should pay the full cost of treatment unless they choose to take out insurance.[61]

Pre school age children (1-5 years)

5.56 The proposal is based on a recognition that the provision of information to parents about the effects of prolonged exposure to some liquids and foods should reduce the prevalence and severity of dental decay among preschoolers and that early access to preventative care builds positive attitudes to dental health, reduces the number of children requiring hospitalisation and reduces costs of dental care.

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58 Submission No.91, p.4.

59 Submission No. 51, p.4.

60 Submission No.67, p.27-39. See also Submissions No.41, pp.4-6 and No.87, pp.5-8.

61 *Committee Hansard,* 23.3.98, pp.121-22.

5.57 The program incorporates a targeted dental educational program for parents of high risk pre-school children. Children of Health Card holders in selected areas, who are identified by child care and maternal nurses as having a dental problem, would receive a voucher for dental care. It is anticipated that, for sites with a population of 5 000 2-4 year olds, 700 would be identified by nurses each year as needing dental treatment and be issued with a voucher. It is estimated that 16 pilot sites in eight States and Territories would cost $3.61 million.

Young adult Health Card holders (18-25 years)

5.58 There is evidence that young adult Health Card holders are not using dental services and are showing significant deterioration in their dental health. The proposal recognises the need for early treatment of dental problems and education to improve personal preventative practices. A targeted dental education program would aim to build upon the benefits accrued from school dental programs so that they are not lost.

5.59 The program would provide eligible people, who have not received a course of publicly supported dental care within 3 years, with a voucher for a single course of dental care from a public or private provider. The provider would be free to charge a patient co-payment. The cost for 20 pilot sites in all States and Territories is estimated at $6.24 million. This is based on pilot sites with 5 000 young adult Health Card holders, with 80 per cent of eligible people receiving a check-up and course of restorative care every 3 years.

Aged adult Health Card holders (65 years and over)

5.60 Aged Health Card holders who are on a dental waiting list and who have not received public dental care within the last 3 years, would receive a voucher for a single course of dental care from a public or private provider. The provider could also charge a co-payment. The scheme would include denture services. The estimated cost for 20 pilot sites in all States and Territories is $6.24 million. This is based on pilot site populations of 5 000 eligible people, with 80 per cent receiving a check-up and course of restorative care every 3 years and 300 receiving denture services each year.

The homebound

5.61 Most States have limited domiciliary dental services. With the trend towards retention of natural teeth by the elderly and the need for regular maintenance and treatment to avoid dental disease and retain oral health, the demands on such services are increasing. A level of oral health that allows for good diet will contribute to the ability of the homebound to retain their level of independence and stay out of costly institutional care. The Committee is aware of the recent release of the Commonwealth Government's 'Staying at Home' package of care and support for older Australians, but notes that it contains no specific assistance for maintaining the oral health of elderly homebound people.

5.62 The program proposal includes the development of a dental health educational program for health and welfare professionals who visit homebound people. Homebound people identified by visiting professionals as needing dental treatment would receive a voucher for dental treatment from a public or private provider. Again, the provider could charge a co-payment. It is estimated that, for 20 pilot sites in all States and Territories, each funding treatment for 500 homebound people, the cost would be $4.32 million.

Remote and rural communities

5.63 All States have difficulty in attracting dentists to rural and remote areas, people have to travel great distances for treatment, while low income earners often have no accessible publicly funded dental program. The proposal is for 10 pilot programs, each with a staffed and equipped mobile dental clinic. Selected remote areas would be visited by the mobile clinic for several weeks, depending on population and demand, to provide restorative and denture treatment for Health Card holders. It would also treat non–eligible people on a full fee paying basis. The clinic would return every six months to one year, depending on need. The estimated cost would be $2.6 million, allowing for the treatment of approximately 8 000 Health Card holders.

Indigenous Australians

5.64 In recognition of the special needs and circumstances of Aboriginal people regarding dental services, it is proposed that the Commonwealth develop specific proposals for pilot dental programs in consultation with indigenous Australians; sponsor the development of active cooperative links between State public programs and Aboriginal dental programs; and develop a program to encourage the training of indigenous dentists and auxiliary staff. The costs are estimated at $4.5 million.

Recommendation 5: That the Commonwealth assist the States and Territories to establish, conduct and evaluate highly targeted pilot programs to address the priority oral health needs of the following specific disadvantaged groups: pre school-age children (1 to 5 years), young adult Health Card holders (18 to 25 years), aged adult Health Card holders (65+ years), the homebound, rural and remote communities, and indigenous Australians. Such programs should include a capacity for the individual beneficiary to make a contribution to the treatment costs.

Action for the longer term – coordinated policy planning and development

5.65 The history of public dental care in this country has been one of minimal, if any, national, coordinated effort to foster long-term oral health within the whole community. Planning has often been State and Territory based and recent Commonwealth involvement has been focused on shorter term gains.

5.66 The evidence provided to the Committee indicated a situation where Australians' state of oral health could be profoundly affected by both their social and economic circumstances and by their geographical location. There is no national system at present for dental care, nor is there effective national planning to improve the oral health of all Australians. The situation was summed-up in one submission which stated:

> Current public oral health services are somewhat fragmented at a national level. The absence of a uniform "safety net" means that some individuals and groups are unable to access oral health care in Australia. This has led to different responses to the provision of oral health services in each State.[62]

National goals, standards, priorities and service targets

5.67 There was a commonly held view in some submissions for 'the Commonwealth Government to be involved in public dentistry, and indeed to take the lead in developing and implementing national dental health policies'.[63] Much of the evidence referred to the need to concentrate not just on fixing immediate problems, but rather to focus on longer-term preventative measures. As the Corio Community Health Services stated, 'short term financial considerations will produce negative longer term implications for the general oral health of disadvantaged Australians'.[64]

5.68 As noted above, the crucial role for the Commonwealth in providing a leadership role was widely advocated. It was seen as imperative that the Commonwealth should take the lead in reforming the public dental health domain by working in partnership with States, Territories and stakeholders to:

- set national goals for oral health;
- establish national standards for the provision of, and access to, care and quality of dental services;
- set national priorities for reform in the delivery of public dental services for low income earners; and
- monitor national oral health goals through maintenance of a national data collection and evaluation centre, a national oral health survey and research into current and projected needs.[65]

5.69 Associated with establishing national goals and standards, it was proposed that the following minimum national service targets need to be adopted:

62 Submission No.95, p.7.

63 Submission No.45, p.1. See also, for example, *National Seminar Communique,* pp.2-5; Submissions No.49, p.3; No.51, pp.7-8; No.125, p.9.

64 Submission No.46, p.7.

65 *National Seminar Communique,* pp.3-4. See also Submissions No.48, p.8; No.53, p.4; No.80, p.2; No.86, p.12; No.96, p.4; No.125, p.10; No.128, p.7; No.131, p.12; and No.133, p.9.

- No Australian should have to wait more than 24 hours to receive emergency dental care;
- Treatment should be available for decayed teeth and other oral disease in time to prevent expensive complicated dental care or tooth loss, generally within one year; and
- Regular dental check-ups should be available at least every three years in any oral health care program (and more frequently if possible).[66]

5.70 In addition, it is essential that Commonwealth monitoring of expenditure on public dental health services continue to be undertaken and a suggested avenue through which this could occur is for such services to be included in the Productivity Commission's Annual Review of Government Service Provision.

5.71 The Committee endorses this view that the Commonwealth should take on a leadership role which focuses on developing the longer term oral health of the nation. It agrees that without longer term planning, it is only too likely that the problems being experienced now in oral health will continue and compound.

5.72 The fields which should be addressed by the Commonwealth, in partnership with State and Territory Governments and other stakeholders, were described by Professor Spencer of the AIHW:

> There is the assessment role, such as the monitoring and evaluation of oral health and the progress towards setting oral health targets for the community…there is an issue of the monitoring, for instance, of the extent of population-wide preventive strategies, such as water fluoridation.
>
> Our second area is the area of broad policy development. I think we already had an example or two, such as policy with regard to water fluoridation, policy with regard to dental health education, maybe the appropriate labelling of all foods and beverages with regard to sugar content, the setting of policy with regard to dentistry's position in national dietary targets and dietary guidelines – all areas in which it seems to me there should be a dental involvement. I think that can come only at a national level from Commonwealth Government initiatives…
>
> The third area is the area of evaluation. I believe that we have a responsibility to be looking at the way in which eight different states and territories are responding to the challenges in dental public health, evaluating their response and learning from what works and does not work, as well as promoting health and improving access to dental care. If that is going to be conducted across all states and territories, it seems to me that there is a lead role for the Commonwealth in such activities.

66 This proposal was supported by, among others, Submissions No.51, p.7; No.53, p.1; No.63, p.4; No.75, p.1; No.86, p.20; No.120, p.7; and No.133, p.8.

> The last area is…the area of assurance of access to dental care. I believe very firmly that there needs to be a commitment to the access of all Australians to appropriate dental care under certain circumstances.[67]

5.73 The Queensland Government submitted that the Commonwealth has the opportunity to establish oral health goals and targets in partnership with the States and Territories as it has for mental health and other areas of general health. The Queensland Government anticipated that this would ensure an improved standard of oral health, enable States and Territories to provide services with a focus on improving the oral health of the community and shift service delivery to more preventative strategies.[68]

National Public Health Partnership

5.74 A number of submissions cited the National Public Health Partnership as a model for the development of oral health policy that would enable a national focus on oral health issues and embrace a public health model drawing oral health further into the full spectrum of health.[69] Under the National Partnership, Commonwealth, State and Territory Ministers have agreed to work on a public health agenda to improve collaboration and coordination in public health efforts across the country and facilitate an exchange with key stakeholders in developing national public health priorities and strategies.

5.75 DHFS also argued that the National Public Health Partnership is potentially relevant to oral health. The Department referred to the underpinning Memorandum of Understanding between Health Ministers which defines the public health roles and responsibilities of the jurisdictions:

> For the Commonwealth, this role is focussed primarily on leadership and collaboration; development of national public health policy; fostering innovation; advocacy; and monitoring, evaluation and reporting on national programs. The responsibilities of the States and Territories also focus on collaboration, at both the national and local level; and participation in the Partnership work program.[70]

5.76 In the Committee's view, this leadership role is not being fulfilled by the Commonwealth's current attitude towards involvement in national oral health matters. This perception was reinforced by responses given in answer to the Committee's questioning by Departmental representatives.[71]

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67 *Committee Hansard,* 23.3.98, p.95.

68 Submission No.128, p.10.

69 For example, Submissions No.38, p.6; No.95, p.7; No.120. p.8; and No.128, pp.15-16.

70 Submission No.121, p.8.

71 In particular *Committee Hansard,* 6.3.98, pp.9-10.

Recommendation 6: That the Commonwealth Government adopt a leadership role in introducing a national oral health policy, and give consideration to the possibility of using the National Public Health Partnership as the vehicle for developing and implementing that policy in partnership with the States and Territories.

Recommendation 7: That the national oral health policy include the:

- **setting of national oral health goals;**
- **establishment of national standards for the provision of, and access to, oral health care and the quality of services;**
- **establishment of national strategies and priorities for oral health care reform, with an emphasis on preventive dentistry;**
- **setting of minimum service targets; and**
- **monitoring national oral health goals through the maintenance of a national data collection and evaluation centre and undertaking research into current and projected needs.**

National oral health survey

5.77 The Committee noted evidence regarding the need to monitor progress against goals and, in particular, to update information for national planning and other purposes by conducting a national oral health survey. Reference has already been made in this report to the age of many of the oral health statistics currently available in this country. The Queensland Government referred to 'a dearth of reliable epidemiological data about the oral health status of the population of Australia'.[72]

5.78 Achieving improvements in the oral health of the population requires accurate and valid data for the purpose of monitoring and evaluating the effectiveness of the strategies adopted in achieving goals and targets. The ADA put the persuasive case that a national oral health survey is required:

> …to establish data on the oral health status and oral health needs of the Australian community. Good information systems must be in place to guide decisions in planning, funding allocations and evaluation of oral health outcomes and appropriate utilisation of funds. Data from the previous survey is now ten years old and all but useless. Furthermore, the procrastination of the Commonwealth Health Department in delaying publication of a 1987/88 survey until 1993 made the exercise even less relevant. It is essential that data be collected, collated and disseminated without undue delay.[73]

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72 Submission No.128, p.10.

73 Submission No.51, p.11.

5.79 The AIHW outlined for the Committee a proposal it has developed for a national adult dental survey in 1999 at an approximate cost of $1.78 million. The aims of the survey are structured around national indicators and associated targets for oral health and in relation to adult Australians would:

- describe the prevalence of oral disease;
- describe the socio-economic distribution of oral disease;
- evaluate changes over 10 years in the prevalence of oral disease;
- validate self-reported estimates of oral disease outcomes; and
- evaluate progress toward national adult oral health targets for the year 2000.[74]

5.80 This proposal for a second National Adult Dental Survey was prepared by the AIHW in 1995 and put to the Department in 1996. The AIHW informed the Committee that since 1996 the survey proposal had remained under discussion in the Department and from mid-97 had become linked to the development of the National Public Health Partnership.[75]

Recommendation 8: That the Commonwealth allocate resources for a national oral health survey, to be conducted as a priority, to establish data on the oral health status and oral health needs of the Australian community.

Oral health expertise in the Commonwealth Health Department

5.81 The Committee believes that, if the Commonwealth is to fulfil its proposed leadership role in the field of national oral health, it must have access to professional advice and be adequately resourced. It noted evidence regarding the need for the Commonwealth Department of Health and Family Services to maintain a specific cell (and some have suggested a Chief Dental Officer) with expertise which would assist in the development, coordination, monitoring and evaluation of national oral health policies and strategies.[76] The disadvantages of not having appropriately qualified policy advisers available within the Department were referred to by the ADA:

> This neglect of dental health issues by the Commonwealth has not only occurred with the more recent cessation of the CDHP and the closure of its managerial Dental Health Unit. Prior to these more recent events, previous Governments have failed to appoint a suitably qualified and competent dentist advisor within the Federal Health Department. Many of the deficiencies in the CDHP could have been avoided by appropriate advice from such a quarter. This advice is essential for the development and evaluation of any dental health programmes and the input of this person to

74 Submission No.61, p.4.

75 Submission No. 61, p.2.

76 For example, Submissions No.38, p.6; No.68, p.2; No.95, p.10; and No.111, p.4.

> the Federal Health bodies such as the National Health and Medical Research Council (NHMRC) would be of immense value.[77]

Recommendation 9: That the Commonwealth Department of Health and Family Services create a dedicated section or appoint an appropriately qualified senior officer with responsibility for oral health matters, and that the necessary resources to fulfil the role and responsibilities of such an office be provided.

Conclusion

5.82 It has been argued that public dental care in Australia is inadequate. The evidence before the Committee left no doubt that many Australians are suffering pain, discomfort, difficulty eating, financial hardship, embarrassment and other complications as a result of their inability to access appropriate dental care.

5.83 The current range of public dental systems administered by States and Territories lack coordination and fall short of meeting community needs. The return to another form of CDHP is not, by itself, a solution. The Committee considers that solutions lie in a combination of short term action to relieve immediate problems for those who are suffering particular disadvantage and longer term preventative, educative and planning measures to ensure equity of access to dental care and improved oral health for all Australians. This requires national coordination and planning and, as the Committee has argued, leadership from the Commonwealth.

5.84 As the Catholic Social Justice Commission stated:

> These should not be seen as simply "nice to have" programs in good economic times but dispensable in less good times. They are essential if the nation is truly committed to being a fundamentally fair and caring society.[78]

5.85 While public dental service providers are doing their best in difficult circumstances, it is clear that the status of oral health in this country indicates a system which is unfair and, for many, less than caring. The Committee concurs with the sentiments expressed in one of the submissions:

> We believe that in Australia, a comparatively wealthy country, it is unacceptable for people to be in pain, for which effective treatment is available, and to be denied treatment.[79]

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77 Submission No.51, p.7.

78 Submission No.71, p.7.

79 Submission No.75, p.1.

5.86 The Committee urges the Commonwealth Government to implement the recommendations of this report as a first step in it taking a leadership role in improving national oral health into the new millenium.

Senator Mark Bishop
Chairman

May 1998