SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE

REPORT ON PUBLIC DENTAL SERVICES

MAY 1998

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Senator Patterson wishes to record that, having been appointed to the Committee after the completion of the Committee's public hearings, she was not in a position to participate either in the final consideration of the report or the formulation of its recommendations.

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LIST OF ABBREVIATIONS AND ACRONYMS

ACA	Aged Care Australia
ACCC	Australian Competition and Consumer Commission
ACCHS	Aboriginal Community Controlled Health Service
ACOSS	Australian Council of Social Service
ADA	Australian Dental Association
ADF	Australian Defence Force
AFAO	Australian Federation of AIDS Organisations
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
ATSI	Aboriginal and Torres Strait Islander
BSL	Brotherhood of St Laurence
CDHP	Commonwealth Dental Health Program
CHF	Consumers' Health Forum of Australia
COTA	Council on the Ageing
DHFS	Department of Health and Family Services
DHSV	Dental Health Services Victoria
DVA	Department of Veterans' Affairs
EDS	Emergency Dental Scheme
GDS	General Dental Scheme
HCRRA	Health Consumers of Rural and Remote Australia
HIC	Health Issues Centre
LOTE	Language Other Than English
NACCHO	National Aboriginal Community Controlled Health Organisation
NCOSS	Council of Social Service of NSW
NRHA	National Rural Health Alliance
NSA	National Seniors Association
PHA	Public Health Association of Australia
SACOSS	South Australian Council of Social Service
SADS	South Australian Dental Service
SDA	Shop, Distributive and Allied Employees' Association
UDH	United Dental Hospital, Sydney

RECOMMENDATIONS

The Committee recommends:

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.

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.

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.

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.

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.

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.

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.

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.

CHAPTER 1

INTRODUCTION

Terms of reference

1.1 This matter was referred to the Committee on 29 October 1997 for inquiry and report by 30 April 1998. The reporting date was later extended to 28 May 1998.

1.2 The complete terms of reference for the inquiry are:

Current arrangements for the provision of public dental services in Australia, with particular reference to:

(a) the current and future dental care needs of low income earners and other disadvantaged groups of Australians and the capacity of both private and public dental services to meet those needs;

(b) the effect of the abolition of the Commonwealth Dental Health Program;

(c) the nature of the Commonwealth's responsibility to make laws for the provision of dental services pursuant to section 51(xxiiiA) of the Australian Constitution and the extent to which the Commonwealth is currently fulfilling that responsibility;

(d) the Commonwealth's role and responsibility in setting and monitoring national goals for oral health in Australia; and

(e) options for reform in the delivery of public dental services, including an exploration of the efficiency and effectiveness of a range of options for delivering dental services to low income earners.

Conduct of the inquiry

1.3 The inquiry was advertised in *The Weekend Australian* on 15-16 November 1997, and through the Internet. Submissions were also invited from government, community and other groups and individuals involved with the provision of public dental services in Australia. The closing date for submissions was originally 3 February 1998, although the Committee continued to receive submissions throughout the course of the inquiry.

1.4 Prior to the lodgement of submissions, Dental Health Services Victoria convened a national seminar on the role of the Commonwealth in the provision of dental services for the disadvantaged. The aim of the seminar was to consider the findings of research on the dental care needs of the disadvantaged, exchange views on the key policy issues, and to work to agree on national policy positions that could be submitted to the Senate inquiry. The seminar, held on 16 January 1998, was attended by over 100 participants from 54 separate groups, including dental health and

community services, public health officials from many parts of Australia, relevant interest groups and research academics. A communique of the agreed outcomes of the national seminar was agreed to by the participants and released at the conclusion of the seminar.[1]

1.5 The Committee received 137 submissions indicating the high level of interest in the subject. Many of the submissions endorsed the policy propositions contained in the communique from the national seminar. Some of the submissions were in the form of letters from individuals and case studies documenting the hardships faced by disadvantaged members of the community in accessing dental services. Appendix 1 contains a list of submissions made to this inquiry.

1.6 The Committee held two days of public hearings in Canberra on 6 and 23 March 1998. Witnesses who gave evidence at the public hearings are listed in Appendix 2. Additional information was tabled at the hearings and provided to the Committee following the hearings in answer to questions taken on notice. This information is also listed in Appendix 1.

1.7 The Committee expresses its appreciation to all those people who made submissions, provided additional material and information, or gave evidence to the inquiry.

Background to the inquiry

1.8 The reference of this matter to the Committee resulted primarily from the cessation of the Commonwealth Dental Health Program (CDHP) from 1 January 1997. The CDHP was established in 1994 in response to the National Health Strategy's Background Paper *Improving Dental Health in Australia* (1992) and concentrated on providing measures to improve access to dental services for disadvantaged Australians. The Commonwealth ceased funding for the CDHP as a result of decisions taken in the 1996 budget context. The cessation of the Program was the subject of considerable debate in the Senate at the time and during the 1996-97 Budget estimates hearings of the Community Affairs Legislation Committee. From 1 January 1997, the States and Territories resumed full responsibility for public dentistry.

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1 Submission No.67, pp.3-5. The Communique released by the National Seminar is at Appendix 1 to this submission.

CHAPTER 2

CURRENT AND FUTURE DENTAL CARE NEEDS

2.1 The need for quality dental care is an issue that is relevant to all Australians. The cost associated with providing this dental care is likewise a universal issue, affecting individuals in respect of the dental treatment they seek and affecting the whole community in the context of its wider costs. For example:

- national expenditure on dental services in 1994-95 was $1.94 billion;[1]
- it was estimated that in 1983 there were one million days work lost and over three million days of limited activity, associated with oral disease in the Australian population;[2]
- the NSW Dental Health Branch estimated that the cost of oral disease to the NSW community alone in 1995 approached $500million;[3]
- oral disease in Australia ranks among the most frequently experienced illness episodes;[4]
- dental disease is almost entirely preventable and the costs of these preventative measures are insignificant when compared with the costs of providing restorative care;[5]
- dental health is essential for good nutritional status and poor diet is one of the main causes of poor health in Australia (60 per cent of deaths in Australia are diet-related);[6] and
- recent research in the United States of America indicates a strong correlation between periodontal disease and heart attack.[7]

2.2 In quoting oral health statistics here and elsewhere in the report, the Committee notes that, with the exception of some data collected across the years 1994 to 1996 under the Commonwealth Dental Health Program (CDHP), much of the national data dates back to 1983 and the last Australian oral health survey.

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1 *Committee Hansard,* 23.3.98, p.97.

2 National Health Strategy, *Improving Dental Health in Australia,* Background Paper No. 9, 1992, p.11.

3 Submission No.131, p.2.

4 AIHW Dental Statistics and Research Unit, *Dental Care for Adults in Australia,* AIHW, 1993, p.1.

5 Submission No.51, p.1.

6 Submission No.88, p.1.

7 *Committee Hansard,* 6.3.98, p.40.

Oral health and general health

2.3 Oral health is concerned with the well-being of the mouth and its structures including the teeth, tongue, jaws, supporting tissues and salivary glands. Poor oral health has a range of consequences including pain, difficulty in eating and the avoidance of certain foods (which can lead to wider health problems), impaired speech, loss of self esteem, restricting social and community participation, and impeding the ability to gain employment. Generally, a person's overall quality of life is affected.

2.4 Dr Deborah Cole, Director of the Royal Dental Hospital of Melbourne, referred to some of the consequences of poor dental health:

> … It horrifies me that many people, especially decision makers, have no realisation of the dental consequences for the financially disadvantaged. These people with their broken down mouths have their job prospects diminished, are more likely to have problems dealing with landlords, bank managers, the police, doctors, lawyers and many other people they come into contact with in their daily lives. The value judgements that all these people make on a daily basis … come into effect to help these people stay in the poverty trap.[8]

2.5 The Committee was advised that although there are many diseases that affect the mouth, the two most common, and hence those constituting the major public health problem, are tooth decay (dental caries) and periodontal diseases, which affect the gums and tooth supporting structures. While dental caries has decreased in prevalence in the past 20 years (although remaining a major health and social problem), the need for periodontal maintenance programs are becoming more evident as more people retain their teeth. Both diseases are largely preventable.[9]

2.6 Oral disease has traditionally been treated and funded separately from other medical conditions. However, the interrelationship between oral health and the health of the whole body was constantly emphasised in evidence. Oral health should be recognised as an essential and integrated component of general health.[10] Dr Martin Dooland, of Dental Health Services Victoria (DHSV), stated in evidence that the link between oral and general health is most obvious from dentally compromised patients and most dramatic for life-threatening oral conditions. Dr Dooland noted, however, that 'the general health of over five million concession card holders is being damaged in less startling but very real ways by their poor and uneven access to basic oral health care, unlike the access they have to government subsidised medical care for other conditions'.[11]

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8 Submission No.87, p.1.

9 Submissions No.95, p.1 and No.128, p.3.

10 For example Submissions No.37, p.2; No.76, p.1; No.97, p.10; and No.133, p.8.

11 *Committee Hansard,* 23.03.98, p.119.

Groups with particular disadvantage

2.7 While the need for dental care is universal, certain people within Australian society are currently in greater need than others due to a range of barriers preventing them maintaining a desirable level of oral health. This is encapsulated in the finding of the Australian Institute of Health and Welfare (AIHW) Dental Statistics and Research Unit that:

> Research regarding variation in dental health within the adult community has highlighted manifest social inequalities in dental health status and access to basic dental care in the Australian adult population.[12]

2.8 It is important to note that, while rates of dental disease may vary due to factors such as the presence or absence of fluoridated water, low income earners and other disadvantaged groups have similar patterns of dental disease to the general population. The Victorian Government submitted that 'the major difference between these two groups is not so much in the experience of oral disease, but in access to and experience of treatment'.[13]

2.9 People disadvantaged in terms of their experience of dental care can be categorised as belonging to a number of broad groupings within Australian society. It must be remembered, however, that as individuals, they may suffer a range of disadvantages which apply to a number of groupings. For instance, as well as being a low income earner, a person might also live in a remote area and suffer the dental complications of a major illness. In such circumstances, their problems are compounded.

2.10 The most disadvantaged groups, as raised in evidence before the Committee, are addressed below.

Low income earners, including Health Card holders

2.11 The overwhelming weight of evidence before the Committee pointed to low income earners and their dependants as a significantly disadvantaged group in the area of dental health.

2.12 This group was generally seen as including those people who are eligible for health care cards and, therefore, publicly funded dental care. These are people who have a Pensioner Concession Card, Health Benefits Card, Health Care Card or Commonwealth Seniors' Health Card.[14] The Tasmanian Dental Service noted that Health Card Holders are receiving nearly twice as many extractions as the rest of the

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12 AIHW Dental Statistics and Research Unit, *Commonwealth Dental Health Program Baseline Evaluation Report 1994*, AIHW, 1995, p.1.

13 Submission No.127, p.5.

14 AIHW Dental Research and Research Unit, *Commonwealth Dental Health Program Evaluation Report 1994-1996,* AIHW, 1997, p.ix.

community, even though their underlying dental disease rate is not significantly higher.[15]

2.13 Research undertaken into the oral health status of low income earners indicates a significant level of inequality when compared with the rest of the population. In his evidence Professor John Spencer, Director of the AIHW Dental Statistics and Research Unit, summarised the range of factors which are generally accepted as characterising the standard of oral health and treatment. When applied to this portion of the population they become indicators of inequality:

> Certainly in incomes below $20,000 per year, we start to see the highest levels of perceived need: experience of both … toothache and inability to chew and eat all foods – those sorts of issues. We see the higher rate of problem or emergency visiting. We see the higher rate of extractions. We see the lower rate of restorations. We see the groups with longer intervals between their dental visits, including five years or more between dental visits.[16]

2.14 The following statistics illustrate these inequalities:

- People aged 45-64 with the lowest quintile of household income[17] are eight times more likely to have no natural teeth and 1.7 times more likely to wear a denture, than people from the wealthiest quintile.
- Health Card holders aged 45 and over are more than 1.7 times more likely to be edentulous (without teeth) and 1.4 times more likely to wear a denture than non health card holders.
- Dentate Card holders aged 45-64 report having an average of five more missing teeth than non health card holders.
- Dentate people from the lowest income quintile are 2.4 times as likely as those from the highest quintile to have attended a dentist as long ago as five or more years.[18]
- People from disadvantaged backgrounds are more likely to have poor oral health than the general population and are about twice as likely to have lost their natural teeth.[19]
- Among those whose last dental visit was in response to a dental problem, the group with the highest extraction rate – Card holders whose last visit was to a public clinic – had the lowest filling rate. Fillings are restorative whereas

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15 Submission No.41, p.2.

16 *Committee Hansard,* 23.3.98, p.100.

17 Those surveyed were divided into five groups, or quintiles, by level of income.

18 AIHW Dental Statistics and Research Unit and Social and Preventive Dentistry at the University of Adelaide, *A Research Database on Dental Care in Australia: Final Report,* April 1993, p.50.

19 Research Database report, p.5.

extractions are the equivalent of dental morbidity. The group with the lowest extraction rate – non Card holders whose last visit was to a private clinic – had the highest filling rate. People visiting for a checkup within the private sector were more likely to receive restorative care than those who last visited a public clinic.[20]

2.15 In 1996 it was estimated that of people who went to a private dentist, over 94 per cent of those who went for a checkup and nearly 97 per cent of those who went for a problem, were seen within one month. Public patients had a less favourable outcome. Only 65.9 per cent of those with problems and 47.5 per cent of those going for a checkup were seen within one month. Some 6.2 per cent of those with problems and 21.1 per cent of those seeking a checkup reported that they had to wait for 12 months or longer.[21]

2.16 The Committee also noted compelling evidence that the reason a person visits a dental service influences a person's oral health outcomes. People who present with a pre-existing problem are less likely to receive preventative services and more likely to lose their teeth.[22] Low income earners and their dependants are more likely to be in a situation where irregular, emergency dental treatment and poor oral health predominate.

2.17 Dr Cole, encapsulated the problem of oral health for low income people, stating that:

> Australia is now a country where you can pick the poor by their teeth.[23]

2.18 This assertion was borne out by a survey conducted through the South Australian Council of Social Service (SACOSS). That survey, conducted in October – November 1997, collected information on a range of dental health issues relating to low income clients of financial counselling and emergency relief agencies. Its question 'Do you have any comments about getting dental care?' elicited responses which included the following:

> You can't get any except for emergency and then all they do is pull them out.
>
> It's too expensive.
>
> I have given up on my teeth because the waiting lists are so long. I haven't even bothered to get myself on the list, I figure my teeth will have fallen out by then.
>
> I live in fear of having a toothache and not being able to afford a dentist. I am also looking for work and trying to look as presentable as possible and

20 Research Database report, pp.174-175.

21 AIHW, *Australia's Health 1996: Fifth Biennial Health Report of the AIHW*, AGPS, Canberra, 1996, p.177.

22 Submission No.120, pp.2-3.

23 Submission No.87, p.1.

> my teeth have needed cleaning for over 3 years. I would be willing to help with some of the payments if I knew that help was available when required.[24]

2.19 The survey found that nearly 60 per cent of the survey group had experienced toothache within the last twelve months compared with an incidence of about 11 per cent for non health care cardholders. About 25 per cent had visited a dentist in the previous 12 months and 25 per cent had not visited a dentist for more than three years. Some 50.8 per cent of respondents needed dental care urgently, 26 per cent reported associated health problems due to dental problems and 59 per cent of people on waiting lists for dental care had been on the waiting list for more than two years.[25]

2.20 The major barrier to low income earners seeking dental care is its cost. For many Australians the cost of private dental care is prohibitive, as attested to by the many submissions received by the Committee from individuals dependant on the public system. The Shop, Distributive and Allied Employees' Association (SDA) put the widely accepted view that for low income families private health insurance to cover oral health services 'is simply not an option at all'.[26]

2.21 The Victorian Dental Therapists Association noted the higher burden of dental disease suffered by lower socio-economic groups, quoting a study in 1997:

> There is a positive relationship between income and dental visits. Dental practitioners have the highest fees of any ancillary health service for a standard session, and ancillary health insurance returns only half of the cost of dental visits. It does not, therefore, remove the income barrier of out-of-pocket costs to obtaining care, which represents a much higher proportion of a low earner's income.[27]

2.22 Those reliant on the public system, however, are unlikely to receive treatment comparable to that of private patients. Compelling evidence was presented to the Committee reinforcing this claim. At the present time in the public system there is an increasing emphasis placed on meeting the demand for emergency care rather than restorative and preventative care, which would have longer term benefits for patients. Evidence received by the Committee indicated that this emphasis was a necessity resulting from financial limitations. Some patients are only treated for emergency matters as the waiting lists are so long that appointments for checkups are superseded by emergencies. It has been reported that in some areas waiting lists stretch to years rather than months and some have been closed so there is no access to public dental services. Further, public dental services do not provide a full range of dental

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24 Submission No.105, Appendix C, pp.1-2.

25 Submission No.107, pp.2-3.

26 Submission No.54, p.2.

27 Submission No.76, p.2. The Association quoted J.M.Lewis, *Interests, Inequity and Inertia: Dental Health Policy and Politics in Australia,* University of Melbourne, 1997.

treatment.[28] The current status of waiting lists in the public dental system is addressed in detail in Chapter 3.

2.23 The Brotherhood of St Laurence (BSL) submitted that its research findings:

> … indicate a strong relationship between income status and dental health status. Whilst a similar relationship may also be found with other health problems, such as heart disease and some cancers, what marks dental health services as different from other health services is that the relationship between income and poor health reflects lack of access to appropriate treatment. Moreover, that lack of access must be seen in longitudinal terms; it is not merely a question of lack of access now but also the effects of lack of access in the past.[29]

2.24 The Committee notes that lack of access now will have a continuing impact on this group's future oral health status and the level of demand for public care. Extended periods of poor access to dental care which could prevent dental disease, will compound their problems in the future. The Brotherhood referred to a 'perpetuation of disadvantage',[30] which, on the basis of the evidence before the Committee, appears to be an apt description of the circumstances in which many low income earners find themselves.

2.25 Evidence was also received which indicated that many doctors report patients attending for dental problems in order to obtain pain relief or antibiotics. According to the Australian Catholic Social Welfare Commission:

> It is doubtful whether the abolition of the programme [the CDHP] is even achieving its fiscal goal, since people with chronic pain due to oral health problems are now going to doctors as their first port of call and receiving prescriptions for pain-killers. The uncapped Medical Benefits and Pharmaceutical Benefits Schemes are therefore picking up much of the cost of the abolition of the CDHP.[31]

2.26 The Committee was informed that some people visited their doctor for pain relief when they had toothache and for antibiotics when they had infections and it was noted that prescription painkillers are cheaper than ones bought over the counter. Such channelling of dental problems into the general medical sphere places a burden on the Medicare and Pharmaceutical Benefits Schemes as well as being, at best, a short term solution. Doctors are only be able to treat the symptoms rather than the problem, so that patients would eventually require dental treatment.[32]

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28 Submission No.100, p.2.

29 Submission No.85, p.3.

30 Submission No.85, p.3.

31 Submission No.80, p.1.

32 Submissions No.85, pp. 5-6; No. 87, p.2; No.50, p.1.

2.27 Without doubt the cost of adequate dental care combined with the limitations of the current public dental system mean that many low income earners and their dependants have a standard of oral health which is inferior in comparison when compared with the general population.

2.28 This is not a problem which will diminish without intervention. Evidence was received from the Consumers' Health Forum of Australia (CHF) that:

> … the number of people on low income relying on publicly subsidised dental health services is likely to increase gradually but substantially in the coming years. Demographic factors behind this increase include not only the ageing of the population, but also trends suggesting that the proportion of the population in the paid workforce may decline, leading to an increase in the number of employed persons on low incomes. Therefore, the number of people unable to access or afford privately funded dental health services is likely to comprise a significant proportion of the population in years to come.[33]

Preschoolers and young adults as specific target groups

2.29 The Committee received evidence that, within the broad grouping of Australians dependant on low incomes, two groups of young Australians were at specific risk of dental problems. These were preschool children and young adults.

2.30 Evidence before the Committee indicated that the dental health of Australian children has improved dramatically in the last 30 years and the average amount of decay in the permanent teeth of twelve year old children has fallen. Nevertheless, 30 per cent of children enter primary school with untreated dental decay and less than a third of 2-4 year olds have visited a dentist. A small but significant proportion of preschoolers suffer very severe and extensive dental decay requiring hospitalisation and treatment under general anaesthetic.[34] Dr Dooland of DHSV gave evidence that this is a nutrition issue:

> It is particularly so with low-income groups, particularly single parents, from pacifying children with sweet liquids, even milk, for extended periods at night-time. That damages the teeth in a very great way. Providing information to young mothers and pregnant mothers, targeted identification of those children and making sure that they get early management are the economical way of handling those peaks of need.[35]

2.31 The BSL referred to the fact that the oral health of young Australians as a group is more comparable than the oral health status of adults due to a range of factors including fluoridation and school dental clinics (ie. there is more commonality across

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33 Submission No.125, p.6.

34 Submissions No.67, p.8 and No.92, pp.2-4. See also Submission No.27 which quoted statistics from the AIHW.

35 *Committee Hansard,* 23.3.98, pp.130-131.

socio-economic groups). The Brotherhood also pointed to the period of transition to adulthood, however, as a period when lack of access, affordability, unemployment or low paid work intervene to undermine these benefits.[36] Lack of regular dental care and changes in lifestyle have led to a deterioration in dental health for some young adults, particularly for low income earners.[37] Professor Spencer, of the AIHW, advised the Committee that:

> Young adults seem to be at risk of using emergency dental services and of receiving extractions when they use dental services, particularly those that are eligible for public sector dental care. The school dental service carries children through to the end of their eligibility in a state of good dental health – among the best in the world… As soon as they leave that service, though, the sorts of problems that exist in the community at large with accessing dental care re-emerge. There is a deterioration in oral health of young adults as lifestyle changes occur. Certainly we find that those who have come from less privileged backgrounds, those that are unemployed, have really quite high rates of dental decay. The problem is carrying forward the gains that have been made among children and adolescents really into young adults.[38]

Aged people

2.32 Many of Australia's elderly people are on low incomes and subject to the disadvantages described above. In addition, older Australians face a range of other problems in accessing dental care, for instance due to illness or restricted mobility.

2.33 The Committee noted that some elderly Australians are entitled to dental treatment due to their status as veterans or war widow/ers. This status gives them access to free treatment for basic services, although there is a financial limit on the provision of some services.

2.34 There is a strong correlation between age and low income. Private income decreases with age and affordability of dental health services is a critical issue for the elderly. Evidence received from the Council on the Ageing (COTA) indicated that over 70 per cent of Australians aged over 65 (ie. 1.7 million people in 1997) rely on part or full age pensions. This put most single older people on a pension income of between $160 and $199 per week and older married couples on the pension receive an income of $200 to $400 per week. By contrast, a recent survey of COTA members indicated that their members had been quoted costs for dental work ranging from $600 to $2 000 for replacement dentures and a similar range of costs for bridges, crowns and other maintenance work.[39]

36 Submission No.85, p.2.

37 Submission No.67, p.8.

38 *Committee Hansard,* 23.3.98, p.89.

39 *Committee Hansard,* 23.3.98, p.112.

2.35 Private dental care has become less affordable and the Victorian Government, in its submission, cited the fact that between 1985 and 1996 the cost of an average course of treatment has increased by 25 per cent more than social security payments.[40] Evidence was also received from Aged Care Australia (ACA), that the ability of older people to pay for dental services has diminished due to the introduction of user contributions towards the cost of aged care services and the higher contribution for medications.[41] COTA also noted that older people on a pension have little capacity for saving for large cost items and that their capacity to contribute to the cost of dental care is very limited.[42]

2.36 The distress caused to elderly Australians who may have difficulty affording adequate dental care at an age when oral health affects the quality of life so greatly, was evidenced by some of the anecdotal comments contained in individual submissions to the Committee:

> I am appalled at what I have to pay to have my remaining teeth attended to … Pensioners are being held to ransom by the dentists …[43]
>
> … it is humiliating to have to beg our political masters to alleviate our suffering. Perhaps they could … use the hundreds of millions from the National Welfare Fund which we former workers compulsorily contributed to …[44]
>
> … I … have fought hard all my life to retain my teeth, by having regular check-ups, etc. Now it seems that at an age when I should be receiving more care, there is much less help available.[45]

2.37 As Australia's population is ageing the needs of the elderly in maintaining a good standard of oral health will require more emphasis. In future, the percentage of older Australians within the total population will continue to grow as will the number dependant on public dental services. At present 13 per cent of the population is over 65 years of age and it is estimated that by the year 2010 this figure will have risen to over 22 per cent.[46] In Victoria, the Metropolitan Hospitals Planning Board estimated in 1995 that Victoria's aged population would increase by 30 per cent in the next fifteen years.[47]

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40 Submission No.127, p.9.

41 Submission No.49, pp.1-2.

42 *Committee Hansard,* 23.3.98, p.116.

43 Submission No.8, p.1.

44 Submission No.10, p.1.

45 Submission No.34, p.1.

46 Submission No.59, p.3.

47 Submission No.127, p.7.

2.38 There is a trend towards increased retention of teeth by older people. This brings with it increased caries (tooth decay) and periodontal disease and an increased need for dental care.[48] An AIHW report has found that:

> … the number of natural teeth in people aged 65 and over in 1994 was 62.1 per cent more than it was in people 65 and over in 1989 (Carter et al. 1995). The combination of changes in age distribution and declines in tooth loss is thus likely to result in an increase in demand for dental care by older Australians.[49]

2.39 The proportion of elderly people who are edentulous is rapidly shrinking and it is estimated that by 2020 only about 20 per cent of the elderly will have full upper and lower dentures.[50] The Committee also received evidence from COTA indicating that the number of people with dementia is increasing and that, in future, more people with dementia will have their own teeth.[51] This will translate into difficulties of care and more people in need of special dental assistance.

2.40 The Australian Dental Association (ADA) submitted that:

> … twenty years ago, dental treatment for the over seventies consisted typically of occasional new dentures and a very quick cleaning of these dentures by the elderly person, the carer or nursing home staff. Due to advances in dental care being enjoyed by today's adults, we are now seeing a dentate elderly population with restorative and preventive needs and many of these requiring treatment for an increasingly complex number of dental problems.[52]

2.41 For the elderly, good dental health, meaning well-maintained natural teeth or well functioning dentures, is a basic pre-requisite of good nutrition. Poorly maintained teeth or badly functioning dentures restrict diet and poor diet is linked to conditions in older people such as cardio-vascular disease and bone thinning as well as contributing to memory loss and poor cognitive functioning. Pain and suffering from untreated dental problems can contribute to depression and other mental health problems and the long term use of pain killers and antidepressants. COTA argued that poor dental health can contribute to the deterioration in the overall health of older people that can lead to premature admission to nursing homes or death.[53]

2.42 Older Australians have a legacy of dental disease and repair which necessitates continuing dental care, particularly in light of dental problems incurred as a result of living through the Depression, world wars and immediate post war years

48 Submissions No.41, p.5 and No.91, p.2.

49 AIHW, *Australia's Health 1996*, p.79.

50 Submission No.64, p.1.

51 Submission No.97, p.5.

52 Submission No.51, p.3.

53 Submission No.97, pp.1-2.

without the benefit of fluoridation. The ageing process results in the wearing down of the teeth, fillings and gums. Shrinkage of gums exposes teeth roots which are then susceptible to decay. Dr Wendell Evans, Senior Lecturer in Preventive and Community Dentistry at the University of Melbourne, emphasised that:

> As one ages, the consequences for dental needs are that they tend to become more, rather than less, complex UNLESS comprehensive preventive programs are in place.[54]

2.43 Dr Evans stressed the need for regular check ups for preventative and maintenance care in the elderly. Without such check ups previous efforts to maintain functioning teeth could be undermined to the extent that repair may not be warranted or the costs of repair may be prohibitive, leading to a situation of worsening oral health or removal of teeth.[55]

2.44 An important point was also made that while elderly people in nursing homes have access to qualified medical practitioners, their carers and health professionals generally have no oral health training. The Victorian Government submitted that 'one of the barriers to dependant older people obtaining oral health is the lack of dental health knowledge and skill of carers (Berley et al, 1988)'.[56]

2.45 Dr Peter Foltyn, Consultant Dentist at St Vincent's Hospital Dental Department submitted that:

> Oral health care has not been seen as a priority nor has it been fully appreciated by the medical profession and government. Many doctors have a limited working knowledge of oral and dental anatomy and the close relationship between oral health and general health. As we near the year 2000 many of our "baby boomers" will be approaching retirement age. Some will be entering nursing homes or residential care facilities with most teeth intact, or heavily restored with extensive crowns and bridges, unlike the average 50-60 year old of a decade or two ago who was edentulous. Oral neglect by a nursing home or other facility will see teeth deteriorate significantly within twelve months of entry to that facility… Education and prevention strategies in oral health care must be put in place now in order to limit a disaster amongst our aged and disabled.[57]

2.46 Functionally dependent older Australians, including the homebound and institutionalised, are particularly disadvantaged. They have high requirements for extractions, scaling, oral hygiene instruction and dentures but most States have extremely limited domiciliary services. For example, the Tasmanian Dental Service conceded that the current and future dental needs of the homebound, institutionalised and disabled is a significant problem that is beyond the scope of the dental workforce

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54 Submission No.64, p.1.

55 Submission No.64, p.2.

56 Submission No.127, p.21.

57 Submission No.59, p.5.

in Tasmania',[58] while in Victoria there are only two publicly funded domiciliary vans and few private dentists to provide domiciliary care to this group.[59] The Victorian Government noted that 'people in institutions require sound dental health to ensure that their level of dependency does not increase'.[60]

2.47 Dr Jane Chalmers informed the Committee that the AIHW Dental Services Unit in conjunction with the ADA (SA Branch) was conducting an investigation of the oral health of the increasingly dentate nursing home population. The study was providing many insights into the problems encountered by nursing home staff and dental staff when organising dental care for nursing home residents. Dr Chalmers was hopeful 'that the data from this and other geriatric dental investigations will be used to assist both the government and private sector with the development of appropriate and effective dental services for older Australians'.[61]

2.48 The following needs of the elderly were identified in evidence before the Committee:

- access to affordable care which includes regular oral health assessments and the provision and maintenance of dentures;
- services that minimise travel requirements, including visiting dental services for the institutionalised and homebound;
- specialist services that cater for people with dementia, who are less able to communicate if they have a dental problem;
- the education of carers in oral health issues; and
- a co-ordinated, interdisciplinary approach between dentists, other health care providers and dieticians.

Rural and remote Australians

2.49 Evidence before the Committee suggested that 'there is a marked inequity of dental services depending on where one resides'.[62] There was widespread acknowledgment among those providing evidence that Australians dwelling in rural and remote areas were subject to particular disadvantage.

2.50 The Australian Council of Social Service (ACOSS) drew attention to the spread of dental practitioners. The Australian average is 43 per 100 000 people. Capital cities average 51.2 per 100 000 compared with 28.7 per 100 000 outside capital cities. In some rural areas the rate is much lower, for example in some rural

58 Submission No.41, p.5.

59 Submission No.127, p.21.

60 Submission No.127, p.21.

61 Submission No.62, p.2.

62 Submission No.90, p.2.

areas of Western Australia there are only 5.9 practitioners per 100 000 people.[63] The Committee also noted evidence that in some rural areas no dental service is available.[64]

2.51 The National Rural Health Alliance (NRHA) cited a range of reasons for dentists not taking up rural practice, namely lower earning capacity, lack of professional support, lack of continuing education, and lack of employment, health and educational opportunities for their families.[65] In Queensland, strategies such as a rural incentive scheme where above award payments are made to dentists and a Dental Scholarship scheme that commits a few graduates to rural locations, have been successfully used to attract dentists to rural practice.[66]

2.52 The Committee received evidence that in some areas of Australia there was no opportunity for public adult dental care 'due to the complete absence of public facilities and the inability of provision of adequate financing for treatment through private facilities'.[67] The lack of access to dental services and the costs of transport to services from rural and remote areas compound the disadvantage of this portion of the population. Mobile dental services are generally regarded as the most viable way to service remote communities, although they are costly to establish, operate and maintain. Case studies were provided to illustrate the disadvantage of people living in remote areas.[68]

2.53 The NRHA cited longer waiting times for routine services at both public and private surgeries in rural areas: up to 2.5 years wait in rural New South Wales as opposed to 7.5 months in Sydney. The Alliance also made the point that long distances may be travelled to access specialist services.[69] This lack of access to care has an impact on the dental health of people in rural and remote areas, as does the decreased likelihood of them having a fluoridated water supply and their often more limited range of affordable fresh produce with its concomitant problems for nutrition.

2.54 An AIHW report in February 1997 identified a higher proportion of decayed, missing or filled teeth for rural patients compared to urban patients from all age groups except those aged 55-64 years. The highest rates of decayed teeth were for rural patients aged 25-34 years.[70] DHSV informed the Committee that, according to its data, children in rural areas had 60 per cent more dental decay than children in urban areas.[71] Reduced access to services has long term effects as children and young

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63 Submission No.120, p.3. ACOSS cited AIHW, *Dental Practitioner Statistics Australia, 1994*.

64 Submission No.128, p.3.

65 Submission No.129, p.4.

66 Submission No.128, p.13.

67 Submission No.51, p.3.

68 *Committee Hansard,* 6.3.98, pp.34, 56.

69 Submission No.129, p.3.

70 Submission No.128, p.4.

71 Submission No.67, p.11.

people, in particular, may not receive preventative and early treatment which would improve their oral health status for the future.

2.55 Mr Gordon Gregory, Executive Director of the NRHA, expressed the view that:

> Overall, the status of rural health is worse than in the major cities. In general, the more remote the individual, the worse his or her health is likely to be. This situation is exacerbated by relatively poor access to health services, few options, higher costs and an adverse cultural approach to health matters in country areas.[72]

Indigenous Australians

2.56 The Fifth Biennial Health Report of the AIHW in 1996 noted that:

> As early as 1925 Aboriginal groups were reported as having a substantial advantage over other Australians with regard to dental health (Campbell & Moore 1930). Although there is little published information specifically comparing the dental caries experience of contemporary Australian Aboriginal people with that of other Australians, the existing literature indicates a loss of this historical advantage. For instance, while there has been a major decrease in caries experience in other Australian children since the 1970s … there has been an increase in caries experience in Aboriginal children (Schamschula et al. 1980).[73]

2.57 The National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that indigenous Australians now suffer greater levels of dental disease than non-indigenous Australians generally. NACCHO drew attention to the high level of diabetes in the Aboriginal population, which may lead to the development of severe periodontal disease and to the greater number of Aboriginal people who are ill and have a greater risk of severe dental infection. NACCHO cited the National Aboriginal Health Strategy (1989) as identifying dental health as a major problem in Aboriginal communities due to factors such as limited access to services, high costs, lack of awareness and fear.[74] Other relevant factors include poverty, diet and lack of fluoridated water.[75]

2.58 The Northern Territory Government indicated that in the Territory the impact of poor dental health is particularly evident among Aboriginal people, who comprise about 27 percent of the population, the majority of whom are resident in remote locations. The Territory Government also noted that dental health is one among a complex of problems related to diet and other living situation factors. These include chronic diseases such as diabetes, heart and renal disease, which are more prevalent

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72 *Committee Hansard,* 6.3.98, p.57.

73 AIHW, *Australia's Health 1996,* p.28.

74 Submission No.78, pp.2-3.

75 *Committee Hansard,* 6.3.98, p.66.

among Aboriginal people as a group, and which have compounding adverse effects on health outcomes.[76]

2.59 Most indigenous people cannot afford private dental care and are dependent on public services. For Aboriginal people resident in remote communities, private treatment is simply not an option because these communities do not have resident private sector dentists.[77] The size of waiting lists for public dental treatment at the present time precludes optimal dental care for those reliant on the public system. This is addressed in detail in Chapter 3. NACCHO submitted that:

> The result is that in many regions any dental care comes down to a “relief of pain” basis, usually an extraction, with no coordinated care or education being provided. It also means that the dental services that do exist in ACCHSs [Aboriginal Community Controlled Health Services] are providing dental care for people outside of their communities. Many urban services are seeing people who have travelled long distances from rural and remote areas, because they cannot access appropriate dental care locally or regionally.[78]

2.60 NACCHO also stated that in remote and rural communities ‘we are approaching the situation where they will have no services at all’ and that ‘in many areas Aboriginal children *do not* receive dental care at school’.[79] The Territory Government commented that the extended nature of Aboriginal families, and cultural obligations, mean that Aboriginal people may move between a number of different locations during the year. This contributes to difficulties with service delivery and the completion of treatment programs.[80]

2.61 The AIHW provided evidence that indigenous Australians had a higher rate of edentulism than non-indigenous Australians (16.3 per cent versus 10.9 per cent). They also have a higher percentage of patients who usually visit dentists for a problem than non-indigenous Australians (63.7 per cent versus 49.7 per cent).[81]

2.62 The AIHW’s Fifth Biennial Health Report in 1996 referred to data from the Children’s Dental Service in the Northern Territory that provides a program for school age children. This data indicated that Aboriginal children had a greater number of infant teeth affected by dental caries than other Australian children and that there was nearly a threefold variation in the mean number of decayed teeth between other Australian born children and Aboriginal children. It concluded that ‘Aboriginal

76 Submission No.133, pp.2-5.

77 Submission No.133, p.2.

78 Submission No.78, p.5.

79 Submission No.78, p.6.

80 Submission No.133, pp.3-4.

81 Submission No.61A, p.2.

children thus have a double disadvantage: more disease experience and a higher ratio of disease experience being untreated'.[82]

2.63 The AIHW's Report noted that tooth extraction is counter to the desired goal of maintaining functional natural dentition for life and to the advocated treatment which emphasises monitoring and prevention. Figures indicated that a higher percentage of Aboriginal and Torres Strait Islander (ATSI) patients received extractions than other patients. In some age groups the difference was significant. For example, in the 25-44 year age group at non-emergency visits, 25.7 per cent of ATSI people received extractions, compared with 6.4 per cent of other patients.

2.64 The report also noted that in some instances ATSI people had a lower rate for fillings. Fillings are viewed as attempts to restore damaged teeth and prevent further deterioration which may lead to the need for extraction. At emergency visits 23.4 per cent of ATSI patients received fillings, compared with 40.5 per cent of other patients. For both emergency and non-emergency visits, the trend across age groups was for the percentage of people receiving fillings to decrease for ATSI patients, whereas for other patients the percentage receiving fillings remained high. The report found that:

> Older Aboriginal and Torres Strait Islander patients… receive a pattern of dental care which involves more extractions and fewer fillings. This pattern indicates less favourable treatment processes.[83]

2.65 Indigenous Australians, whether or not they live in rural and remote areas, are recognised as being a significantly disadvantaged group. Their needs include access to affordable services, oral health education and prevention programs and services which are delivered in a way which ATSI people can feel confident in accessing.

Medically compromised patients

2.66 Evidence was received by the Committee that there was a small yet significant group of Australians whose illnesses put them in greater need of dental care than the general population and who, often, were disadvantaged in respect of that need.

2.67 Many medically compromised patients are affected by their illness to such an extent that they cannot continue working and, due to financial pressures, must rely on public dental services. In rural and remote areas there are often inadequate accessible public dental facilities and in cities the public facilities are over-burdened. The Committee was informed that:

> Some facilities have 2-3 years waiting lists whilst others have closed their waiting lists altogether citing inadequate resources and only providing relief

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82 AIHW, *Australia's Health 1996*, pp.28-29.

83 AIHW, *Australia's Health 1996*, pp. 178-179.

> from pain and are certainly unable to provide preventative dental care or a meaningful treatment plan for patients requiring more extensive treatment.[84]

2.68 A range of illnesses and treatments have implications for the oral health of the patient. These include heart disease, oral cancers, immunological conditions and organ transplants.[85] In such cases routine oral examinations are necessary. Often dental treatment is required before a patient can proceed with surgery, including heart valve replacement, organ transplant surgery, or radiotherapy to the head and neck. Patients with immune deficiencies such as AIDS often require biopsies of oral lesions and management of xerostomia (dry mouth). It is also noteworthy that the symptoms of a wide range of illnesses, including HIV, are often evidenced in the mouth.

2.69 Dr Foltyn gave evidence regarding the case of:

> People with specific medical problems that impact on oral health; or the reverse – the oral health complicates their medical management. For patients with head and neck cancer, very often the oral health is an integral part of their medical management; and unless you get it right with removal of teeth or cleaning the mouth up in patients who are having specific heart surgery, patients die. The mouth has to be clean.[86]

2.70 People with HIV/AIDS have a higher incidence of gingivitis, cavities, and dental disease than normal. Advances in HIV drug treatment have also been linked to more rapid deterioration in dental health by increasing the prevalence of xerostomia.[87] The early detection of oral symptoms of HIV by dentists can help save lives as preventative treatments may be possible.

2.71 The Australian Federation of AIDS Organisations (AFAO) reported difficulties in finding dentists with experience of dealing with HIV as well as extended waiting times at some HIV clinics. AFAO stated that people with HIV in rural areas were ‘among the most marginalised groups in the country’. AFAO referred to breaches of confidentiality regarding the HIV status of people in rural areas and the preference by many for the anonymity of the city, despite the transport costs involved. AFAO also noted that, as people with HIV/AIDS are living longer and many have allowed dental problems to worsen as they thought they would not live long, there is a need to extend the level of dental work undertaken at clinics (for example, to include crowns) in order to restore their appearance and possibly assist them to re-enter the workforce.[88]

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84 Submission No.59, p.3.

85 *Non dental pathology and systemic diseases with oral symptoms*, List tabled at hearing on 23.3.98 (DHSV).

86 *Committee Hansard,* 6.3.98, p.36.

87 Submission No.124, p.2.

88 Submission No.124, pp.3-5.

2.72 For many medically compromised patients, treatment or routine dental assessments are required on medical grounds and failure to provide treatment may further compromise their general health. Dr Foltyn gave the example of an elderly pensioner with a cancer in the mouth who required modification to her dentures and must pay for the service even though it is needed in order to assist her medical treatment.[89]

2.73 Dr Mark Schifter, of the Westmead Hospital Dental Clinical School, submitted to the Committee that the number of people who are economically disadvantaged due to significant ill-health, whether chronic debilitating medical problems or acute, major and devastating illnesses, is an ever increasing proportion of the population as a result of our ageing community and progress in interventional medicine. In his opinion:

> This group is badly disadvantaged for several reasons: this issue remains under-recognised; secondly, largely because of historical necessity, the main focus of public dental services, and its present workforce is to treat dental caries and its effects, for the relatively healthy, ambulatory, but economically deprived segment of the population.[90]

The homeless

2.74 The Committee received evidence that people who are homeless find it very difficult to access mainstream services and that homeless-specific services were vital to ensure fair access for this disadvantaged group.

2.75 The Council for Homeless Persons Australia cited a report it had produced which documented a 'deplorable' and 'appalling standard of oral hygiene' among the homeless and largely untreated dental decay and disease.[91] Statistics provided to the Committee by the Council included:

- of homeless people surveyed, more than half had tooth decay, 80 per cent had some form of disease and of those, 62 per cent had severe periodontal disease with advanced, irreversible damage;
- 37 per cent of the sample group had no teeth and of these, 30.6 per cent had no dentures. Of those with dentures, nearly half had been wearing them for more than 30 years, compared with an accepted norm of five years; and
- in the 12 months to June 1997, an estimated 147 000 people (of whom 31 per cent were children) used homeless services and a further estimated 304 000 requests for support or accommodation could not be met.[92]

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89 *Committee Hansard,* 6.3.98, p.34.

90 Submission No.74, p.2.

91 Submission No.48, p.4.

92 Submission No.48, pp.2, 5.

2.76 The Committee noted with concern the evidence of Dr John Wilkinson of the Sydney United Dental Hospital (UDH), regarding the fact that many young homeless people have open wounds in the mouth which leave them open to contracting a range of diseases including Hepatitis A, B and C and HIV.[93]

2.77 The homeless face barriers to access in the form of costs both of treatment and transport, waiting periods, substance dependencies and mental illness. Their transient lifestyle makes continuity of care difficult. Nevertheless, the Committee also received evidence that, despite the difficulties in meeting the needs of the homeless, there had been some success in using specially targeted programs.[94]

The mentally ill

2.78 Another disadvantaged group identified in evidence was the mentally ill. The Canberra Schizophrenic Fellowship informed the Committee that many of the people who develop mental conditions, such as schizophrenia or bi-polar disorder are too ill to work and are dependent on public dental care. The Fellowship advised that the onset of major mental illness often occurs in the late teens or early twenties and dental problems dealt with inappropriately in young people may subsequently become a source of major difficulties.[95]

2.79 The Fellowship noted that though there is access to public emergency dental care:

> it is almost impossible for most people with a mental illness to negotiate the methods for accessing emergency treatment… The effects of medication and of illness often make it difficult for people with a mental illness to make a phone call early in the morning. If they do manage to reach a phone, the lines are often engaged and the whole business becomes so frustrating that it is just too much for people who are already ill… It is not easy for many people who have a mental illness to wait for long periods of time. They may not always understand the consequences of leaving when they cannot stand any longer to be in a confined space.[96]

2.80 The UDH in Sydney referred to the mentally ill as one of the groups which had specific difficulties in accessing mainstream dental services. It submitted that this group needs transport, accompanying health workers and resource intensive preventative interventions in order to ensure appropriate and timely dental care.[97]

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93 *Committee Hansard,* 6.3.98, p.41.

94 Submission No.48, p.6.

95 Submission No.11, p.1.

96 Submission No.11, p.2.

97 Submission No.91, p.4.

Overseas-born, Language Other Than English (LOTE) speakers, including refugees

2.81 Members of this group suffer the obvious difficulties associated with language barriers to accessing services. Often they lack information on what services are available to them. There were almost 100 000 settler arrivals in Australia in 1995-96 and many settlers would find cost a barrier to good dental care.

2.82 The Committee received evidence that the dental needs of people from many immigrant communities have been found to be greater than those of locally born residents.[98] Information provided to the inquiry by the AIHW indicated that:

- Overseas-born, LOTE speakers had a higher percentage for whom dental visits were a large financial burden (15.8 versus 9.8 per cent) and who would have a lot of difficulty in paying a $100 dental bill (20.3 versus 13.5 per cent) than Australian-born, English speakers.
- Among those receiving publicly funded dental care, overseas-born, LOTE speakers had a higher percentage reporting emergency dental care than Australian-born, English speakers (67.9 versus 49.2 per cent).
- Among those receiving publicly funded dental care, overseas-born, LOTE speakers had a higher percentage with advanced periodontal attachment destruction (15.6 versus 6.1 per cent), yet they received a lower rate of preventative services (0.13 versus 0.23 services) and a lower rate of periodontal services (0.13 versus 0.24 services/courses of care) than Australian-born, English speakers.[99]

2.83 The Refugee Resettlement Committee in the ACT, informed the Committee that newly arrived refugees have, prior to arriving in this country, been in stressful situations where there were nutrition and hygiene problems and an almost total lack of dental health services. On arrival they usually have a great need for urgent and extensive dental treatment. The Resettlement Committee also submitted that, though provisions were made to assist refugees in accessing services, financial and staffing pressures often result in less than adequate treatment. Many migrants exist on low incomes, particularly if they must wait two years before being eligible for social security benefits.[100]

Forms of disadvantage

2.84 Just as a range of groups suffering disadvantage in dental care has been identified, so there are a number of forms of disadvantage that must be addressed if the inequalities in oral health are to be rectified. These are inter-related and it is common for more than one of them to affect those who are disadvantaged.

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98 Submission No.91, p.3.

99 Submission No.61A, pp.3-4. These results are from the analysis of data collected during 1994-96.

100 Submission No.72, pp.1-2.

2.85 As has been noted earlier, the cost of private dental care inhibits many Australians from seeking or maintaining a good standard of oral health. This fact was reinforced by the numerous submissions from members of the public as well as from comments in submissions by community organisations. The significant barrier which cost represents to many consumers was highlighted by the call made by COTA for an inquiry into the costs of dental care to create greater transparency regarding the costs of dentists' services,[101] as well as by the Health Issues Centre in Melbourne which sought a referral of the cost and pricing structures of dental services to the Australian Competition and Consumer Commission.[102] A significant number of submissions also called for some form of improved, subsidised dental system for the disadvantaged.

2.86 The relationship between dental treatment and income level indicates that those without the funds for private dental care have generally received treatment that has focused on emergency procedures rather than preventative and restorative care. Evidence referred to earlier in this chapter indicates that many disadvantaged Australians are caught in a cycle of emergency care, receiving dental treatment that eases the immediate burden of pain, but which is clearly second best in terms of their long term oral health.

2.87 Waiting lists in the public dental system are a factor directly affecting the type of care received. Evidence presented to the Committee painted a disturbing picture of waiting lists for public dental care ranging from months to years and, in some cases, closed lists. The dental problems of those waiting for treatment would usually have worsened by the time they receive treatment and several service providers indicated that, increasingly, they were forced to bring forward for treatment those patients whose oral health had reached emergency status. Such waiting times, which are far beyond that normally experienced by patients in the private system, clearly mitigate against a continuing program of care which focuses on prevention and longer term oral health.

2.88 Physical access to services is, without doubt, a significant issue for many Australians, particularly those living in rural and remote areas. Evidence already cited indicates that, in certain areas of this country, dental services are difficult to access and patients must travel considerable distances to receive care. Less obvious, though no less important, is the need to ensure that suitable services are accessible to other groups including the home bound and the institutionalised members of the community.

The use of private and public services in addressing disadvantage

2.89 It is clear to the Committee that in their current state, neither the public nor private dental systems are effectively meeting the needs of all Australians.

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101 Submission No.97, p.16.

102 Submission No.98, p.2.

2.90 A large number of Australians are unable to access private dental care and the experience of those reliant on the public system is that it cannot currently deliver services to meet the needs of all its clients. Burgeoning waiting lists, the increasing focus on emergency rather than maintenance or preventative work and cuts to services mean that, for many, the likelihood of accessing appropriate care is diminishing. Yet the need for public dental care is growing. The Committee also notes that, the longer members of the community have inadequate dental care, the more their problems will compound and the more difficult and expensive it will be to rectify those problems.

2.91 As previously noted, annual expenditure in Australia on dental services is nearly $2 billion. In 1994-95 the Commonwealth Government spent $105 million and State Government expenditure was approximately $141 million in this field.[103] Over the five financial years 1990-91 to 1994-95 Commonwealth Government expenditure grew from $33 million to $105 million. Its expenditure has since dropped as a result of the CDHP's cessation. State Government expenditure over the same period increased from $117 to $141 million and, according to Professor Spencer of the AIHW, there is little evidence of a withdrawal of funding by State Governments with the implementation of the CDHP.[104]

2.92 The Committee received evidence regarding the fact that dental services are the least subsidised area of health services and that its situation is atypical when compared with other areas of health service which the Commonwealth is enabled by the Constitution to fund. In 1994-95 two thirds of the total expenditure on health services was subsidised by government. Government subsidises 74 per cent of expenditure on institutional services, 83 per cent of expenditure on medical services and just under half of expenditure on pharmaceuticals. By comparison, dental services received only a 13 per cent government subsidy and that was in the year the Commonwealth made a substantial contribution through the CDHP.[105] This differentiation between dental and general health was an issue which received widespread unfavourable comment in evidence to the Committee.

2.93 Although there is an undersupply of dental professionals in certain rural and remote areas, there was no evidence put to the Committee that as a nation, we are undersupplied with professionals to service Australia's population or that Australia lacks the capacity to meet the needs of those who are disadvantaged under the current arrangements.

2.94 While there is no single solution to the problems described above, the Committee is of the view that vast improvements can be made to meet the needs of the disadvantaged by better utilising the capacities of both the private and public sectors. As the South Australian Dental Service stated:

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103 *Committee Hansard,* 23.3.98, p.97.

104 Submission No.61, Attachment, *Policy Options for Public Funded Dental Care,* p.2.

105 Submission No.61, Attachment, p.3.

> The capacity of the private and public dental services to meet the current and future needs of low income and other disadvantaged groups was well demonstrated during the life of the Commonwealth Dental Health Program. That willingness and capacity continues to exist.[106]

106 Submission No.86, p.26.

CHAPTER 3

COMMONWEALTH DENTAL HEALTH PROGRAM

3.1 This Chapter reviews the operations of the Commonwealth Dental Health Program (CDHP). The Chapter discusses the benefits and deficiencies of the Program and reviews the impact the CDHP has had since its abolition on the main beneficiaries of the Program, including aged people and other socially and economically disadvantaged groups in the community.

Background to the operation of the CDHP

3.2 The CDHP, based on the recommendations of the 1991 National Health Strategy, was introduced in January 1994. The National Health Strategy documented in a Background Paper titled *Improving Dental Health in Australia* social inequalities in oral health status and access to dental care among Australian adults. The CDHP had the overall objective of improving the dental health of financially disadvantaged people in Australia. The specific aims of the Program were:

- to reduce barriers, including economic, geographical and attitudinal barriers, to dental care for eligible adults;
- to ensure equitable access of eligible persons to appropriate dental services;
- to improve the availability of effective and efficient dental interventions for eligible persons, with an emphasis on prevention and early management of dental problems; and
- to achieve high standards of program management, service delivery, monitoring, evaluation and accountability.[1]

3.3 The principal objectives of the Program were to direct the dental care received by adult Health Card holders from emergency to general dental care; extraction to restoration; and treatment to prevention.[2]

3.4 States signed Agreements with the Commonwealth Government for the years 1993-94 to 1996-97. The Western Australian Agreement operated from 1994-95 to 1996-97. The Agreements specified the aims and structure of the Program, Commonwealth and State/Territory responsibilities, as well as financial, data collection and evaluation arrangements that governed the grant of funds. The conditions set out the basis under which the States agreed to provide a specified number of services to eligible persons. The conditions also specified that States had to

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1 AIHW Dental Statistics and Research Unit, *Commonwealth Dental Health Program Evaluation Report 1994-96*, AIHW, 1997, pp.5-6.

2 AIHW study , p.1.

maintain their baseline level of recurrent funding to adult dental services under the Program.[3]

3.5 The CDHP funding was allocated to two separate components – the Emergency Dental Scheme (EDS) and the General Dental Scheme (GDS). The EDS was implemented to broaden the possible range of treatment options for patients making emergency or problem visits. Specifically it was aimed at increasing the retention of teeth through treatment of disease with fillings rather than extractions. The GDS was implemented to draw people receiving public-funded care into routine general dental care.[4]

3.6 A total of $245 million was provided by the Commonwealth under the Program over the four years from 1993-94 to 1996-97 inclusive. This comprised payments to the States of $240 million for service provision and State administration costs and a further $4.6 million for national projects and evaluation purposes.[5] The Commonwealth ceased funding the CDHP on 31 December 1996, following which the States resumed full responsibility for public dentistry.

Eligibility

3.7 Holders of Health Cards and their dependants aged 18 years or more were eligible for services under the CDHP. From 1 July 1994, eligibility was broadened to include holders of the new Commonwealth Seniors' Health Card. At the commencement of the Program there were some 4.12 million Health Card holders Australia wide who were eligible for services under the Program. In December 1994 the number of eligible clients was 4.46 million. The later figure included adult dependants and approximately 30 000 Commonwealth Seniors' Health Card holders. School age children of Health Card holders were not covered under the Program. All States provided access to dental care for students who were dependants of Health Card holders through the School Dental Service or the Adult/General Dental Services.[6]

Service exclusions

3.8 The CDHP provided for basic levels of dental care. Full and partial dentures were specifically excluded from the Program (as programs for these services already existed in most States), as were other specialist services such as crowns, bridges and orthodontics. The expensive nature of these services was such that their inclusion under the Program would have necessarily meant that fewer people would have been able to access basic levels of care.[7]

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3 Submission No.121, p.2.

4 AIHW study, p.72.

5 Submission No.121, p.3.

6 Submission No.121, p.1.

7 Submission No.121, p.2.

Target numbers

3.9 In accordance with the Agreements with the States throughput measures were agreed annually, as initially it was difficult to be precise about how many people would be treated under the Program. Under the Program a total of 1.5 million services were provided to eligible adults.[8]

Benefits provided by the CDHP

3.10 Evidence to the Committee suggested that the Program had been generally successful in terms of providing access to services for low income groups, reduction in waiting lists and in the shift in treatment options away from extractions and towards restorative treatments.[9]

3.11 The Australian Council of Social Service (ACOSS) stated that 'there is significant evidence that the Commonwealth Dental Health Program was very successful and that its abolition has had an immediate and very damaging impact on the ability of low income people and other disadvantaged Australians to receive the oral health care they need'.[10] The Victorian Healthcare Association also argued that the Program enabled greater access to dental services for 'high need groups' such as the homeless, indigenous Australians, people living in rural and remote areas, new migrants and people with disabilities.[11]

3.12 The views expressed to the Committee in relation to the general success of the Program were supported by evaluation studies conducted by the Australian Institute of Health and Welfare (AIHW) Dental Statistics and Research Unit. The Unit conducted a series of surveys designed to assess the Program's effectiveness in changing the profile of oral health and access to dental care of the eligible Card holder population relative to the broader community.[12]

3.13 The AIHW evaluation of the Program concluded that:

> The CDHP increased the number of eligible card-holders who received public-funded dental care in any year, reduced their waiting time, increased their satisfaction with care, and moved the provision of services in the direction of less extractions and more fillings. However, during the 24

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8 Submission No.121, p.2. DHFS stated that the 1.5 million figure strictly relates to occasions of service, rather than to individuals as a number of clients received more than one service under the Program. See *Committee Hansard,* 6.3.98, p.16.

9 Submissions No.120, p.6; No.61, p.7; No.38, p.4; No.53, p.4; No.85, p.7; No.107, p.5; No.63, p.3. See also *Committee Hansard,* 6.3.98, p.18.

10 Submission No.120, p.6.

11 Submission No.63, p.3.

12 These surveys included information from the wider community via annual national telephone interview surveys with an associated postal survey of satisfaction with care received; from eligible card holders who received publicly funded care; and about publicly funded services provided to card holders. See AIHW study, p.1.

> months since implementation, a substantial shift from emergency to general dental care was not achieved, which will have limited the movement away from extractions and added to provider dissatisfaction. Despite improved public-funded dental care for more card-holders, card-holders are still disadvantaged in terms of their oral health and access to dental care.[13]

3.14 The AIHW found that eligible card-holders benefited from the Program with 200 000 additional persons receiving public-funded dental care in any year (under the full funding in 1995-96). Some 616 000 persons who had received public funded dental care prior to the CDHP, also benefited from shifts in the mix of services with the additional resources available under the Program.[14]

Waiting times

3.15 Evidence to the Committee suggested that the CDHP lead to a significant reduction in waiting times for dental treatment.[15] The AIHW in its evaluation report stated that in the two years following the introduction of the Program the proportion of card holders waiting less than one month for a check-up increased from 47.5 per cent to 61.5 per cent, and those waiting for 12 months or more decreased from 21.1 to 11.3 per cent.[16] Dental Health Services Victoria (DHSV) stated that prior to the introduction of the Program waiting lists of up to 5 years applied for general dental care. Under the CDHP waiting lists for general treatment decreased to about 6 months on average.[17]

3.16 Dr Robert Butler, Executive Director of the Australian Dental Association (ADA), argued that the introduction of the Program:

> …produced an incredibly beneficial effect on its waiting lists. In a very, very short time these waiting lists that I have referred to as being about two years in the dental hospitals were down to below six months. That was a very, very rapid reduction. Not only was it a reversal of the numbers of people on the waiting list, but it was a growing figure before and it became a declining figure. So it had a tremendous effect on access.[18]

Treatment profiles

3.17 The preventative focus of the CDHP was emphasised, as evidence indicated that the Program led to fewer extractions and more fillings being received by recipients. The ADA stated that as a result of the Program ‘dental health status was

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13 AIHW study, p.4.

14 AIHW study, pp.1-2, 73.

15 See Submissions No.63, p.3; No.77, p.2; No.120, p.6.

16 AIHW study, p.2.

17 Submission No.67, p.14. See also Submission No.51, p.5.

18 *Committee Hansard,* 6.3.98, p.18.

improved and fewer teeth were being lost as a result of dental diseases'.[19] The Health Department of Western Australia similarly noted an effect of the Program was to move people from emergency care to the restorative focus of the Program as people were encouraged to try to retain teeth and maintain their dentition.[20] The NT Government also referred to this positive change in attitude towards dental health.[21]

3.18 The AIHW study found that in the two years following the introduction of the Program, Card holders received fewer extractions (especially among those last visiting for a problem, 43.8 to 36.5 per cent) and more fillings (among those last visiting for a check-up, 21.7 to 53.5 per cent). The study also found that here was a decreased perceived need for extractions or fillings among card holders and an increase perceived need for check-ups.[22]

More frequent dental visits

3.19 Under the Program there was also a pattern of more frequent visits for dental care. The AIHW study found that the proportion of card holders who made a dental visit in the previous 12 months increased from 58.6 to 67.4 per cent.[23] The ADA noted that the Program enabled card holders 'many who had previously resigned themselves to episodic emergency care only were able to enjoy the benefits of access to dental treatment resources'.[24]

Other benefits

3.20 The AIHW identified a number of secondary benefits under the CHDP. These included the development of a dental policy focus in the Commonwealth Department of Health and Family Services (DHFS), the support of management information systems in the States and Territories (which required annual dental plans) and participation in the monitoring and evaluation of adult access to dental care (conducted by the AIHW Dental Statistics and Research Unit). AIHW stated that as a result 'a better informed environment emerged which could sustain more detailed dental health policy analysis, leading to improved service and oral health'.[25]

3.21 Further, the AIHW noted that a number of smaller ancillary activities were supported such as the Remote and Aboriginal Dental Care Demonstration Projects and

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19 Submission No.51, p.5.

20 Submission No.130, p.3.

21 Submission No.133, p.6.

22 AIHW study, p.2.

23 AIHW study, p.2.

24 Submission No.51, p.5.

25 AIHW study, p.84.

Rural Dental Projects under the National Oral Health Advisory Committee and the Quality Assurance Program which was being developed.[26]

3.22 In 1995 the National Oral Health Advisory Committee approved several projects aimed at improving access and equity in rural and remote areas, particularly for Aboriginal and Torres Strait Islander communities. A total of $677 312 was provided for twelve months, ending in June 1996, for five remote areas demonstration projects. These included funding for the Durri Aboriginal Medical Service (AMS), based in Kempsey NSW, for a new mobile dental clinic to serve additional communities and the Western District of Central Australia, based in Alice Springs, to expand the dental team and permit more time to be spent in remote communities.[27]

3.23 In addition, $1.9 million was approved in February 1996 under the National Oral Health Advisory Committee rural initiatives program, for 12 months funding of initiatives in rural areas to provide mobile dental teams for priority areas identified by the States as lacking services or with long waiting times.[28] AIHW stated that these demonstration projects were ‘important public dental health initiatives and rare instances of a national focus on oral health and dental care in Australia’.[29] DHFS also noted that the demonstration projects piloted effective methods of reaching rural and remote communities, including the training of local Aboriginal Health Workers.[30]

Deficiencies of the CDHP

3.24 Notwithstanding the many positive features of the CDHP identified in evidence to the Committee a number of criticisms were made of the Program. These criticisms largely related to features of the Program, which would have been addressed by a more comprehensive oral health program and were aimed particularly at enhancing the delivery of services under the CDHP.

3.25 One deficiency noted by the ADA and AIHW was the restricted range of services offered for the treatment of patients.[31] The ADA stated that in many cases this encouraged removal of teeth, which could have been saved. The Association argued that comprehensive dental treatment options must be available to all patients.[32] The ADA noted, however, that while there were initially ‘some deficiencies in obvious preventive treatments that were offered under the program…we did get some change early in the program as a result of our lobbying on that’.[33]

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26 AIHW study, p.3.

27 Submission No.121, p.4.

28 Submission No.121, pp.4-5.

29 AIHW study, p.84.

30 Submission No.121, p.6.

31 AIHW study, p.3.

32 Submission No.51, p.10.

33 *Committee Hansard,* 6.3.98, p.22.

3.26 Another problem identified by the ADA, AIHW and Public Health Association of Australia (PHA) was that the relatively low level of fees for referrals to private practice meant that there was not sufficient incentive to encourage widespread practitioner participation in the Program.[34] The ADA noted that in many cases, these fees 'did not even cover costs and it was difficult to persuade many practitioners to undertake treatment for public patients under these circumstances'.[35] The ADA further noted, however, that many of the serious anomalies in the Government fee scale have recently been addressed so that this potential barrier to the profession's participation in future programs would not occur.[36]

3.27 The ADA stated that the Association 'collectively and nationally – supported by states – supported the principle of the Commonwealth dental health program'.[37] The ADA noted that while there were 'pockets of resistance' to participation in the CDHP, especially from sections of the profession in NSW, generally around the country participation by the profession was 'quite good'.[38] The AIHW also indicated that the majority of dentists, when offered the opportunity, participated in providing services under the Program.[39]

3.28 Another problem raised by the ADA concerned certain administrative problems with the CDHP such as the separation of emergency and general dental care and the nature of some referrals, for instance for items not covered under the Program. The ADA noted, however, that these problems were 'fairly minor'.[40] The AIHW noted that most of the concerns raised in relation to the Program could be addressed by policy changes leading to restrictions on emergency care and an emphasis on a more comprehensive, but highly targeted dental care program.[41]

3.29 The AIHW also noted that despite the intention of the CDHP of moving away from emergency dental care towards general dental care, there was only a small shift in public funded care away from problem and emergency care. The AIHW noted that emergency dental care is associated with higher rates of tooth extraction and lower rates of fillings for decayed teeth.[42]

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34 Submissions No.51, p.10; and No.73, p.3; AIHW study, p.3.

35 Submission No.51, p.10.

36 Submission No.51, p.10.

37 *Committee Hansard,* 6.3.98, p.22.

38 *Committee Hansard,* 6.3.98, pp.22-23.

39 AIHW study, p.3.

40 *Committee Hansard,* 6.3.98, p.22.

41 AIHW study, p.3.

42 AIHW study, p.2.

Impact since cessation of the CDHP

3.30 The abolition of the CDHP has had significant effects on the dental care needs of low income and disadvantaged people. The major impacts have been on public dental waiting lists and waiting times, and an overall deterioration in the oral health status of low income and disadvantaged groups in the community.

3.31 The ADA, commenting on the social impact on people since the termination of the Program, stated that:

> Preventable disease has not been addressed and irreparable damage and loss of teeth has resulted. State dental health budgets have been severely attenuated with this loss of funding and the States have not generally been able to make up this shortfall... In most areas of Australia, a waiting time for a simple filling now involves a period of some two years at least and tooth extraction rates are again increasing.[43]

3.32 The PHA, commenting on the adverse effects of the cessation of the Program, stated that:

> The axing of the program in January 1996, just as it was showing positive oral health and access outcomes was a major blow to the provision of publicly funded oral health care. Its demise has left a large gap in access to oral health services for those who traditionally received inadequate oral health care. In addition, the loss of the CHDP has effectively generated a large demand for oral services which is now largely unmet.[44]

Waiting lists and waiting times

3.33 Evidence received by the Committee indicated that since the abolition of the CDHP waiting lists and waiting times for treatment have increased dramatically.[45] At the time of the cessation of the Program in December 1996 there were approximately 380 000 Health Card holders on public waiting lists across Australia, representing an average waiting time of 6 months for non-emergency dental treatment. Currently there are some 500 000 people nationally on waiting lists, representing waiting times ranging from 8 months to 5 years (see the table below).[46]

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43 Submission No.51, p.5.

44 Submission No.73, p.3.

45 Submissions No.51, p.5; No.67, p.15; No.120, p.6; No.103, p.5; No.125, p.7.

46 Submission No.67, p.15.

Table 1: Waiting Lists for Publicly Funded Dental Care with the Loss of the CDHP

	Number of people-mid 1996	Number of people-mid 1997	Estimated average waiting time
NSW	78 000	140 000	Up to 58 months
SA	53 800	78 000	22 months
ACT	1 400	3 600	15 to 30 months
TAS	Not available	13 400	30 months
VIC	101 000	143 000	16 months
QLD	Not available	69 000	10 months
WA	Not available	11 000	8 months

Source: Submission No.67 (Dental Health Services Victoria), p.15.

3.34 The ADA also noted that since the termination of the Program 'waiting lists have blown out and there are now over half a million people on waiting lists for general dental care throughout Australia. This number represents only those Health Care Card Holders who have placed their names on the lists and there are many more who have simply given up due to the waiting times involved'.[47]

3.35 ACOSS also remarked that in the short time since the abolition of the Program waiting lists 'have grown by 20 per cent and now stand at half a million. One hundred thousand people have joined the queue for services in the past twelve months as a result of this short-sighted expenditure cut'.[48]

3.36 The Committee notes that the House of Representatives Standing Committee on Family and Community Affairs commented in an October 1997 report that since the cessation of the CDHP 'there is now some evidence that waiting times for public dental treatment are increasing'. The House of Representatives Committee recommended 'that the Commonwealth Government conduct an annual review of waiting periods for public dental treatment, with a view to ensuring waiting periods do not revert to those experienced prior to the introduction of the Commonwealth Dental Health Program'.[49]

3.37 Information provided from State and Territory Governments and dental services has confirmed the significant increase in the numbers of people on waiting lists and in waiting times for public dental services since the cessation of the Program.

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47 Submission No.51, p.5.

48 Submission No.120, p.6.

49 House of Representatives Standing Committee on Family and Community Affairs, *Concessions – WhoBenefits? Report on Concession Card Availability and Eligibility for Concessions*, October 1997, p.79.

3.38 In New South Wales waiting lists have increased from 92 066 in 1995-96 to 118 504 in 1996-97, with waiting times increasing in some areas to 58 months.[50] At the United Dental Hospital (UDH) of Sydney, which serves residents of Central and South Eastern Sydney, the waiting time for general adult dental care was 4 months in June 1996 when the CDHP was in full operation. After the abolition of the Program, the waiting time increased to 16 months in June 1997 and 20 months in December 1997.[51]

3.39 In Victoria waiting times increased between June 1996 and June 1997 from 12 months to an average of 18 months for general dental care. In the same period the number of people waiting for dental care increased from 101 000 to 139 000.[52] In South Australia waiting lists increased from 41 000 in May 1996 to 77 000 in November 1997 and waiting times from 12 months in August 1996 to 23 months by the end of November 1997.[53] Other States/Territories reported similar increases in waiting times for dental services.[54]

Change from general care to emergency care

3.40 Evidence indicated that since the cessation of the CDHP there has been a shift in the type of care provided by public dental services towards emergency care.[55] Dr Butler of the ADA stated that:

> What is happening now is that the patients who do get access to the public facilities are more often than not very heavily restricted to emergency care only. …in some major hospitals, patients are coming back every five or six months with another crisis – having another tooth extracted or something. That is the sort of dentistry that we had hoped had gone out years ago.[56]

3.41 The Council of Social Service of NSW (NCOSS) also noted that:

> Long waiting times will also mean that the public system becomes increasingly focused on emergency care. Disadvantaged people who are discouraged from seeking care by extremely long waiting lists are much more likely to access services when an emergency situation occurs.[57]

3.42 Analysis of services provided in public dental clinics also indicates that the rate at which teeth are extracted has increased since the abolition of the Program. In

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50 Submission No.131, p.11.

51 Submission No.91, p.6.

52 Submission No.127, p.10.

53 Submission No.86, pp.11-14.

54 Submissions No.41, p.2; No.77, p.3; No.130, p.3.

55 Submissions No.86, p.14; No.91, pp.6-8; No.120, p.6.

56 *Committee Hansard,* 6.3.98, p.19.

57 Submission No.53, p.3.

Victoria the number of extractions increased 10 per cent between July 1996 and October 1997.[58] A similar trend was seen in South Australia, although the increased extraction rate was 6 per cent over the same period.[59] The UDH in Sydney also reported a higher proportion of persons presenting for emergency care who received extractions in 1997 (40 per cent) than in 1996 (31 per cent).[60]

3.43 DHSV stated that the increasing extraction of teeth is a particular concern because extractions are a major cause of functional problems of a dental origin (eating, speaking, and socialising) and is the major inequality in oral health suffered by low income earners.[61]

Community expectations

3.44 Some evidence suggested that the CDHP raised awareness of dental care among the eligible adults and encouraged people to expect a certain standard of dental care, which is now not generally available.[62] Dr Dell Kingsford Smith of the UDH in Sydney asserted that:

> The level of dental awareness and of the rights that people had during that window of opportunity of the Commonwealth dental health program… was so great that people now have an enormous expectation that that is the level of care they ought to be getting.[63]

3.45 The Northern Territory Government also argued that the CDHP had ‘influenced a positive change to dental health’ for clients in both remote and urban locations. Their submission stated that:

> Until the inception of the CDHP, demand for dental programs was relatively low for reasons including low priority of dental health within the general sphere of health, lack of knowledge about the impact of poor dental health…and acceptance of pain. With the advent of preventive programs established under CDHP, many clients chose to keep their teeth rather than resort to extractions because of delayed access to treatment.[64]

Effect on individuals

3.46 The Committee received anecdotal evidence from numerous pensioners and other people on low incomes which expressed their concern at growing waiting lists for dental services and the personal pain and anguish they are experiencing as a result

58 Submission No.127, p.10.

59 Submission No.86, p.15.

60 Submission No.91, p.8.

61 Submission No.67, p.16.

62 Submissions No.130, p.3; No.131, p.8; No.133, p.6.

63 *Committee Hansard,* 6.3.98, p.44.

64 Submission No.133, p.6.

of the abolition of the Program. One 70-year old pensioner stated that she could ‘no longer afford dental treatment’.[65] Another elderly pensioner wrote saying that he required ‘urgent treatment to save the teeth I have left’.[66] Another pensioner stated that measures were needed to ‘help us poor pensioners to regain what should be a right in a rich country so that we can at least preserve our physical dignity’.[67]

3.47 Welfare groups similarly emphasised the deleterious effect of the abolition of the Program on individual pensioners and beneficiaries.[68] The Council on the Ageing (COTA) reported that its Seniors Information Service in NSW received over 100 calls between July and November 1997 on dental care issues following the abolition of the CDHP. The majority of the calls were from older people wanting information as to where they might obtain dental care sooner than relying on the public system.[69] A survey conducted in South Australia in 1997 of low income clients of financial counselling agencies found that 51 per cent of respondents reported needing urgent dental attention and 60 percent had experienced toothache in the last twelve months necessitating immediate action.[70]

3.48 DHSV stated that State dental programs now are only able to treat the immediate problem causing the dental emergency and place the person’s name on a waiting list. As the waiting lists generally exceed two years the person’s oral condition deteriorates further before a course of care is available; the person often suffers repeat episodes of pain and emergency treatment while on the waiting list; and treatment is more complex and costly as a result of the time interval taken to treat the condition.[71]

Effect on State/Territory funding

3.49 The Committee received evidence that since the cessation of the CDHP most State and Territory governments have been unable to make up the expenditure shortfall as a result of the withdrawal of Commonwealth funding, and therefore have a reduced capacity to respond to the oral health needs of the most disadvantaged groups in the community. The Queensland Government indicated that it has maintained full replacement funding for dental services in that State following the cessation of the Program.[72]

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65 Submission No.14, p.1.

66 Submission No.27, p.1.

67 Submission No.26, p.1.

68 Submissions No.120, p.6; No.85, pp.3-5; No.53, p.3.

69 Submission No.97, p.8.

70 Submission No.105, pp.1-5. See also Submission No.107, pp.4 -6.

71 Submission No.67, p.18.

72 Submission No.128, pp.2, 5-6.

3.50 The New South Wales Government submission noted that the abolition of the CDHP has resulted in a $34 million reduction in Commonwealth funding for NSW for general oral health care. The New South Wales Government stated that:

> This has had profound effects on the oral health of the NSW population and the ability of the Area Dental Services to provide oral health care. The loss of the Commonwealth Dental Health Program resulted in a 47 per cent reduction of funding for adult oral health care annually resulting in approximately 230 000 pensioners and other Social Security beneficiaries no longer being able to access oral health care.[73]

3.51 The New South Wales Government further stated that while the Commonwealth has ceased funding the CDHP, NSW increased its funding for general dental services by $2 million to $69 million in 1997-98.[74]

3.52 In evidence to the Committee, the South Australian Dental Service stated that:

> The loss of the Commonwealth Dental Health Program funding has had significant implications for the financial capacity of the South Australian Government through the South Australian Dental Service, in being able to realistically meet the current, let alone the future dental care needs of low income earners and other disadvantaged groups in this State.[75]

3.53 Other States and Territories expressed similar concerns. In the ACT the Territory dental service indicated that funding was reduced by almost 50 per cent of its adult dental care budget with the abolition of the CDHP.[76] The Northern Territory Government stated that funding constraints have led to a reduction in the number of dental teams in certain areas. The submission noted that CDHP funding cuts will impact 'disproportionately' on rural dental services in the Territory.[77] The Western Australian Department of Health stated that the Western Australian Government does not have sufficient resources to meet the increased demand for dental services following the withdrawal of the CDHP and that without the involvement of the Commonwealth Government 'there will not be an adequately resourced basic dental health program for adults in Australia'.[78]

Reduced access to dental services

3.54 The cessation of the CDHP has led to a diminished capacity of most States and Territories to respond to the oral health needs of the eligible population. In New South Wales, the Government stated that the loss of the Program has resulted in a

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73 Submission No.131, p.11.

74 Submission No.131, p.9.

75 Submission No.86, p.8.

76 Submission No.77, p.3; *Committee Hansard,* 6.3.98, pp.83-85.

77 Submission No.133, p.6.

78 Submission No.130, p.4.

47 per cent reduction of funding for adult oral health care annually resulting in approximately 230 000 pensioners and other social security beneficiaries no longer being able to access oral health care.[79] The Victorian Government stated that in 1995-96 some 211 600 people received public dental services, whereas in 1996-97 only 172 000 accessed care.[80] In Queensland, the State Government noted that without the decision of that Government to provide full replacement funding following the abolition of the Program services to eligible adults would have had to be reduced by some 120 000 treatments annually.[81]

3.55 The Committee received evidence that the abolition of the CDHP has had a severe impact on the ability of the aged and other low income and disadvantaged groups to receive an appropriate level of oral health care.[82] As noted in Chapter 2, these groups suffer particular disadvantage in accessing dental services and generally have poorer oral health than other people in the community. The effect of the cessation of the Program on these groups is discussed below.

Aged people

3.56 Several organisations, including COTA, Aged Care Australia (ACA) and the National Seniors Association (NSA) stated that the withdrawal of the CDHP has significantly reduced access by older people to public dental health services.[83] COTA emphasised that dental health care is a 'core health issue' for older people because of its implications for their quality of life.[84]

3.57 ACA stated that for older people:

> Extremely long waiting lists severely restrict access with the result that timely access to dental health care for prevention and maintenance is unavailable. Because of the inability of many older people to afford private dental health care services, many are denied access to any dental health care.[85]

3.58 Evidence also indicated that access to dental health services is a particular problem for older people in nursing homes and residential care facilities.[86] ACA stated that the demise of the CDHP saw the cessation of mobile dental health units to older people in residential care in some metropolitan areas. Dental health services are not included in the residential care prescribed services and thus residents must pay for

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79 Submission No.131, p.13.

80 Submission No.127, p.10.

81 Submission No.128, p.5.

82 Submissions No.120, p.6; No.53, p.3; No.97, pp.7-8.

83 Submissions No.97, pp.7-9; No.49, p.2; No.83, p.3. See also *Committee Hansard,* 23.3.98, pp.112-18.

84 *Committee Hansard,* 23.3.98, p.112.

85 Submission No.49, p.2.

86 Submission No.59, pp.5-6 and Submission No.97, p.7.

these services themselves. For many older people the cost of private dental health care is prohibitive.[87]

People in rural and remote areas

3.59 Organisations representing people living in rural and remote areas stated that with the abolition of the CDHP many people in these areas would be without ready access to dental care. The organisations stated that the Program provided many areas in rural Australia with access to public dental care services for the first time.[88] The National Rural Health Alliance (NRHA) stated that the Program 'was clearly meeting a need for people on low incomes, including many in rural and remote areas.'[89] In Western Australia the Program was available to some 100 000 people in rural and remote areas of the State, but since its termination the number of people in country areas eligible for subsidised services has fallen to 65 000.[90]

3.60 Health Consumers of Rural and Remote Australia (HCRRA) noted that increasing waiting times will adversely affect many rural families with many families now only able to visit a dentist in crisis situations. HCRRA also noted that the limited transport available means that families must travel substantial distances for often long awaited appointments and must incur the additional accommodation and out-of-pocket expenses.[91]

Aboriginals and Torres Strait Islanders

3.61 The Committee received evidence that Aboriginal and Torres Strait Islander (ATSI) communities have been adversely affected by the abolition of the Program.[92]

3.62 The National Aboriginal Community Controlled Health Organisation (NACCHO) argued that some regions have been 'hit particularly hard' by the cessation of the CDHP. In NSW several Aboriginal Community Controlled Health Services (ACCHSs) have had their dental positions cut – 'a similar fate has befallen ACCHSs across the country'.[93] The Northern Territory Government indicated that dental service teams operating from Darwin, Alice Springs, Katherine and Gove had been reduced or had their services modified following the cessation of CDHP funding.[94]

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87 Submission No.49, p.2.

88 Submission No.40, p.1 and Submission No.129, p.6. See also *Committee Hansard,* 6.3.98, pp.56-65.

89 *Committee Hansard,* 6.3.98, p.58.

90 *Committee Hansard,* 6.3.98, p.58.

91 Submission No.40, p.1.

92 Submissions No.78, pp.5-7 and No.23, pp.7-11. See also *Committee Hansard,* 6.3.98, pp.66-78.

93 Submission No.78, p.6.

94 Submission No.133, pp.5-6.

3.63 The impact of the cessation of the Program on local Aboriginal communities was illustrated in the case of the Durri Aboriginal Medical Service (AMS). The Durri AMS stated that since July 1997 it has been unable to provide dental health services to the local Aboriginal community of the North Eastern region of NSW after providing the service successfully for 18 months prior to the abolition of the CDHP.[95] The AMS stated that the service 'was well received by the community members and provided an essential service that has been overlooked for many years'.[96]

3.64 NACCHO stated that in other States such as Tasmania, the abolition of the CDHP would mean ACCHSs would be forced to make fee-for-service payments to dentists in private practice to keep pace with the demand for dental services. [97]

Medically compromised patients

3.65 Evidence indicated that medically compromised patients have had reduced access to public dental services as a result of the cessation of the Program.[98] Dr Peter Foltyn, a Consultant Dentist at St Vincent's Hospital, Sydney, in evidence to the Committee, outlined the problems faced by these patients, including long waiting lists for public treatment in hospitals in the larger cities, and the often inadequate provision of public dental facilities in rural and remote areas.[99]

3.66 Dr Foltyn stated that many patients requiring dental treatment as part of their medical management before undergoing a surgical or medical procedure have been 'unable to access the appropriate treatment in the public sector'.[100] Dr Foltyn added that the abolition of the Program 'has denied many patients ready access to a treatment adjuvant to their primary medical condition'.[101]

Other disadvantaged groups

3.67 The Council for Homeless Persons noted that the CDHP was important in providing access to dental care for homeless people. The Council noted that, for example, the Program enabled the Gill Dental Health Clinic at the Salvation Army in Melbourne to treat over 1 000 homeless people in the nine months to August 1996. Prior to the establishment of the Program the Clinic could only offer a rudimentary service to homeless people.[102] The Council stated that 'people who are homeless were

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95 Submission No.23, p.10.

96 Submission No.23, p.9.

97 Submission No.78, p.6.

98 Submission No.91, pp.4, 9; *Committee Hansard,* 6.3.98, pp.34-38.

99 Submission No.59, p.3.

100 Submission No.59, p.3.

101 Submission No.59, p.6.

102 Submission No.48, p.5.

able, often for the first time, to pursue dental treatment that was both accessible and affordable'.[103]

3.68 Organisations representing people with intellectual disabilities also argued that the abolition of the Program was causing problems of access to dental care. The Intellectual Disability Services Council stated that 'almost without exception people with intellectual disability are poor, and rely upon a number of public services for their well being'.[104] The organisations noted that increasing waiting lists are causing pain and discomfort for people with disabilities unable to access dental services and additional worry and concern for their carers.[105]

3.69 Organisations representing people with HIV/AIDS stated that people with AIDS have been disadvantaged as a result of the cessation of the Program which has reduced access to dental services for AIDS sufferers, particularly those who are already financially disadvantaged.[106] The Australian Federation of AIDS Organisations (AFAO) stated that the abolition of the CDHP has 'caused financial pressure and increased difficulties for positive people – a community with a much greater need for dental services than the general population'.[107]

Conclusions

3.70 Evidence to the Committee indicates that the CDHP was successful in meeting its aims, especially in terms of providing greater access to dental services for low income and other disadvantaged groups in the community. Since the cessation of the Program access to dental care has been reduced with increasing public dental waiting lists. There are now over half a million people on waiting lists for general dental care throughout Australia. The Committee believes that it is unacceptable that this situation should occur contributing as it does to social inequalities in the community and affecting the most vulnerable and disadvantaged groups in society.

3.71 Evidence to the inquiry also indicates that there has been an overall deterioration in the oral health status of persons previously utilising services under the CDHP and a shift in the type of care provided from general dental care to emergency care. Evidence presented to the Committee also showed that since the abolition of the Program most State and Territory Governments have been unable to make up the expenditure shortfall caused by the withdrawal of Commonwealth funding which is affecting the ability of most State and Territory Governments to respond to the needs of the most disadvantaged groups in the community.

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103 Submission No.48, p.4.

104 Submission No.45, p.1.

105 Submission No.45, p.1 and Submission No.11, pp.1-2.

106 Submission No.124, pp.1-5 and Submission No.119, pp.1-6. See also *Committee Hansard,* 6.3.98, pp.37-38.

107 Submission No.124, p.1.

CHAPTER 4

COMMONWEALTH'S RESPONSIBILITY FOR THE PROVISION OF DENTAL SERVICES

4.1 This Chapter considers the terms of reference dealing with the nature of the Commonwealth's responsibility to make laws for the provision of dental services pursuant to section 51(xxiiiA) of the Australian Constitution and the extent to which the Commonwealth is currently fulfilling that responsibility.

Constitutional powers

4.2 Section 51 of the Constitution states that:

> The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:
>
> (xxiiiA) The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorise any form of civil conscription), benefits to students and family allowances.

4.3 The Attorney-General, the Hon Daryl Williams, advised the Committee that 'although section 51(xxiiiA) of the Australian Constitution empowers the Commonwealth Parliament to make laws with respect to the provision of dental services, the section imposes no "responsibility" of a legal nature to make such laws'.[1]

4.4 While the argument as to legal responsibility was not disputed in evidence given to the Committee, the clear indication of Commonwealth power was emphasised in a number of submissions. As Dental Health Services Victoria stated:

> There is no legal or constitutional compulsion on either the Commonwealth or state governments to provide public dental services. The fact that both levels of government have the power to fund dental services does not mean that there is a legal obligation on either level of government to do so.[2]

4.5 The history and importance of the power inserted in section 51(xxiiiA), often called the health and welfare or social security power, were referred to in submissions. This particular power was not included in the original Constitution drafted late last century, when health and welfare matters were considered to be a private responsibility, supported by some State provisions and services by philanthropic and

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1 Letter from the Attorney-General, the Hon Daryl Williams to the Committee Chairman, Senator Mark Bishop, 10.12.97.

2 Submission No.67, p.21.

charitable organisations. The power was granted to the Commonwealth at a referendum in 1946 when the government wanted to provide a wider range of health and social security benefits, on a national basis, to Australians in the post-war period.[3]

4.6 The importance of dental services as a primary health need was indicated by its inclusion, along with medical services, in the Constitution. Medical and dental practitioners were accorded the same status in the Constitution in terms of the prohibition on their civil conscription. It is argued that this implies that medical and dental services were accorded equal status as elements of primary health care. As the Council on the Ageing (COTA) submitted 'the reading of the Constitution leaves little doubt that at the time of the 1946 amendment, a role for the Commonwealth was envisaged in the provision of dental services'.[4]

4.7 Ms Karen Wheelwright, from the Deakin University School of Law informed the Committee of two main limitations on what the Commonwealth can do in the provision of dental services by relying upon s.51(xxiiiA). Firstly, the Commonwealth cannot require the States or private dentists to provide dental services and, secondly, it cannot compel anyone to practise as a doctor or dentist or to perform particular medical or dental services.[5]

4.8 This second limitation derives from the words in the Constitution: 'but not so as to authorise any form of civil conscription'. John McMillan, Senior Lecturer in Law at the ANU, has written that civil conscription refers to any sort of compulsion to engage in practice as a doctor or dentist or to perform particular medical or dental services. The term involves compulsion rather than regulation and hence the constitutional provision will not necessarily be infringed by Commonwealth laws which attach conditions and administrative procedures to the payment of Commonwealth benefits, and in that way affect the way in which medical and dental services are rendered.[6]

4.9 Since the inclusion of the 'social security' power into the Constitution, the Commonwealth has legislated extensively on health and welfare issues, including pharmaceutical, sickness and hospital benefits and medical services, but with the notable exception of dental services. This point, repeatedly made in evidence to the Committee, was summed up by the South Australian Dental Service when it stated:

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3 Submission No.36, p.2 and Submission No.67, pp.21-2.

4 Submission No.97, p.11.

5 Submission No.36, pp.2-3.

6 John McMillan, Senior Lecturer in Law, ANU, *Commonwealth Constitutional Power over Health*, pp.42-45. McMillan's comments are summarised in Submission No.125, p.9.

> The Commonwealth Government has exercised its powers and responsibilities for all other areas listed in the subsection and whilst there is no compulsion here for the Commonwealth to exercise its powers in the provision of dental services, its failure to do so is a demonstrable inequity.[7]

4.10 The Commonwealth's power to support publicly funded dental services is not limited to s.51(xxiiiA). Section 96 of the Constitution, the so-called States grants power, enables the Commonwealth to grant financial assistance to the States on such terms and conditions as it thinks fit. However, the reality is that the amount of funds and the terms and conditions attaching thereto is a matter of considerable negotiation between the Commonwealth and the States. Under s.96, the Commonwealth has provided, and continues to provide, substantial grants to the States for a very wide range of purposes, including for example, funding for hospitals under the Medicare Agreements. It was argued that the power in s.96 would support a jointly funded Commonwealth-State public dental service.[8]

4.11 Section 81 of the Constitution, the 'Appropriations' power, was also identified as allowing the funding of dental services. Ms Wheelwright noted that 'grants to the States for local government purposes already provide some support (inadequate) for dental services through community health services'.[9] John McMillan has commented that the interpretation of s.81 assumed by the Parliament is that an appropriation can be made for any purpose, including a purpose that is not expressed or implied in the Constitution as a subject of Commonwealth legislative power.[10]

4.12 It was, therefore, widely accepted in evidence that the Constitution gives the Commonwealth the power, if not the legal responsibility, to provide or regulate dental services. The Attorney-General's Department confirmed that it was a matter of choice for the Commonwealth to exercise the power or not as it wishes.[11] The point of contention became to what extent the Commonwealth should avail itself of the power.

4.13 The Queensland Government proposed that 'the Constitution provides the opportunity for the Commonwealth to recognise responsibility for leadership and support in the provision of public oral health services'.[12] Given the interrelationship between oral health and general health, as discussed in Chapter 2, many have similarly argued, as the Consumers' Health Forum has, 'that the Commonwealth has a strong social and practical responsibility to become involved in an ongoing way in relation to the nation's dental health'.[13]

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7 Submission No.86, p.18. See also Submissions No.57, p.2; No.76, p.2; No.98, p.6; No.107, p.6; No.120, p.5; and No.133, p.7.

8 Submissions No.36, p.3; No.48, p.7; No.67, p.22; and No.86, p.18.

9 Submission No.36, p.3.

10 McMillan, op.cit., pp.11-15.

11 *Committee Hansard,* 6.3.98, p.16.

12 Submission No.128, p.7.

13 Submission No.125, p.9.

State powers

4.14 The States and Territories also have powers to provide and fund dental health services. In her submission, Karen Wheelwright noted that for historical reasons, public health services have traditionally been provided by the States. Unlike the Commonwealth, State constitutions do not limit the subjects about which State parliaments can legislate, although there are parts of the Commonwealth Constitution which place limits on the powers of the States.

4.15 Ms Wheelwright contends that in the area of dental services, the main limitation would be in the case where both the Commonwealth and a State legislated to provide dental services. In that scenario, the Commonwealth law would prevail insofar as there was a direct conflict between the Commonwealth and State laws or the Commonwealth intended to cover the field. Ms Wheelwright commented that to acknowledge the States' historical dominance is not the same thing as saying that dental services are a State responsibility.[14]

Commonwealth involvement in dental services

4.16 As has been noted, the Commonwealth was the subject of much critical comment over its minimal involvement in the provision of dental services over many years. Nevertheless, there are a number of useful and positive examples of where the Commonwealth has been involved, or is currently involved, with the States and Territories in the provision of dental services.[15] Programs that the Commonwealth has been or is currently involved with are noted below:

- *Australian School Dental Program*: The Commonwealth's first major involvement in the provision of oral health care was in the early 1970s through the Australian School Dental Program. The program was aimed at providing treatment for all school children up to the age of 15 years and with Commonwealth funding to be 100 per cent of capital costs and 75 per cent of recurrent operational costs. While funding was initially by specific purpose Commonwealth grants to the States, Commonwealth funding progressively decreased until the Commonwealth had effectively withdrawn from the program by the early 1980s after funding was subsumed into general purpose grants.[16]
- *Commonwealth Dental Health Program*: In 1992, the National Health Strategy recommended a program to support the States to provide basic dental care for holders of Commonwealth Health Care Cards. The subsequent response in 1994 was the introduction of the Commonwealth Dental Health Program (CDHP). The operation of the CDHP and the impact on dental services since its cessation are discussed in detail in Chapter 3.

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14 Submission No.36, p.3.

15 Submissions No.67, p.23 and No.127, p.12.

16 Submission No.131, pp.4-5. See also *Committee Hansard,* 6.3.98, pp.4-5 and 23.3.98, p.128.

- *Veterans' Affairs programs*: Eligible Department of Veterans' Affairs (DVA) beneficiaries are entitled to the full range of dental services, although entitlements vary between eligibility for treatment of war-caused conditions only (White Health Care Card holder) and eligibility for treatment of all conditions (Gold Health Care Card holder). There are also financial limitations on the provision of some services. The Government recently announced an extension of Gold Health Care Card availability to an additional number of World War II veterans.

  Dental services, provided through the Local Dental Officer Scheme, are regarded by DVA as an important part of the arrangements for the provision of health care services for eligible veterans, war widows and dependants.[17] The RSL also places great importance upon the maintenance of this Scheme 'so that these deserving persons have an assured avenue of access to dental care'.[18]

- *Armed Forces and Army Reserve Dental Scheme*: Members of the Australian Defence Force (ADF) and the Army Reserve are provided with dental services as part of their overall health status. The full range of dental services that are available to the civilian community are provided to ADF personnel at no charge. The primary aim of ADF dental services is to maintain personnel at a level of dental fitness such that they are unlikely to become dental casualties while deployed. Hence dental treatment is largely preventive in nature.[19]
- The provision of Medicare benefits for dental services to inpatients and patients in public hospitals (eg oral surgery, cleft lip and cleft palate scheme, x-rays ordered by dentists but performed by radiologists).
- Subsidised drugs which may be prescribed by dentists under the Pharmaceutical Benefits Scheme.
- Funding of university training of dentists and dental auxiliaries.

4.17 The Victorian Government commented that 'these are significant contributions and illustrate not only the role of the Commonwealth, but the importance of partnership approaches to health care between the different levels of government'.[20]

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17 Department of Veterans' Affairs, Notes for Local Dental Officers and LDO Fees Bulletin – Effective 1 January 1998.

18 Submission No.19, p.1.

19 Australian National Audit Office, *Australian Defence Force Health Services*, Audit Report No.34 1996-97, pp.71-72.

20 Submission No.127, p.12.

4.18 The Committee considers that, while the Commonwealth does not have a legal responsibility pursuant to the Constitution to legislate for the provision of dental services, the Commonwealth should use its power within this area to take a leadership role in developing strategies for the improvement of national oral health standards. Chapter 5 discusses options by which the Commonwealth could undertake this role.

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:
>
> - 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.

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:

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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.

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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

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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]

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

MINORITY REPORT FROM THE COALITION

The Coalition members of the Committee are pleased to have the issue of dental health brought to the attention of this Committee even if the Australian Democrats, who initiated the reference, only briefly attended the two days of hearings. It is important that the facts regarding the provision of dental health services in this country are explained clearly. Unfortunately we feel that the majority report of the Opposition Parties glosses over a number of important issues.

The Coalition members of the Committee were interested to hear the evidence given to the Committee by a large number of individuals and organisations. We feel that in a possible election year, the Labor and Democrat majority report of the Committee chooses to not fully explain some relevant facts.

For ninety four of the ninety eight years since Federation, the States have had responsibility for dental health of low income earners. The Commonwealth was given the constitutional ability to provide benefits for services in 1947 - an option that has only been exercised for adult Australians during the operation of the Commonwealth Dental Health Program.

The Commonwealth Dental Health Program was announced as a limited program by the former health minister, Senator Richardson. His successor, Dr Lawrence, stated that the program was designed to treat 1.5 million patients over four years. Senator Richardson stated in 1993 "Long waiting lists for dental care will be reduced under a new, $278 million Commonwealth Dental Health program in fulfilment of a key election commitment" (Press release GR 23/93, 17 August 1993). There was no mention of an ongoing commitment.

In 1995 Dr Lawrence, the Health Minister at that time issued a press release stating "the Minister for Human Services and Health, Dr Carmen Lawrence, said [the client charter] was an important part of the Commonwealth's $278 million, 4-year dental health program" and went on to say "The Commonwealth is helping around 1.5 million low income earners access essential dental services, on top of those already treated through State funded dental programs." (CL 310/1995, no date listed).

Again, there is no mention of ongoing funding, and the target of 1.5 million people treated would strongly suggest a limit on the program. If this wasn't clear enough, Dr Lawrence went on to say "Public dental services are the responsibility of the States. It is their responsibility to provide a full range of dental services to public clients" (CL 310/1995).

The Coalition Government brought the Commonwealth Dental Health Program to a close only after the 1.5 million patient target was reached earlier than expected. The aims of the program set down by the former ALP Government were met.

While the Government concedes that public dental services are in a number of cases lacking, the fact remains and acknowledged by both major political parties, that it has always been the province of the States.

The Committee was saddened to hear a number of reports of failings in the State dental health services. A number of commentators have blamed the cessation of the Commonwealth Dental Health Program for these failings. It is worth noting, however, that the Commonwealth program did not cover (and never intended to cover) dentures or complex crown and bridge work, a source of many of these complaints.

The large increase in waiting lists is disturbing to the Committee. It would suggest that either demand patterns or service provision by the States has changed since 1993. While it may be argued that the Commonwealth Dental Health Program has increased the demand pressures on the States, the service provision aspects were not fully explained to the Committee. It is possible that the pattern of provision of services by some States may have altered. The Coalition members of the Committee are particularly concerned about the provision of services to rural and remote areas, and to indigenous peoples.

In the context of the history of the Commonwealth Dental Health Program, the Coalition members of the Committee do not agree with a number of the recommendations in the majority report. While the Australian Democrats have been most consistent in their belief that effective dental services should be funded by the Commonwealth at significant cost, the current position of the Australian Labor Party seems removed from the position taken just three years ago by former Minister Dr Lawrence.

The recommendations in the report would appear to the Coalition members to be an expensive and ineffectual method of tackling a problem which has traditionally been the responsibility of the States.

The Coalition members of the Committee are happy to support recommendations three and four. Recommendations six, seven and eight are partially supported, although the Coalition members of the Committee are reluctant for the Commonwealth to issue directives to the States, who should be free to deliver services in the manner that they see fit.

The Coalition members of the Committee see value in the States and the Commonwealth combining resources for a national oral health survey to be conducted by the Australian Institute of Health and Welfare, and will recommend this action to the Government.

Senator Sue Knowles
Deputy Chairman
(LP, Western Australia)

Senator Marise Payne
(LP, New South Wales)

Senator Karen Synon
(LP, Victoria)

APPENDIX 1

ORGANISATIONS AND INDIVIDUALS WHO PRESENTED WRITTEN PUBLIC SUBMISSIONS AND ADDITIONAL INFORMATION TO THE INQUIRY

1 Ms Sharon Kellett (NSW)
2 Ms Cathie Sargeant (TAS)
3 Mr and Mrs W Niemann (VIC)
4 Ms Dorothy Davies (VIC)
5 Mr H Silverberg (QLD)
6 Combined Pensioners & Superannuants Association – Grenfell Branch (NSW)
7 Mr and Mrs D R Stubbs (NSW)
8 Mrs Betty Forster (WA)
9 Mrs Margaret Donk (NSW)
10 I D Vance (NSW)
11 Canberra Schizophrenia Fellowship Inc (ACT)
12 Greypower WA (WA)
13 Women's Health Victoria (VIC)
14 Mrs G M Dean (NSW)
15 Australian Medical Association - South Australian Branch (SA)
16 Grey Power NSW - Parramatta Branch (NSW)
17 Retired Union Members' Association of S.A. Inc. (SA)
18 Ms Kalyna Flowerpott (SA)
19 The Returned & Services League of Australia Ltd (ACT)
20 Ms Ingrid Stanley (SA)
21 Mr Stephen Webb (VIC)
22 Ms Judy O'Malley (VIC)
23 Durri Aboriginal Corporation Medical Service (NSW)
   - Additional information, dated 29 January 1998
24 Mrs Felicity Woppenkamp (VIC)
25 Dr A C H Smith (VIC)
26 Mr Richard Blake (VIC)
27 Mr Frank Dowsett (VIC)
28 Ms Kathleen McCall (VIC)
29 Mr David Massey (VIC)

30 Mr Robin W Sherwen (VIC)
31 Dr Harold W. Lea (NSW)
32 Miss Kay J Haby (VIC)
33 Mrs Corinne Morrison (VIC)
34 Mrs D V Walker (VIC)
35 Dr A Nazareth (VIC)
36 Ms Karen Wheelwright (VIC)
37 NSW Retired Teachers Association (NSW)
38 Ms Leonie M Short (QLD)
39 East Bentleigh Community Health Centre Inc (VIC)
40 Health Consumers of Rural and Remote Australia Inc (ACT)
41 Tasmanian Dental Service (TAS)
42 Northcote Community Health Centre (VIC)
43 Mr David Wales (VIC)
44 Baulkham Hills Shire – Pensioners, Veterans, Superannuants, Retirees and Semi-Retired Professionals (NSW)
45 Intellectual Disability Services Council (SA)
46 Corio Community Health Services Inc (VIC)
47 Dr Chris Griffiths (NSW)
48 Council for Homeless Persons Australia (VIC)
49 Aged Care Australia (VIC)
50 National Council of Women of Australia (VIC)
51 Australian Dental Association (NSW)
52 Professor Iven Klineberg (NSW)
53 Council of Social Service of New South Wales (NCOSS) (NSW)
54 Shop, Distributive & Allied Employees' Association (VIC)
55 Mr Kris Hanna MP (SA)
56 Hamilton Base Hospital (VIC)
57 Dr Kaye Roberts-Thomson (SA)
58 Ms Melody Parker (VIC)
59 Dr Peter Foltyn (NSW)
60 Professor Arie Rotem (NSW)
61 AIHW Dental Statistics and Research Unit (SA)
61A AIHW Dental Statistics and Research Unit – Supplementary Submission (SA)
62 Dr Jane Chalmers (SA)
63 The Victorian Healthcare Association Ltd (VIC)

64 Dr Wendell Evans (VIC)

65 Banyule Community Health Service (VIC)

66 Maroondah Social and Community Health Centre (VIC)

67 Dental Health Services Victoria (VIC)
- Correspondence and a list of non dental pathology and systemic diseases with oral symptoms, tabled at hearing 23 March 1998
- Additional information, dated 1 April 1998

68 Dr Michael J Fleetwood (ACT)

69 Mr Kim Peart (TAS)

70 Dr Paula Bacchia (VIC)

71 Catholic Social Justice Commission – Archdiocese of Canberra and Goulburn (ACT)

72 Refugee Resettlement Committee Kippax (ACT)

73 Public Health Association of Australia Inc (ACT)

74 Dr Mark Schifter (NSW)

75 Victorian Unemployed Workers Coalition (VIC)

76 Victorian Dental Therapists Association (VIC)

77 ACT Community Care (ACT)

78 National Aboriginal Community Controlled Health Organisation (ACT)
- Additional information, dated 17 April 1998

79 Association of Independent Retirees Inc (VIC)

80 Australian Catholic Social Welfare Commission (ACT)

81 Mrs Margaret Shortall (VIC)

82 Mrs Elizabeth King (VIC)

83 National Seniors Association (QLD)

84 The Geelong Hospital (VIC)

85 Brotherhood of St Laurence (VIC)

86 South Australian Dental Service (SA)

87 Dr Deborah Cole (VIC)

88 The Australian Nutrition Foundation (VIC)

89 Association for the Study of Community Dentistry (VIC)

90 Dr Mark Cordato (NSW)

91 Central Sydney Area Health Service and South Eastern Sydney Area Health Service (NSW)

92 Dr Rachel E Martin (VIC)

93 Bairnsdale Regional Health Service (VIC)

94 Professor Michael J Aldred (VIC)

95 Dr Paul Wood (QLD)

96 Westmead Hospital Dental Clinical School (NSW)
97 Council on the Ageing (Australia) (VIC)
98 Health Issues Centre (VIC)
99 Ms Joanna Gash MP (NSW)
100 ACT Community and Health Services Complaints Commissioner (ACT)
101 University of Adelaide - Faculty of Dentistry (SA)
102 The Australian Dental Therapists Association (VIC)
103 Combined Pensioners and Superannuants Association of New South Wales Inc (NSW)
104 East Preston Community Health Centre Inc (VIC)
105 South Australian Financial Counsellors' Association Inc (SA)
106 Mr and Mrs A&L James (VIC)
107 South Australian Council of Social Service (SACOSS) (SA)
108 Older Persons Action Centre (VIC)
109 Dr Judith Lewis (VIC)
110 Ms Barbara Hurley (VIC)
111 Ms Alison Miles (NSW)
112 Professor M J Tyas (VIC)
113 The Australian Family Party (SA)
114 Hunter Area Health Service (NSW)
115 Professor Harold H Messer (VIC)
116 ACT Council of Social Service (ACTCOSS) (ACT)
117 Swan Hill District Hospital (VIC)
118 Mr Peter Cullen (ACT)
119 National Association of People Living with HIV/AIDS (NSW)
120 Australian Council of Social Service (ACOSS) (NSW)
121 Commonwealth Department of Health and Family Services (ACT)
- Additional information, dated 9 April 1998
122 Catholic Social Justice Council – Perth Archdiocese (WA)
123 G M Adam (WA)
124 Australian Federation of Aids Organisations Inc (NSW)
125 Consumers' Health Forum of Australia Inc (ACT)
126 Mr Greg Hamilton (NSW)
127 Victorian Government (VIC)
128 Queensland Government (QLD)
129 National Rural Health Alliance (ACT)
- NRHA 1996-97 Annual Report, tabled at hearing 6 March 1998
130 Health Department of Western Australia (WA)

131 New South Wales Government (NSW)
132 Dr W L Hall (VIC)
133 Northern Territory Government (NT)
134 Gerontology Foundation (NSW)
135 Council of Retired Union Members Association of New South Wales (NSW)
136 Ms Christine Bayer (SA)
137 Mr Paul Turner (VIC)

Note: The Committee authorised publication of a letter from the Attorney-General, The Hon Daryl Williams, to the Committee Chairman, Senator Mark Bishop, dated 10 December 1997.

APPENDIX 2

WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS

Friday, 6 March 1998, Senate Committee 2S1, Parliament House

Department of Health and Family Services

Dr John Loy, First Assistant Secretary, Health Services Development Division
Mr Michael Mossop, Director, Special Access Programs Section

Attorney-General's Department

Mr Frank Marris, Senior General Counsel, Office of General Counsel

Australian Dental Association

Dr Robert Butler, Executive Director

Professor Iven Klineberg, Dean, Faculty of Dentistry, University of Sydney
via teleconference

Dr Peter Foltyn, Consultant Dentist, St Vincent's Hospital, Sydney
via teleconference

Central Sydney Area Health Service and South Eastern Sydney Area Health Service

Dr John Wilkinson, Director, Dental Services, United Dental Hospital, Sydney
Dr Dell Kingsford Smith, Research Co-ordinator, United Dental Hospital, Sydney

Public Health Association of Australia

Ms Leonie Short, Convenor, Oral Health Special Interest Group

National Rural Health Alliance

Mr Gordon Gregory, Executive Director
Ms Leonie Short, Delegate

Health Consumers of Rural and Remote Australia

Ms Marg Brown, Chairperson
Ms Michele Foley, Policy Officer

National Aboriginal Community Controlled Health Organisation (NACCHO)

Ms Kathy Bell, Policy Officer, NACCHO
Mr Stephen Blunden, Chief Executive Officer, NACCHO
Ms Susan Harris, Dental Program Co-ordinator, Durri Aboriginal Medical Service
Ms Jonine Gilmour, Dental Program Co-ordinator, Durri Aboriginal Medical Service

ACT Community Care

Ms Jill Davis, Director, ACT Dental Health Program
Dr Mike Fleetwood, Principal Dental Officer

Monday, 23 March 1998 Senate Committee Room 1S3, Parliament House

AIHW Dental Statistics and Research Unit

Professor John Spencer, Director

South Australian Dental Service

Mr Richard Hassam, Chief Executive Officer
Dr David Burrow, Director, Statewide Dental Services

Council on the Ageing *via teleconference*

Ms Veronica Sheen, National Policy Officer
Ms Jill Thompson, Policy Officer

Dental Health Services Victoria

Dr Martin Dooland, Chief Executive