Submission
No 226

INQUIRY INTO DENTAL SERVICES IN NSW

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Theme:

Summary

INQUIRY INTO DENTAL SERVICES IN NSW

SUBMISSION TO THE NEW SOUTH WALES LEGISLATIVE COUNCIL STANDING COMMITTEE ON SOCIAL ISSUES

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EXECUTIVE SUMMARY

Oral health is a basic expectation of all Australians. Oral health and disease are important in their own right and for their association with general and systemic health. Unfortunately, responsibility for funding public dental care continues to be exploited by both sides of politics at a State and Federal level to the detriment of those members of the public who are reliant on public dental services.

As the professional body representing dentists in NSW and the ACT, ADA NSW supports the view that dentists must be responsible for the diagnosis, treatment planning, and delivery of dental procedures and continuing evaluation of the oral health of the patient. Dentists are also responsible for the support, direction and supervision of allied dental personnel in the conduct of prescribed duties for which they are legally accountable.

Australia's best oral health services are equal to the best in the world. Despite this, improvements to oral health and an ageing population have contributed to a greater need for dental services. It is lamentable that in Australia today, large numbers of Australians continue to face hardship in purchasing or accessing private dental care. Instead, they must rely on public dental services that, through government neglect, offer little in the way of treatment outcomes except for emergency care and pain relief.

Factors that have contributed to the increasing demand for dental care including population change, an ageing population, changing rates of edentulism and broad economic, social and technological changes. Per capita demand for dental visits increased by approximately 50 per cent between 1979 and 1995 for both the dentate and edentulous populations. Based on this demand, the demand for future dental visits and services is expected to continue to increase significantly in both the private and public sectors. In the public sector however, waiting lists and waiting times are already so long that many (if not most) people eligible for public dental services are effectively denied all but emergency care and pain relief.

Per capita spend on public dental services in New South Wales is now the lowest of all States and Territories and falls significantly below the Northern Territory, Queensland, Tasmania and South Australia. ADA NSW believes that State and Federal funding should be made available for the provision public dental services; the Federal government should play a leading role in developing and coordinating a national approach to oral health planning and all levels of

government should ensure that adequate funds are provided to meet public oral health needs. State government funding in New South Wales for oral health care services should match, at the very least, the per capita funding of Queensland. This would increase the oral health budget to approximately $220.6 million.

At a Federal level, Commonwealth initiatives to encourage private health insurance (including ancillary cover) through the 30 per cent rebate on private health insurance should not diminish the Federal Governments responsibility to develop, implement and fund oral health policies that benefit those Australian who can least afford private dental care. The 30 per cent rebate currently favours high income earners who can generally afford private dental care. More attention needs to be focused on providing direct funding for those who cannot afford private dental care or private health insurance.

As access to oral health care becomes increasingly difficult (if not impossible) in the public sector and in rural and regional areas, innovative measures will be needed to overcome these problems. The Oral Health Fee for Service Scheme (OHFFSS) was developed to improve access to basic oral health care for eligible persons and their dependents by engaging private practitioners to provide acute oral health care to public patients. ADA NSW supports the OHFFSS but calls on the State government to ensure that fees levels, with or without patient co-payment, adequately remunerate practitioners and guarantee the involvement of the greatest number of participants.

In relation to workforce issues, current remuneration rates and the limited range of services and funding available make it increasingly difficult to recruit and retain dental officers in the public sector. Structured career pathways and/or vocational training will not alone overcome these problems. Governments at all levels must do more to ensure that university dental faculties are appropriately funded and that student fees do not act as a barrier to entry into dentistry for talented young Australians at a time when the dental workforce is predicted to begin shrinking within the next decade.

Finally, only a population health approach can offer a way to manage the growing demand that is occurring for dental services, utilising both public and private resources as effectively as possible, and working across sectors and communities to maximise oral health gains and promote oral health in the community.

INTRODUCTION

The Australian Dental Association (NSW Branch)

The Australian Dental Association (NSW Branch) Limited ("ADA NSW") is the professional association representing dentists, whether practising in the public or private sector, in New South Wales and the Australian Capital Territory. It provides services for and on behalf of members to enable them to deliver the best possible standard of care to the community. The Branch has over 3200 members which represents approximately 85% of practising dentists in NSW (75% of registered dentists); 180 members are practising in the ACT, representing 75% of registered dentists.

Inquiry Terms of Reference

This submission is prepared by the Australian Dental Association (NSW Branch) in response to the Legislative Council Standing Committee on Social Issues 'Inquiry into Dental Services in NSW', referred to the Committee by resolution of the Legislative Council on 7 April 2005. The terms of reference for the Inquiry are:

1. That the Standing Committee on Social Issues inquire into and report on dental services in New South Wales, and in particular:
   (a) the quality of care received in dental services,
   (b) the demand for dental services including issues relating to waiting times for treatment in public services,
   (c) the funding and availability of dental services, including the impact of private health insurance,
   (d) access to public dental services, including issues relevant to people living in rural and regional areas of New South Wales,
   (e) the dental services workforce including issues relating to the training of dental clinicians and specialists,
   (f) preventive dental treatments and initiatives, including fluoridation and the optimum method of delivering such services, and
   (g) any other relevant matter.

2. That the committee report by Friday 31 March 2006.

AUSTRALIAN DENTAL ASSOCIATION

NATIONAL ORAL HEALTH POLICY

Introduction

Oral health is a basic expectation of all Australians. Oral health and disease are important in their own right and for their association with general health.

1. Definitions

ORAL HEALTH is the absence of active disease in the mouth. It affects overall well being and enables people to participate in their chosen roles without discomfort or embarrassment.

DENTISTRY is the science and art of preventing, diagnosing and treating diseases, injuries, developmental and acquired defects of the teeth, joints, oral cavity and associated structures.

PUBLIC HEALTH DENTISTRY is the science and art of preventing oral disease, promoting oral health and improving the quality of life through the organised efforts of society.

HEALTH PROMOTION is the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health, representing a mediating strategy between people and their environment, confining personal choice and social responsibility for health to create a healthier future.

The Australian Dental Association (ADA) endorses the principles for health promotion as outlined in the Ottawa Charter. Five broad actions are proposed therein:

- Create supportive environments, i.e. ensure that the physical and social environments in which people live maximise the possibility of leading healthy lives.
- Ensure that governments and the community develop sound health-directed public policies.
- Strengthen community action.

- Help individuals to develop personal skills to achieve healthy outcomes.
- Redirect health services away from a treatment-based model to a preventive one. [WHO 1986]

A DENTIST is an appropriately qualified oral care provider, registered by a State or Territory Registration Board to practise all areas of dentistry.

A DENTAL TEAM comprises a mix of dentists and appropriate allied dental personnel and should at all times be headed by a dentist.

2. Priorities for National Oral Health

Community oral health promotion – Dentistry must work with the whole community to identify preventive health issues and implement appropriate policies.

Delivery of oral health care – Dental services should be made available, with Government assistance if necessary, to all members of the community.

Research – There should be continuing research into the prevalent causes and control of dental disease.

Workforce Training – Training programs of the highest standard, funded by Government through tertiary and vocational training institutions, are the foundation of a high standard of national oral health.

3. Community Oral Health Promotion

The following areas are identified as being essential to improve the oral health of the community.

- Use of fluorides.
- Diet and nutrition.
- Oral hygiene.
- Discouragement of tobacco use.

- Trauma prevention and management.

4. Delivery of Oral Health Care

Dentistry is an essential health service and should be available to every individual.

It should be recognised that the dentist, by providing a full spectrum of care is the fundamental provider of dental services to the community and dentist based systems of care and delivery must be accorded top priority. Where allied dental personnel are utilised, they must be part of a dental team.

The provision of dental services to the community should be based primarily on private practice and freedom of choice.

An essential part of public health dentistry is the identification and targeting of special needs groups. These include children, adolescents, elderly, disabled, those living in rural and remote areas, those with language difficulties and indigenous Australians.

The administration and planning of any oral health scheme or services at a national, State or local level should include dentists as the core experts.

A Division of Oral Health is required within the Commonwealth Department of Health to ensure appropriate advice is given to the Commonwealth Government.

Federal and State funding should be available for oral health care for disadvantaged members of the community, with State and Territory Governments having autonomy to direct the funds provided to them by the Commonwealth into both private and public sectors for delivery of services.

Where the responsibility for funding all or part of public oral care is disputed between Federal and State Governments, the ADA will seek resolution in order that comprehensive and high standard services are maintained.

Unfortunately, it is the view of ADA NSW that ownership of responsibility continues to be exploited by both sides of politics at a State and Federal level to the detriment of the public in New South Wales who are reliant on public dental services.

5. Research

Commonwealth and State governments must conduct regular oral health surveys.

There should be continuing research into the causes and control of dental diseases and government funding should adequately support this dental research. Dental research may also receive additional support and funding from the dental profession and the community. Where dental research is funded by commercial interests, these interests must be transparent at all times to members of the dental community.

6. Workforce Training

Universities providing training for dentists, postgraduate training for dental specialists and continuing education for graduates should be adequately funded.

State Governments have a special role to play in allowing dental workforce students to acquire clinical skills in workplaces providing public dental care. This is a fundamental obligation of State Government contributions to national oral health.

Training must match the demographic and disease prevalence needs of the community.

Australia must be largely self-sufficient with regard to the training of its dental workforce and Governments must ensure adequate funding to achieve this situation.

AUSTRALIAN DENTAL ASSOCIATION

DENTAL WORKFORCE POLICY

1. Definitions

ALLIED DENTAL PERSONNEL: Allied dental personnel are those, other than dentists, working in the provision of dental services - namely dental assistants, dental therapists, dental hygienists, dental prosthetists and dental technicians.

OPERATIVE: Operative allied dental personnel are those whose autonomous duties and tasks include invasive dental procedures.

NON-OPERATIVE: Non-operative allied dental personnel are those whose autonomous duties and tasks do not include any invasive dental procedures.

PRESCRIPTION: Prescription is detailed written instruction provided by a dentist to allied dental personnel, and usually specifies the treatment to be performed.

INSTRUCTION: Instruction is the oral elaboration of prescription and may include a teaching component.

SUPERVISION: Supervision is the direction and/or oversight by dentists of the performance of duties by allied dental personnel. Supervision can be direct (i.e. the dentist is physically present in the treatment facility at all times the patient is being treated by allied dental personnel) or indirect (i.e. the dentist need not be physically present in the treatment facility, but must be able to be contacted at all times the patient is being treated by allied dental personnel).

2. Categories

The following categories of allied dental personnel are recognised:

Non-operative:

- dental assistant,
- dental technician

Operative:

- dental hygienist,
- dental therapist,
- dental prosthetist.

3. Principles for Dentists Working with Allied Dental Personnel

Responsibilities of Dentists:

The dentist must be responsible for the diagnosis, treatment planning, and delivery of dental procedures and continuing evaluation of the oral health of the patient. The dentist is also responsible for the support, direction and supervision of allied dental personnel in the conduct of prescribed duties for which they are legally accountable.

With respect to allied dental personnel other than dental prosthetists, it is the responsibility of the dentist to:

- ensure that all members of the dental workforce at all times have appropriate competence and training for the tasks that are delegated to them,
- have an understanding of the roles of all members of the dental workforce,
- inform patients that a specified part of their treatment is to be undertaken by allied dental personnel,
- monitor and supervise the performance of allied dental personnel,
- consult with patients regarding the treatment plan and to instigate referral to specialists,
- provide adequate prescription and instruction to ensure that the procedures and/or treatment to be performed are understood,
- be available for consultation and management of any complications that may occur,
- ensure that all delegated procedures have been performed satisfactorily.

Responsibilities of Allied Dental Personnel:

It is the responsibility of allied dental personnel to -

- have an understanding of the role of all members of the dental workforce,
- carry out only those delegated tasks for which they are legally authorised in the relevant State or Territory and for which they are formally trained and have appropriate competence,
- refer to a dentist any condition or task which is outside their competence and training, including changes in a patients health status or medication,
- hold appropriate professional indemnity cover.

4. Regulation of Practice of Allied Dental Personnel other than Dental Assistants

Dental hygienists, dental therapists and dental prosthetists must be registered and practice in accordance with all statutory requirements. Regulation of practice must be vested in the Registration Boards enacted by legislation under the relevant State and Territory Acts which must provide that:

- the duties be clearly defined,
- the course of training be prescribed,
- registration be required and a register regularly maintained,
- penalties apply for contravention of any provisions of the relevant Act.

5. Education and Scope of Practice of Allied Dental Personnel

Education for allied dental personnel must reflect their defined scope of practice, which should be nationally uniform.

Dental Assistant

Basic training of dental assistants must be at Certificate III level in the vocational sector and in accordance with the National Competency Standards.

With additional training to Certificate IV level in the vocational sector, and in accordance with the National Competency Standards, the duties of dental assistants extend to:

- oral health education,
- dental radiography for usual dental examination,
- assistance during general anaesthesia and conscious sedation.

Duties shall comprise established procedures associated with chairside assisting and practice administration

A dental assistant must work under the supervision of a dentist.

Dental Hygienist

Education of dental hygienists must be to at least Diploma level and of two years duration. The training should be conducted in the higher education sector in a tertiary institution associated with the training of dentists in a course accredited by the Australian Dental Council [ADC]

The duties of a dental hygienist should be directed towards oral health education and the prevention of dental diseases, including dental caries and periodontal disease.

Treatment services provided by a dental hygienist must be provided in accordance with a written treatment plan which has been signed and dated by a dentist who has personally examined the patient, and:

- such treatment plan shall be effective for not more than twelve months,
- the need for examination of the patient by the dentist after completion of the
- treatment plan by the dental hygienist will depend on the needs of the patient,
- the treatment provided and the experience and competency of the dental hygienist.

The role of the dental hygienist in the provision of dental treatment shall be subject to the following:

- The dental treatment must fall within the following range of statutory duties:

1. established procedures associated with chairside assistance and practice management,
2. oral health education,
3. instruction in monitoring and recording of plaque control routines and recording of periodontal disease,
4. prophylaxis,
5. polishing of restorations,
6. fluoride therapy, application of remineralising solutions and desensitizing agents,
7. debridement to remove supragingival deposits from teeth,
8. debridement to remove subgingival deposits from teeth,
9. application and removal of rubber dam,
10. application of non-invasive fissure sealants,
11. taking of alginate impressions other than for the fabrication of prosthetic appliances,
12. removal of periodontal packs,
13. taking of dental radiographs,
14. orthodontic band sizing,
15. removal of orthodontic appliances including orthodontic cements and resins,
16. placement and removal of non-metallic separators and alastic modules.

The dental treatment must be supervised by a dentist who is on the premises at the time of treatment, except in the case of dental treatment within categories referred to in 1 to 7 above provided on the premises of long term residential care, either government or licensed under local government legislation, for the elderly or persons with physical or intellectual disability, provided that a medical practitioner or registered nurse is at close call.

Dental Therapist

Training of dental therapists should be phased out. However, any education of dental therapists must be to at least Diploma level and of two years duration. The training should

be conducted in the higher education sector in a tertiary institution associated with the training of dentists in a course accredited by the ADC.

A dental therapist must work under the supervision of a dentist.

The duties of dental therapists shall be directed towards prevention of dental diseases and control of dental caries in school children.

The provision of treatment by a dental therapist must fall within the following range of statutory duties:

1. established procedures associated with chairside assisting and practice management,
2. oral health education,
3. oral health examination,
4. taking of dental radiographs,
5. application and removal of rubber dam,
6. pre- and post-operative instruction,
7. irrigation of the mouth,
8. fluoride therapy, application of remineralising solutions and desensitising agents,
9. debridement to remove deposits from teeth,
10. taking of alginate impressions other than for the fabrication of prosthetic appliances,
11. application of fissure sealants,
12. direct coronal restoration of primary and permanent teeth,
13. pulpotomies in primary teeth,
14. administration of local anaesthesia only by infiltration and mandibular nerve block,
15. forceps extraction of primary teeth under local anaesthesia.

Dental Technician

Dental technician training must be to Diploma level and can be two to three years. Full time study with a period of structured learning of one to two years. The training should be

conducted in the vocational sector and in accordance with National Competency Standards.

A dental technician may work independently of a dentist, but must adhere to the prescription of a dentist and is not permitted any direct dealings with members of the public except in the case of non-invasive shade taking at the direction of the dentist.

The duties of a dental technician shall consist of the following established laboratory procedures:

1. fabrication, maintenance and repair of complete and partial dentures,
2. fabrication of inlays, onlays, veneers, crowns and bridges,
3. fabrication of mouthguards, occlusal splints, medicament trays and stents,
4. fabrication of appliances used in orthodontics, oral and maxillofacial surgery and other special areas of dentistry.

Dental Prosthetist

Training of dental prosthetists should be phased out. However a dental prosthetist must first be qualified as a dental technician and then gain an Advanced Diploma with a period of structured learning. The training must be conducted in the vocational sector and in accordance with National Competency Standards.

Dental prosthetists may independently provide treatment to the public limited to the provision of dentures and mouth guards in healthy mouths.

All patients should be examined by a dentist prior to treatment by a dental prosthetist.

Career Path

Training institutions should facilitate entry of allied dental personnel into dental workforce training courses that are at a higher level than their current qualification (e.g. dental assistants training to become dental hygienists). This provides a career path for allied dental personnel within the dental workforce based on appropriate training.

THE QUALITY OF DENTAL CARE RECEIVED IN NEW SOUTH WALES

Key Points

- **Australia's best oral health services are now equal to the best in the world;**
- **Improvements in oral health and the ageing of the population both contribute to a greater need for dental services;**
- **Large numbers of Australians continue to face hardship in purchasing and/or accessing private dental care;**
- **Public dental services have become a despairing cycle of band-aid treatment for emergency care and pain relief.**

Over the last three decades there has been an impressive achievement in understanding and controlling or preventing diseases and disorders affecting oral tissues in this country. Australia's best oral health services are now equal to the best in the world. Many Australians are fortunate to be able to access dental care of such a standard, while many more middle and working class Australians are able to access satisfactory or adequate levels of dental care without suffering undue hardship.

Australia can now boast the third lowest incidence of decayed, missing or filled permanent teeth amongst 12 year olds, when compared with other countries.[1] Amongst the adult population there have also been some commendable achievements. The percentage of edentulism (the loss of all natural teeth) among persons aged 65 years and over had dropped from 66% in 1979 to 33% in 1999.[2]

These achievements however have resulted in an interesting paradox. Many Australians imagine that improvements to oral health over the last three decades, (i.e. decreases in dental caries in children and decreases in tooth loss in adults), have led to a corresponding reduction in the need

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[1] Armfield JM, Roberts-Thomson KF, Spencer AJ. *The Child Dental Health Survey, Australia 1999: Trends across the 1990s.* AIHW Cat. No. DEN 95. Adelaide: The University of Adelaide (AIHW Dental Statistics and Research Series No. 27), page 49.

[2] Spencer AJ, Teusner DN, Carter KD & Brennan DS 2003. *The Dental labour force in Australia: the position and policy directions*. AIHW Cat. No. POH 2. Canberra: Australian Institute of Health and Welfare (Population Oral Health Series No. 2), page 8.

for dental services. In fact the opposite has occurred. In 2001 the Australian Health Ministers' Advisory Council noted that:

> "Past improvements in oral health have not translated into reduced need for dental services. Improvements in oral health and the ageing of the population both contribute to a greater need for dental services. Lower caries experience among children has been more than matched by increased awareness of and expectations for maintaining improved oral health. A lower rate of tooth loss in middle-aged and older Australians illustrates 'the paradox of success' when it leads to an increased burden of disease and need for treatment."[3]

Unfortunately, despite these improvements to oral health outcomes, large numbers of Australians continue to face hardship in purchasing and/or accessing private dental care. For these people public dental services are the only alternative. However, waiting lists and waiting times are now so long that many (if not most) people on low incomes needing to access public dental services are effectively denied all but emergency care and pain relief. The rationing of services and limited treatment outcomes available through public dental clinics has now reached a point where most, if not all stakeholders regard the public sector as 'poor dentistry for poor people'.

According to Spencer[4]:

> "public dental care is hampered by buck-passing between the various levels of government. The providing of public dental care is restricted in the scope of activities and has become a despairing cycle of band-aid treatment. The funding of public dental care is inadequate and public subsidy for dental care grossly inequitable."

Nevertheless, he argues that the opportunity still exists to address these fundamental issues so that public dental care contributes positively to people's health and wellbeing in Australia. High levels of oral health and access to dental care has been achieved successfully with children and the challenge now is to maintain the value of this

[3] AHMAC (Australian Health Ministers' Advisory Council), Steering Committee for National Planning for Oral Health 2001. *Oral health of Australians: national planning for oral health improvement: final report.* Adelaide: South Australian Department of Human Services.
[4] Spencer AJ. *What options do we have for organising, providing and funding better public dental care?* Australian Health Policy Institute. 2001/02. Sydney, pp52-3.

investment in oral health into the adult population and especially among those adults dependent on public dental care.[5]

[5] Ibid.

DEMAND FOR DENTAL SERVICES

Key Points

- **A number of factors have contributed to the increasing demand for dental care including population change, an ageing population, changing rates of edentulism as well as broad economic, social and technological change;**

- **Per capita demand for dental visits increased by approximately 50 per cent between 1979 and 1995 for both the dentate and edentulous populations;**

- **Projected demand for future dental visits and services is expected to increase significantly in both the private and public sectors.**

A number of contributory demographic trends are responsible for the increase in total demand for dental care. These are discussed briefly in Table 1 below:

Table 1: Contributors to Increased Demand for Dental Services

Contributors	Impact
Increasing population	As the total number of people in Australia increases, with all other things being equal, the total number of people demanding dental care will also increase.
Decreasing edentulism rates	Edentulous persons (those with no natural teeth remaining) demand dental care at a far lower rate than dentate persons (those who still have some teeth remaining). Historically, the percentage of the population that is edentulous has been declining, resulting in a greater percentage of those who are dentate. Therefore, a decline in edentulism equates to an increase in the dentate population resulting in an increase in total demand.
Age profile of the population	Not all age groups demand the same amount of dental care. If the population age distribution shifts in such a way that a greater proportion of people are in age groups that demand greater dental care, total demand will increase.
Increasing per capita demand	If per capita demand (the average number of dental visits per person) increases then total demand for visits must also increase. Historically, there is evidence that per capita demand for dental visits in Australia has been increasing over time.

Each of these factors is discussed in more detail below.

Population Change

The total population of Australia is increasing. Table 2 (below) summarises these changes from 1980 to 2020. However, while the total population continues to grow, the rate of that growth is declining both in terms of net population increase and also in terms of relative percentage increase. The projected increase of 1.6 million people from 2010 to 2020 is two-thirds of the increase (2.4 million people) observed from 1980 to 1990, while in percentage terms, the projected percentage increase for 2010 to 2020 is less than half the percentage increase from 1980 to 1990.

Table 2: Australian Population, 1980 to 2020[6]

Year	Millions	Net Increase (millions)	% Increase
1980	14.7	-	-
1990	17.1	2.4	16.2
2000	19.1	2.0	12.1
2010	20.9	1.8	9.4
2020	22.5	1.6	7.4

New South Wales had a population of 6,640,400 in 2002, with an estimated population prediction of 7,679,000 for the year 2010[7] and a population of 7,868,700 for the year 2021[8]. New South Wales is projected to remain the most populous State in Australia. The trend for NSW is proportional to that for Australia as a whole, as described above.

Age Profile of the Population

Australia is projected to have a more middle aged and older population over the next twenty five years. The major factors driving changes in the population and demographic structure over this period are declining fertility and mortality rates[9]. From 2000 to 2020 there is a projected marginal decline in the total number of persons aged 17 years or less, and a marginal increase in the total number of persons aged 18–44 years. The total number of persons aged 45–64 years is projected

[6] Australian Bureau of Statistics, Australian Demographic Statistics. ABS Catalogue No. 3101.0, ABS n.d.
[7] Spencer J. (2002) *The 2002 New South Wales Oral Health Workforce Planning Project* Australian Institute of Health and Welfare, The University of Adelaide.
[8] Australian Bureau of Statistics, Australian Demographic Statistics. ABS Catalogue No. 3222.0, ABS n.d.
[9] Australian Bureau of Statistics, Projections of the Populations of Australia, States and Territories, 1995-2051, 3222.0, 1996, AGPS, Canberra.

to increase from 4.3 million in 2000 to 5.5 million by 2010 (a 28% increase) and then to 6.1 million by 2020. The total number of persons aged 65 years or more is projected to increase from 2.4 million in 2000 to 3.0 million by 2010 (a 25% increase) and then to 4.1 million by 2020, a further increase of 37%. By 2014 it is projected that there will be, for the first time in Australia, a greater number of people aged 65 years or more than people aged 5–17 years, and thus more people of retirement age than of school age[10].

Edentulism change

Over the past 20 years there have been dramatic changes documented in the occurrence of edentulism (those with no natural teeth remaining) in Australia, with the percentage of persons who are edentulous declining at a rapid rate. Among those aged 75 years or more, 79% were edentulous in 1979. The projected figure is 23% by 2019. Over the same time period, edentulism among those aged 65–74 years is projected to decline from 60% to 12%. The rate will drop from 40% to 5% among people aged 55–64 years and from 27% to 2% among those aged 45–54 years.

In 1979 there was an estimated 2.2 million edentulous persons in Australia. This had dropped to 1.3 million people by 2002, and is projected to decline to 0.8 million people by 2019. As Stated above, from 2000 to 2010 the population of Australia is projected to increase by 1.8 million people (9.4%) from 19.1 to 20.9 million people. Over this same time period the dentate (toothed) population will increase by 2.2 million people (11.9%) from 17.7 to 19.9 million people. Therefore, the dentate population (those who are most likely to use dental services) will be increasing at a much greater rate than the population as a whole.

Other factors leading to increased demand for dental services

Other factors behind increasing demand include a range of macro-economic factors such as growth in gross domestic product and greater community affluence, as well as broad social factors such as growing awareness about the importance of, and consumer expectations about oral health. Technological developments within dentistry continue to broaden the range of dental services available to the community. Advances in diagnostic testing, more frequent interventions for common dental conditions and the improved efficacy of materials and techniques used in dentistry are also responsible for the increase in demand for dental services.

[10] Australian Bureau of Statistics, Australian Demographic Statistics. ABS Catalogue No. 3101.0, ABS n.d.

Per capita demand change 1979 to 1995

In late 2001-2002, the Dental Statistics and Research Unit (DSRU)[11] undertook the 'Oral Health Workforce Planning Project' for the New South Wales Department of Health, Oral Health Branch. One objective was to prepare a 10-year projection of the demand for oral health services and supply of oral health professionals across all disciplines in both the public and private sectors in NSW, specifically dentists, dental therapists, hygienists, prosthetists and dental assistants.

In order to predict future demand for dental visits, per capita demand for dental visits was analysed in New South Wales using data collected in the ABS Special Supplementary Survey 1979, the National Oral Health Survey of Australia 1987/88, and the 1994, 1995 and 1996 National Dental Telephone Interview Surveys. The data was broken down into ten specific age groups: 0-4, 5-11, 12-17, 18-24, 25-34, 35-44, 45-54, 55-64, 65-74 and 75+ years.

Between 1979 and 1995 the demand for dental visits in New South Wales increased significantly. For dentate persons, demand rose from 0.99 visits per year per capita in 1979 to 1.50 in 1995. For edentulous persons demand rose from 0.30 visits per year per capita in 1979 to 0.48 in 1995. In specific age groups the demand increased substantially, particularly for the 5-11 and 12-17 year olds and those aged 35 years and over. It was also clear that increasing per capita demand was not being driven solely by the decreasing rate of edentulism. Per capita demand had increased by approximately 50 per cent between 1979 and 1995 for both the dentate and edentulous groups.

While the factors behind this increasing demand are complex, past trends in demand give a basis for exploring the likely trends in demand into the future. Therefore, demand can be projected on the basis of linear calculations of past trends.

Dental problems remain very common. For example, dental caries (dental caries is a demineralisation of the tooth surface caused by bacteria) has been reported as the most widespread health condition in the population[12]. Use of dental services is increasing among adults. The percentage of adults making a dental visit in the previous 12 months for the 65 years

[11] DSRU is a collaborating unit of the Australian Institute of Health and Welfare, established in 1988 at The University of Adelaide.

[12] AIHW (Australian Institute of Health and Welfare). (2000) *Australia's Health 2000: the seventh biennial report of the Australian Institute of Health and Welfare*. Canberra: AIHW.

or more age group increased from 21% in 1979[13] to 61% in 1999[14]. Furthermore, tooth loss has declined and the percentage of edentulism among persons aged 65 years or more has dropped from 66% in 1979[15] to 33% in 1999[16].

While there are relatively stable numbers of children and young adults, population growth is projected as a result of substantially higher numbers of middle-aged and older adults, with consistent increases over time in the age groups 35–44 years to 65 years or more[17]. In addition to increase in the number of adults in the population, increase in the number of teeth requiring treatment is also expected as tooth loss declines[18].

The trends in use of services, oral health and population demographics indicate a shift in emphasis towards adult patients. The oral health trends indicate an increase in the pool of teeth at risk of oral disease. The increased number of adults retaining their teeth is likely to have an impact on dental practice.

Oral health trends have shown that levels of tooth loss have decreased, and as a result the pool of teeth potentially at risk of oral diseases has grown. The percentage of adult patients aged 45–64 years and 65 years or more has increased[19], reflecting demographic trends towards increased population growth among adults and retention of teeth within these cohorts.

Low-level interventions such as diagnostic and preventive services have increased, related to the increased pool of teeth at risk of dental problems. High-level interventions such as endodontic and crown and bridge services have also increased, related to retention of teeth among adult age cohorts. Overall, the service rate per visit has increased, reflecting growth in most service areas among adult patients, and a shift to adults for restorative services.

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[13] ABS (Australian Bureau of Statistics) (1979) *Dental health (persons aged 15 years or more) February – May 1979*. Canberra: ABS Cat. No. 4339.0.

[14] AIHW DSRU: Carter KD, Stewart J & Spencer AJ. (2001) National *Dental Telephone Interview Survey 1999*. Adelaide: AIHW DSRU, The University of Adelaide.

[15] ABS (Australian Bureau of Statistics) (1979) *Dental health (persons aged 15 years or more) February – May 1979*. Canberra: ABS Cat. No. 4339.0.

[16] AIHW DSRU: Carter KD, Stewart J & Spencer AJ. (2001) National *Dental Telephone Interview Survey 1999*. Adelaide: AIHW DSRU, The University of Adelaide.

[17] ABS (Australian Bureau of Statistics) (1990) *Estimated resident population by sex and age: States and Territories of Australia: June 1989 and preliminary 1990*. Canberra: ABS Cat. No. 3201.0.

[18] Spencer AJ & Lewis JM. (1988) *The delivery of dental services: information, issues and directions*. Community Health Studies XII:16–30.

[19] ABS (Australian Bureau of Statistics) (1990) *Estimated resident population by sex and age: States and Territories of Australia: June 1989 and preliminary 1990*. Canberra: ABS Cat. No. 3201.0.

Projecting increases in demand for dental services to 2010

According to the Australian Institute of Health and Welfare, the weighted number of dental visits per dentate person per year is projected to increase from 1.50 visits in 1995 to 1.86 visits in 2010[20], a 24.0% increase. The most significant features of the age-specific pattern of projected demand are:

- The continued increase in demand for visits among children and adolescents;
- The maintenance of the trough in demand among young adults; and
- The substantial growth in demand among dentate adults 35-44 years old and above.

Table 3: Estimated Dental Visits per Dentate Person per year

	Year			
Age	**1995**	**2000**	**2005**	**2010**
0-4	0.20	0.20	0.20	0.20
5-11	1.85	2.07	2.29	2.52
12-17	2.17	2.39	2.56	2.82
18-24	1.34	1.38	1.42	1.46
25-34	1.11	1.12	1.13	1.14
35-44	1.41	1.55	1.69	1.83
45-54	1.52	1.73	1.93	2.14
55-64	1.54	1.74	1.93	2.13
65-74	1.49	1.74	1.98	2.23
75+	1.40	1.63	1.85	2.08
Total (weighted)	**1.50**	**1.62**	**1.74**	**1.86**

Table 4 (below) presents the total demand for specific service areas for all age groups from 1995 and projected for 2010 under the assumption of a 50% continuation in linear trends in dental services per visit and 50% continuation in linear trends in dental visits per person per year. The projected total demand for services indicates considerable increases in Diagnostic, Preventive, Endodontic, Restorative and Crown and Bridge service areas. Only small increases in the number of services is projected for Oral Surgery, Prosthodontic, Orthodontic and General Miscellaneous areas.

[20] AIHW (Australian Institute of Health & Welfare) Dental Statistics and Research Unit (2003) *Demand for Dental Care.* AIHW Catalogue No. DEN 103 Research Report No. 8

Table 4: Estimated Dental Services per Visit for Specific Service Areas

	Year			
Service Area	**1995**	**2000**	**2005**	**2010**
Diagnostic	0.61	0.66	0.72	0.77
Preventative	0.35	0.40	0.46	0.51
Periodontic	0.02	0.02	0.02	0.02
Oral Surgery	0.08	0.08	0.07	0.07
Endodontic	0.12	0.14	0.17	0.19
Restorative	0.63	0.62	0.61	0.60
Crown & Bridge	0.07	0.08	0.08	0.09
Prosthodontic	0.11	0.09	0.08	0.06
Orthodontic	0.02	0.03	0.03	0.04
Miscellaneous	0.04	0.04	0.05	0.05
Total (weighted)	**2.05**	**2.16**	**2.27**	**2.38**

Past trends in demand for dental visits and dental services clearly predict increased demand for dental services. Demand for dental visits per person per year increased overall and particularly among school-aged children and adults aged 35 and over, whether edentulous or dentate. Demand for dental services per visit also increased substantially and more evenly across all age groups. It was apparent that much of the demand for dental services lies in the areas of Diagnostic, Preventive and Endodontic services. Population growth and ageing, plus the increased percentage of adults who are dentate, will continue to drive total demand higher.

Projected demand for dental visits 2000 to 2010

Using data collected between 1979 and 1995 (referred to above) the demand for dental visits in New South Wales in 2000 through to 2010 was then projected in each age group on the basis of:

- the estimated resident population of New South Wales (increasing from approximately 6.5 million in 2000 to 7.1 million in 2010);
- the estimated resident population who were or who are projected to be dentate and edentulous (taking into account trends in edentulism as more people in each age group retain a greater number of natural teeth);

- the per capita demand for dental visits for both dentate and edentulous persons based on a continuation of growth at the rate between 1979 and 1995 (extrapolated forward at either 0, 25, 50, 75 or 100 per cent of the linear trend continuing across the period 1996 to 2010).

It is not certain that the trend of the recent past (increasing per capita demand) will continue into the future. While continuation of 100 per cent growth in per capita demand was certainly thought possible, the authors of the 2002 NSW Oral Health Workforce Planning Project Report placed more emphasis on a conservative figure of 50 per cent rate of growth across 1979 to 1995 continuing through to 2010. Despite taking this reasonably cautious approach, the 50 per cent option nevertheless produces a substantial increase in demand projected for the year 2010 of 23.2 per cent (see Table 5 below).

Table 5: Requirement for dental visits, New South Wales 2000 and 2010[21]

	Dental visits (1000s)					
	2000			2010		
Age	**Growth rate 1995+**			**Growth rate 1995+**		
(years)	**0%**	**50%**	**100%**	**0%**	**50%**	**100%**
0–4	86.0	86.0	86.0	81.5	81.5	81.5
5–11	1,174.6	1,240.6	1,306.6	1,130.9	1,321.6	1,512.2
12–17	1,151.4	1,207.7	1,264.0	1,179.4	1,352.4	1,525.4
18–24	808.5	826.1	843.7	849.1	904.4	959.7
25–34	1,068.3	1,075.8	1,083.3	1,070.7	1,092.9	1,115.1
35–44	1,388.1	1,456.1	1,524.1	1,438.8	1,649.7	1,860.7
45–54	1,232.7	1,323.0	1,413.3	1,464.3	1,784.7	2,105.2
55–64	810.7	864.1	917.5	1,225.4	1,463.9	1,702.4
65–74	548.5	591.9	635.3	723.2	892.6	1,061.9
75+	371.7	402.4	433.1	516.3	642.3	768.3
Total	8,640.6	9,073.8	9,507.0	9,679.5	11,185.9	12,692.4
% change 2000 to 2010				**12.0**	**23.2**	**33.5**

Demand for dental visits within the private and public sectors

The preceding information relates to the population of NSW as a whole and does not differentiate between persons eligible for public dental care (and those who are not) or between persons who access care in the public as opposed to the private sector.

[21] Reproduced in Spencer AJ. *The 2002 New South Wales Oral Health Workforce Planning Project* Australian Institute of Health and Welfare (Dental Statistics and Research Unit) University of Adelaide, 2002

Table 6 below, uses data derived from the AIHW DSRU National Dental Telephone Interview Survey 1994–96 for Australia. It sets out the age specific percentages of eligible and non-eligible persons who had visited a dental service in NSW in the previous 12 months as well as the place of their last dental visit:

Table 6: Age specific percentage of the New South Wales population eligible for use of public dental services and place of last dental visit among persons who had made a dental visit in the previous 12 months[22]

	Eligibility		Place of last visit		
Age (years)	**Eligible**	**Non-eligible**	**Public dental clinic**	**School Dental Service**	**Private practice**
5–11	23.4	76.6	9.0	45.1	45.9
12–17	19.7	80.3	19.9	17.3	62.8
18–24	16.6	83.4	13.3	-	86.7
25–34	13.2	86.8	7.0	-	93.0
35–44	7.9	92.1	6.1	-	93.9
45–54	10.1	89.9	4.9	-	95.1
55–64	24.7	75.3	6.5	-	93.5
65–74	49.0	51.0	10.4	-	89.6
75+	38.9	61.1	11.2	-	88.8
Total (weighted)	**19.1**	**80.9**	**9.4**	**8.3**	**82.3**

As can be seen in Table 6, approximately 19 per cent of persons surveyed in NSW who had used a dental service in the previous 12 months were eligible for public dental services. Not surprisingly, eligibility steadily increased with age. The most common place of last dental visit was private practice, with 82.3 per cent of persons in New South Wales reporting that they last visited this type of practice. Only 9.4 per cent of persons visited a public dental clinic while 8.3 per cent visited a School Dental Service.

The projected demand for dental visits in 2010, based on a person's eligibility, is set out in the table 7 (below). The projection is based on 50 per cent of the rate of growth in demand for visits for the period 1979 to 1995 continuing through to 2010. On this basis the projection results in a 29.5 per cent increase in demand for dental visits by persons eligible to receive public dental services in 2010 and a more modest 21.8 per cent increase for those who are not eligible.

[22] Reproduced in Spencer AJ. *The 2002 New South Wales Oral Health Workforce Planning Project* Australian Institute of Health and Welfare (Dental Statistics and Research Unit) University of Adelaide, 2002

Table 7: Requirement for dental visits, New South Wales 2000 and 2010 for persons eligible and non-eligible for public dental services (growth rate 1995+ 50%)[23]

Age (years)	Dental visits (1,000s)			
	Eligible		Non-eligible	
	2000	2010	2000	2010
0–4	20,125	19,064	65,878	62,405
5–11	290,304	309,248	950,310	1,012,324
12–17	237,921	266,419	969,802	1,085,963
18–24	137,127	150,127	688,938	754,253
25–34	142,009	144,261	933,818	948,628
35–44	115,034	130,330	1,341,097	1,519,413
45–54	133,621	180,259	1,189,357	1,604,480
55–64	213,441	361,584	650,692	1,102,318
65–74	290,037	437,350	301,875	455,201
75+	156,543	249,854	245,881	392,444
Total	**1,736,161**	**2,248,495**	**7,337,649**	**8,937,430**
% change 2000 to 2010		**29.5**		**21.8**

An alternative to projecting demand based on eligibility status is to project demand based on a person's last place of visit for dental care. This is because a high proportion of eligible persons do not actually seek dental treatment in the public sector. Rather, they seek dental care in the private sector. The projected demand for dental visits in 2010, based on a person's place of last visit, is given in table 8 (below). The demand for dental visits is split between private and public dental services (once again based on 50 per cent of the previous linear trend in demand for the period 1979 to 1995).

[23] Reproduced in Spencer AJ. *The 2002 New South Wales Oral Health Workforce Planning Project* Australian Institute of Health and Welfare (Dental Statistics and Research Unit) University of Adelaide, 2002

Table 8: Requirement for dental visits, New South Wales 2000 and 2010 for persons whose last visit was to a private practice or public dental service (growth rate 1995+ 50%)

Age (years)	Dental visits (1,000s)			
	Private practices		Public dental services	
	2000	2010	2000	2010
0–4	86,003	81,469	0	0
5–11	569,442	606,602	671,172	714,971
12–17	758,450	849,296	449,273	503,086
18–24	716,198	784,097	109,867	120,283
25–34	1,000,519	1,016,387	75,308	76,502
35–44	1,367,307	1,549,109	88,824	100,634
45–54	1,258,152	1,697,287	64,826	87,452
55–64	807,965	1,368,749	56,169	95,154
65–74	530,353	799,725	61,559	92,825
75+	357,352	570,361	45,071	71,937
Total	**7,451,742**	**9,323,080**	**1,622,068**	**1,862,844**
% change 2000 to 2010		**25.1**		**14.8**

Reproduced in Spencer AJ. *The 2002 New South Wales Oral Health Workforce Planning Project* Australian Institute of Health and Welfare (Dental Statistics and Research Unit) University of Adelaide, 2002

As can be seen from Table 8 (above), demand for dental visits was projected to increase by 25.1 per cent for persons who last attended a private dental practice and by only 14.8 per cent for persons who last attended a public dental facility. This contrasts with data from Table 7 which is based on eligibility status rather than place of last visit. In Table 7 demand for dental care for eligible persons is projected to increase by 29.5 per cent and by a more modest 21.8 per cent for those who are not eligible. This is because many people who are in theory eligible for public dental services nonetheless attend private practices because they cannot wait for treatment on lengthy public waiting lists. In other words, government policies that effectively ration access to oral health care play an important role in determining the level of demand for these services.

Summary

A number of factors contribute to the increasing demand for dental care including population change, an ageing population, changing rates of edentulism and broad economic, social and technological change. Regardless of how one looks at future demand for dental visits and services, the projected trend is for a continuation of the significant increase in demand for these services established over the last two decades.

AUSTRALIAN DENTAL LABOUR FORCE PROJECTIONS TO 2015

The Dental Statistics and Research Unit have published dental labour force projections[24]. Table 9 below outlines the projected number of practising dentists in Australia from 2005 to 2015.

Table 9: Projected number of practising dentists 2005 to 2015

	2005		2007		2009		2011		2013		2015	
Age Group	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
20-24	110	75	110	75	110	75	110	75	110	75	110	75
25-29	572	402	582	406	589	409	592	410	594	411	596	412
30-34	610	398	618	407	626	414	633	418	639	422	643	424
35-39	704	392	689	397	684	404	683	410	686	415	689	419
40-44	1,025	439	977	460	941	476	915	490	899	501	889	511
45-49	1,132	347	1,111	376	1,082	401	1,051	421	1,023	438	1,000	453
50-54	1,051	231	1,064	263	1,064	291	1,054	317	1,038	339	1,018	358
55-59	887	127	935	155	969	182	991	207	1,000	229	1,001	250
60-64	585	55	639	70	688	87	727	105	758	122	780	139
65-69	274	14	297	19	323	24	348	30	371	36	390	43
70-74	190	5	199	6	211	8	226	10	242	12	259	15
75+	84	4	87	3	91	3	95	3	101	4	108	5
Total	7,224	2,488	7,310	2,638	7,377	2,774	7,427	2,897	7,461	3,006	7,481	3,102
Combined Total	**9712**		**9948**		**10,151**		**10,324**		**10,467**		**10,583**	

These projections were calculated using a total annual recruitment of 489 dentists per year together with medium age/sex specific wastage rates (as predicted by Teusner and Spencer[25]). The national dentist labour force is projected to increase from 8,991 in 2000 to 10,583 by the year 2015, an increase of 17.7%. While projected growth, up to the year 2010, is expected to slightly out pace population growth, by 2013 the practising rate per 100,000 population starts to decline, indicating that projected growth in the labour force will not keep pace with population

[24] Australian Institute of Health and Welfare Dental Statistics and Research Unit (1998) *Australia's Oral Health and Dental Services*. AIHW Cat. No. DEN 13. (Dental Statistics and Research series No. 18). Adelaide: The University of Adelaide.
[25] Ibid.

growth in the longer term. Around this time a large number of baby boomers will begin retiring from the workforce. This will have serious implications for future service delivery.

ELIGIBILITY FOR PUBLIC ORAL HEALTH CARE IN NSW INCLUDING AND WAITING TIMES FOR TREATMENT IN PUBLIC FACILITIES

Key Points

- **On current estimates, between 2.2 million and 3.1 million people are eligible for public dental care in New South Wales;**

- **Waiting lists and waiting times are now so long that many (if not most) people on low incomes needing to access public dental services are effectively denied all but emergency care and pain relief.**

The eligibility of persons for public oral health care is set out in NSW Health Circular 2000/99 which States that:

> "All persons who are normally resident in New South Wales and hold one of the Centrelink concession cards listed below are eligible for free oral health care in NSW public oral health clinics (usually within their Area Health Service of residence). These concession cards include:
>
> - Health Care Cards
> - Pensioner Concession Cards
> - Commonwealth Seniors Health Cards.
>
> All dependants listed on Health Care Cards and Pensioner Concession Cards are also eligible for free oral health care in NSW public oral health clinics usually within their Area Health Service of residence."

Eligibility also extends to preschool (0-5) as well as school aged children:

> "All persons of preschool (0-5 yrs) age and those persons less than 18 years of age undertaking fulltime primary, secondary or tertiary studies at an educational institution (school, TAFE, University and other recognised tertiary institutions) or at home, or hold a concession card in their own right, are eligible for free public oral health care."

Although the criteria for eligibility appears fairly straight forward, the exact number of persons eligible for public dental care in NSW is some what more difficult to determine. According to the AIHW Dental Statistics and Research Unit's National Dental Telephone Interview Survey

1999, 33.5 per cent of adults in NSW were eligible for public dental services.[26] The estimated residential population of NSW in 2001 was 6,609,304. On the basis that 33.5 per cent of these were eligible persons, the Oral Health Branch estimated in September 2004 that there were approximately 2,214,000 persons eligible for public dental care in NSW in 2001.[27] In March this year however the Centre for Oral Health Strategy NSW Stated that approximately 3.1 million people (1.8 million adults and 1.3 million children) were eligible for public dental care in NSW. [28] If this figure is correct, almost 50 per cent of the State's population is eligible for public oral health care.

Waiting times for treatment in public dental facilities

The capacity of the NSW public system to provide treatment for eligible patients is at crisis point. Chronic under-funding has resulted in a system rapidly losing the capacity, infrastructure and staff to deliver critical dental services to those in need across the State.

The inability of public oral health clinics to meet the demands placed upon them ensures general oral health services are provided to public patients mostly in response to emergency and acute needs only, either through the Priority Oral Health Program (POHP) or the Oral Health Fee for Service Scheme. In August 2004 there were 162,303 clients on State-wide oral health waiting lists.[29] Waiting lists and waiting times are now so long that many (if not most) people on low incomes needing to access public dental services are effectively denied all but emergency care and pain relief. Anecdotal reports from our members suggest many public dental clinics have given up altogether on waiting lists for general dental treatment.

[26] Spencer J. *What options do we have for organising, providing and funding better public dental care?* Australian Health Policy Institute Commissioned Paper Series 2001/2, The University of Sydney, 2002
[27] *The NSW Public Sector Oral Health Workforce: a working paper on the present situation, projections for 2010 and proposed activities to address issues*, Oral Health Branch, NSW Health Department, Sydney 2004
[28] *Oral Health Futures Issue Paper: Oral health problems painful, costly and preventable*, Centre for Oral Health Strategy, NSW Health Department, Sydney, March 2005
[29] Ibid.

THE FUNDING AND AVAILABILITY OF DENTAL SERVICES, INCLUDING THE IMPACT OF PRIVATE HEALTH INSURANCE

Key Points

- **Funding for dental services occurs through a combination of direct and indirect government funding, private health insurance and, most significantly, contributions from individual consumers;**

- **Per capita spend on public dental services in New South Wales is now the lowest of all States and Territories and falls significantly below the Northern Territory, Queensland, Tasmania and South Australia;**

- **Both State and Federal funding should be made available for the provision public dental services; the Federal government should play a leading role in developing and coordinating a national approach to oral health planning and all levels of government should ensure that adequate funds are provided to meet public oral health needs;**

- **Initiatives to encourage private health insurance (including ancillary cover) do not diminish a government's obligation to develop, implement and fund oral health policies that benefit those members of the community who cannot afford private dental care;**

- **The Federal Governments 30 per cent rebate on private health insurance benefits high income earners who can generally afford private dental care. More attention needs to be focused on providing direct funding for those who cannot afford private dental care or private health insurance.**

The funding of dental services in Australia

Spending on dental services in Australia is funded through a combination of direct and indirect government funding, private health insurance and, most significantly, contributions from individual consumers. An estimate of total dental spending in Australia is published annually by the Australian Institute of Health and Welfare. The most up to date statistics available are for

2002-03 and were published in September 2004.[30] Based on this information, it is possible to show that:

- Expenditure on oral health ranks seventh highest among the disease groups that account for the greatest level of health expenditure in Australia.

- Total expenditure on dental services in Australia in 2002-03 was $4.37 billion, the equivalent of 6.06% of total health expenditure. This has grown from $1.71 billion 1992-93 when dental services expenditure was the equivalent of 4.90% of total health expenditure.

- As a proportion of total expenditure on dental care, the Commonwealth Government's share has fallen from 2.22% in 1992-93 to 1.78% in 2002-03. (Total expenditure by the Commonwealth has risen from $38 million to $78 million in this period.) Direct expenditure by the Commonwealth Government peaked at $152 million in 1995-96 (the equivalent of 7.31% of total dental expenditure), the year before the Commonwealth Dental Health Program ceased.

- Indirect expenditure by the Commonwealth Government on dental care, through the 30% rebate for private health insurance, was $298 million in 2002-03, the equivalent of 6.81% of total dental expenditure. This figure had risen to $357 million in 2004-05.

- Expenditure by State and Territory and Local Governments was $342 million in 2002-03, the equivalent of 7.82% of total dental expenditure. This is a fall from its peak in 1999-00, when expenditure on dental services was $373 million, the equivalent of 12.94% of total dental expenditure. (State and Territory Governments are responsible for public dental services and school dental programs.)

- Expenditure by private health insurance funds was $680 million in 2002-03, the equivalent of 15.54% of total dental services expenditure. This proportion has halved since 1992-93 when expenditure was $535 million, the equivalent of 31.30% of total dental services expenditure.

[30] Australian Institute of Health and Welfare (AIHW) 2004. Health expenditure Australia 2002–03. AIHW Cat. No. HWE 27 (Health and Welfare Expenditure Series No. 20). Canberra: AIHW.

- The most significant contributor to funding for dental services however is expenditure by individual consumers. This expenditure has grown significantly in the period from 1992-93 to 2002-03, rising from $984 million (the equivalent of 57.58% of total dental expenditure), to $2.96 billion (the equivalent of 67.73% of total dental services expenditure).

The funding of dental services in New South Wales

The Commonwealth Government directly funds a small mix of dental services, for example via funding for specific populations through the Department of Veterans' Affairs, Department of Defence, in-hospital oral care services and outpatient radiological services through Medicare. Nevertheless, the total level of direct Commonwealth funding to New South Wales for oral health services is not thought to be large given that total spending in 2002/2003 was only $78 million.

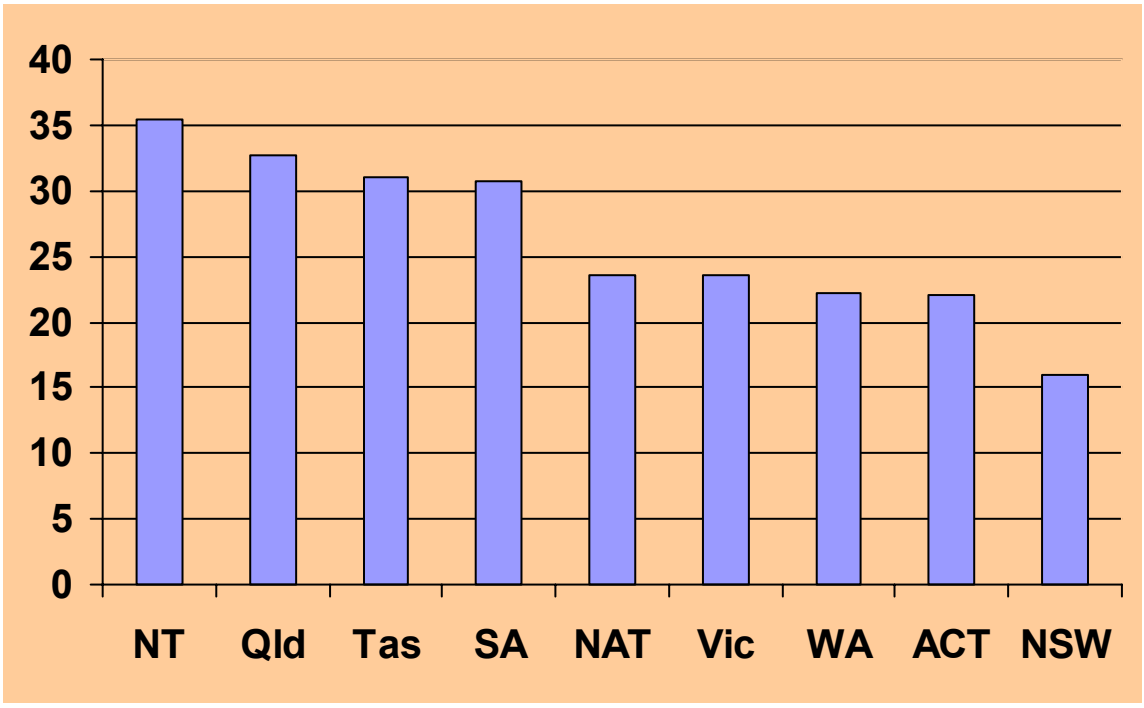
Traditionally, State and Territory governments have assumed foremost responsibility for the provision of public dental services to adults and to children through school dental programs as has occurred in New South Wales.

The Branch has stated publicly that a substantial increase in State government funding is required in order to provide adequate public dental services to the community of NSW. The current level of funding for oral health services in the 2005/2006 budget has been stated to be approximately $120 million (although the Branch has yet to see written confirmation of this figure from either NSW Treasury or NSW Health). This is approximately 1.1% of the total health budget allocated this financial year ($10.9 billion). This level of funding is simply inadequate. As shown in Table 9 below, per capita spend on public dental services in New South Wales is now the lowest of all States and Territories and falls significantly below the Northern Territory, Queensland, Tasmania and South Australia.

Table 10: State and Territory dental expenditure, population and per capita dental expenditure 2004/2005

	2004/2005 dental expenditure ($)	Population as at December 2004[31]	Per capita dental expenditure ($)
Northern Territory	$7,116,000[32]	200,800	$35.43
Queensland	$127,900,000[33]	3,919,500	$32.63
Tasmania	$15,025,000[34]	484,000	$31.04
South Australia	$47,130,000[35]	1,537,900	$30.65
Victoria	$117,700,000[36]	5,002,300	$23.53
Western Australia	$44,500,000[37]	1,998,400	$22.27
ACT	$7,154,800[38]	324,300	$22.06
New South Wales	$109,700,000[39]	6,760,000	$16.23
Australian Total	**$476,225,800**	**20,229,800**	**$23.54**

Figure 1: Per capita State and Territory dental expenditure 2004/2005



[31] Australian Bureau of Statistics, 3101.0 Australian Demographic Statistics, 3 June 2005
[32] Source: Vera McMahon (Business Manager) Northern Territory Oral Health Branch
[33] Source: Penny Slater, Manager (Planning and Evaluation) Queensland Oral Health Unit
[34] Angie Byrom (Statewide Manager) Oral Health Services, Tasmania
[35] Source: Martin Doolan (CEO) South Australian Dental Service
[36] Parliament of Victoria, Public Accounts and Estimates Committee, Report on the 2004-2005 Budget Estimates, November 2004, p.227
[37] Source: Peter Jarman (Manager, Central Clinical & Support Services) WA Dental Health Services
[38] Source: Fran Thomas (Finance Manager) Dental Health Program, ACT Health
[39] NSW Parliament Hansard, Deferred Answer from the Minister for Health, Legislative Council, 24 May 2005

As both Table 10 and Figure 1 (above) demonstrate, per capita spending on oral health care by the New South Wales State Government is now the lowest in the country. Per capita spending in 2004/2005 in the Northern Territory and Queensland was over twice that of New South Wales while Tasmania and South Australia spent almost double the amount spent in this State (on a per capita basis).

This begs the question as to how much the State government should allocate for the provision of public oral health services.

The estimated population of New South Wales in December 2004 was 6.76 million people. If per capita spending on oral health services in New South Wales in 2004/2005 was set at a level equivalent to that of the Northern Territory, Queensland, Tasmania or South Australia, then the total budget allocation would have been (in descending order): $239.5 million; $220.6 million; $209.8 million; or $207.2 million. Instead, the budget allocation for oral health services in New South Wales in 2004/2005 was only $109.7 million.

This level of funding is totally unacceptable given that the combined funding for oral health services in New South Wales by the State and Commonwealth governments prior to 1 January 1997 (when funding for the short lived Commonwealth Dental Health Program was cut) was $103 million per annum. This submission does not intend to re-enter the debate about who is responsible for funding public oral health care services in New South Wales except to State that the Australian Dental Association believes that both State and Federal funding should be made available for the provision public dental services, and furthermore, the Federal government should play a leading role in developing and coordinating a national approach to oral health planning in this country. Until this happens however, it must continue to be the responsibility of the State government to ensure that adequate funds are provided to meet the oral health needs of those members of the community who cannot afford or cannot access private dental care in this State.

It is not an unreasonable proposition that any proposal to increase government funding for oral health care should at least match the per capita funding of Queensland. On this basis, ADA NSW would argue that the minimum annual allocation, based on a population figure for December 2004, should be at least $220.6 million.

The impact of private health insurance

The policy of the Australian Dental Association is to support Commonwealth government initiatives that encourage the community to take out private health insurance (including ancillary cover) through taxation rebates or other financial incentives. However, the financing of these incentive programs should not diminish that Government's obligation to fund reasonable levels of oral health care for those groups in the community who cannot afford, or are unable to access, dental care without this assistance.

The policy of the ADA is to support the 30% rebate for private health insurance on the basis that it makes ancillary cover (through private health insurance) more affordable. Dental cover is a significant aspect of private health insurance as it accounts for over 50 per cent of all ancillary service benefits.[40] Since the 30 per cent rebate for private health insurance was introduced in 1999, the number of dental services provided through private health insurance has grown from 14.4 million in 1999 to 22.7 million in 2004.[41] On this basis it can be argued that the removal of the 30 per cent rebate might lead to much greater unmet demand for dental treatment.

Research conducted by ADA NSW with its membership shows that some of this unmet demand is currently picked up by the private sector either through the waiving of fees or some other form of pro bono work. This research suggests the level of fees involved is in excess of $30 million per annum, including fee subsidization by private of existing publicly eligible schemes. This is supported by the National Oral Plan, *'Healthy Mouths Healthy Lives'* published by the National Advisory Committee on Oral Health (NACOH) and endorsed by the Australian Health Ministers Advisory Council (AHMAC) which notes:

> "The contribution of the private sector also includes the treatment of needy patients through publicly funded schemes, lowering fees for vulnerable patients, and continued support for community prevention measures (eg water fluoridation, tobacco cessation programs, health promotion)."[42]

Any proposed changes to current funding mechanisms would need to be considered in light of the potential impact on levels of unmet need in the community resulting from the high cost of

[40] Private Health Insurance Administration Council (2004), *Operations of the Registered Health Benefits Organisations Annual Report 2003–04*, PHIAC, Canberra, p. 35.
[41] Source: Private Health Insurance Administration Council, 'Statistical Trends in Membership and Benefits', Accessed from www.phiac.gov.au/statistics/trends/index.htm on 13 April 2005.
[42] National Advisory Committee on Oral Health (NACOH). *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013,* p. VI

dental service delivery. The level of government funding for dental services (whether direct or indirect) will impact upon the cost and availability of these services.

Nevertheless, ADA NSW does have concerns about current inequities in the 30 per cent private health insurance rebate. This measure was introduced in January 1999 to encourage people to take up private health insurance. The 30 per cent rebate means that any one spending $100 on private health insurance premiums will receive a $30 rebate from the Commonwealth government via a reduced premium, through direct payments from Medicare or through a tax rebate.

According to latest figure available from the Commonwealth Department of Health and Aging, the proportion of the 30 per cent rebate estimated to relate to dental insurance is $357 million. Individual benefits are much greater for higher income earners than for low income earners. For example, Spencer estimated in 2001 that the mean rebate per individual in various income categories was calculated to range from $12.77 in the <$20,000 income category to $60.29 in the $100,000+ income category. This is despite the fact that traditionally, public expenditure on oral health services has been targeted at low income earners and eligible concession card holders.

Prior to the introduction of the 30 per cent rebate private health insurance the Federal Government shut down the Commonwealth Dental Health Program 7. Two reasons cited at the time were the budget black hole inherited by the new government when it came to power in mid 1996 and that the program had successfully achieved its goal of eliminating significant public dental waiting lists. At the time the program was providing approximately $100 million in direct funding for the provision of dental services by State and Territory governments. In New South Wales, the loss of annual funding from January 1997 was approximately $34 million, or 36 per cent of the public dental budget. Nevertheless, within two years the Federal Government had implemented the 30 per cent private health insurance rebate, including for dental premiums, costing it approximately $300 million per annum. This was approximately three times what the Commonwealth Dental Health Program had cost. While there were some problems with this Federal program, it was relatively successful in reducing dental waiting lists in New South Wales for those members of the public who could little afford treatment in the private sector.

Finally, the 30 per cent private health insurance rebate allows the Commonwealth Government to claim that it plays a significant role in the funding of oral health care, albeit indirectly. Unfortunately, this also allows it to conveniently side-step any responsibility for developing and

implementing a national oral health policy dealing with matters such as oral health promotion, oral health research and workforce issues. The Federal Government has repeatedly stated that the provision of dental services is a State and Territory responsibility. Despite this assertion, ADA NSW believes the Federal Government must play a lead role in developing and implementing a national oral health policy such as the one outlined in the National Oral Plan prepared by the National Advisory Committee on Oral Health established by the Australian Health Ministers' Conference.

ACCESS TO PUBLIC DENTAL SERVICES, INCLUDING ISSUES RELEVANT TO PEOPLE LIVING IN RURAL AND REGIONAL AREAS OF NEW SOUTH WALES

Key Points

- **Access to dental services for many people is becoming increasingly difficult (if not impossible) in the public sector and in rural and regional areas;**

- **The Oral Health Fee for Service Scheme (OHFFSS) was developed to improve access to basic oral health care for eligible persons and their dependents by engaging private practitioners to provide acute oral health care to public patients;**

- **ADA NSW supports the OHFFSS but calls on the State government to ensure that fees levels, with or without patient co-payment, adequately remunerate practitioners and guarantee the involvement of the greatest number of participants.**

For many years now the Branch has been warning of the growing problems affecting access to dental services in this State, particularly in the public sector and especially in rural and regional areas. Recent media reports have graphically highlighted the problems facing publicly eligible patients trying to access public dental services. The scope of the problem begins with insufficient funding and is further exacerbated by an inability to recruit and retain sufficient numbers of dentists in these areas.

There are approximately 240 dentists currently employed in public dental clinics servicing the oral health needs of more than 3 million publicly eligible persons in New South Wales (1.8 million adults and 1.3 million children). Further exacerbating this problem is the fact that there are currently between 40 and 50 vacant positions for dentists in public clinics across the State.

Outside major urban areas the oral health of many people is further compromised because of significant disadvantage in accessing timely and comprehensive oral health care. A major factor is the difficulty in attracting and retaining dentists to rural and remote areas, both general practitioners and specialists, as well as other oral health professionals. This is a problem not just in New South Wales but across the whole country and affects all health care professionals.

Improved oral health delivery and a viable dental workforce in rural and regional areas will only result from improved planning by all Governments in collaboration with the dental profession

and other stakeholders. A co-ordinated approach involving improved education and training, greater local community support and involvement, increased incentives, and better work conditions is urgently needed before significant progress can be made in overcoming barriers to accessing dental care by people who live in rural and regional areas. Although increased government funding is not the sole answer to this problem, it is stating the obvious to note that significant increased funding will be central to any solution.

The inability of public oral health clinics to meet the demands placed upon them ensures general oral health services are provided to public patients mostly in response to emergency and acute needs only, either through the Priority Oral Health Program (POHP) or the Oral Health Fee for Service Scheme (OHFFSS). In August 2004 there were 162,303 clients on State-wide oral health waiting lists.[43] Waiting lists and waiting times are now so long that many (if not most) people on low incomes needing to access public dental services are effectively denied all but emergency care and pain relief.

The Oral Health Fee for Service Scheme

The OHFFSS was implemented in 2001 in consultation with ADA NSW to assist public oral health clinics cope with the increasing demand for oral health care by providing an alternative avenue for acute oral health treatment and provision of denture services. The scheme aims to improve access to basic oral health care for eligible persons and their dependents by engaging private oral health care providers (mostly private practicing dentists) to provide acute oral health treatment and denture services in addition to services provided by Area Health Service staff and visiting dental officers.[44]

The intention of the OHFFSS is to use the extensive network of private dental practitioners already in existence in conjunction with public health facilities. Fees for each item included on the OHFFSS fee schedule are determined by the NSW Health Department. Participating dentists are prohibited from charging additional fees for treatment provided under the scheme, regardless of whether or not the set payment corresponds with their usual or customary fee. Although the NSW Health Department claims that fees for items on the OHFFSS Schedule of Fees are 'reviewed annually in consultation with the NSW Branch of the ADA',[45] this has failed to occur

[43] Ibid.
[44] NSW Health Department, Circular 2004/38 NSW Oral Health Fee For Service Scheme (OHFFSS), issued 29 July 2004
[45] NSW Health Department, Circular 2004/38 NSW Oral Health Fee For Service Scheme (OHFFSS), issued 29 July 2004

in practice. Payment for most items on the list are currently well below the customary fees charged by most private practitioners.

OHFFSS should remunerate private practitioners in accordance with their usual and customary fee, with patient co-payment supplementing the government fee component where necessary. The inadequate level of fees currently provided under the scheme acts as a strong disincentive on private dentists to participate in this program. In many cases, existing fees fails to meet the true cost to the practitioner in providing the treatment. The practitioner in this situation is in effect being asked to subsidise public oral health care. Recent member surveys conducted by the Branch have indicated that many more members would be willing to participate if the level of fees set by the Department more realistically reflected fees in private practice, or if they were able to charge a patient co-payment to supplement the government fee.

The introduction of patient co-payments provides additional revenue to fund dental services for publicly eligible patients. Unfortunately, co-payments most likely depress demand for public dental care, particularly in the most disadvantaged sections of the community. Nevertheless, many Australian jurisdictions have introduced co-payments for dental health services provided in public dental facilities.[46] In 1999 the Chief Executive Officer of Dental Health Services Victoria noted that 'while the introduction of co-payments [was] likely to have had negative effects, without them public dental services in Victoria would have been restricted to relief of pain with even worse consequences.'[47]

Improving access to oral health care services

OHFFSS improves access to basic oral health care for public patient by providing them with an alternative avenue for acute oral health treatment and the provision of denture services. This relieves pressure on public health facilities struggling to cope with increasing community demands for better oral health care. However, fees provided to private practitioners under the scheme must reflect and compensate them for the true cost of providing the service. While there is concern that the introduction of co-payments for OHFFSS patients will impact the greatest upon the most disadvantaged sections of the community, the Branch believes that the benefits to be gained outweigh the detriment. A greater number of publicly eligible patients will be provided with quicker, easier access to a greater number of dental care providers. This will be particularly

[46] Auditor General Victoria, Community Dental Services, October 2002

[47] Dooland, M., The Impact of Co-Payments on Public Dental Services: The Victorian Experience, Health Issues, No. 61, December 1999

beneficial in areas where there are currently no participating private practitioners, or where access to public dental facilities is difficult.

Patient co-payments should also improve the treatment options available for a significant number of public patients who would otherwise be restricted to seeking treatment in public oral health clinics or denied treatment altogether. At the same time, the increased number of private practitioners participating in the scheme should help to relieve pressure on public dental health facilities, thereby mitigating any adverse impact upon those members of the community unable to make a patient co-payment.

ADA NSW is not seeking to introduce patient co-payments for services provided in public dental facilities by publicly employed dental practitioners. Rather, patient co-payments seek to more realistically align fees with the true cost of the service to the provider. As noted, in many cases existing fees fail to reflect the true cost to the dentist providing the service. These practitioners, if they chose to participate, are in effect being asked to subsidise public oral health care on behalf of the government. This situation cannot continue to exist. While it is acknowledged that there are significant concerns about the equity of patient co-payments, the alternative is for government to significantly expand public funding for the treatment of public patients in the private sector. Without one or the other the OHFFSS will collapse as dentists vote with their feet and choose not to participate, further exacerbating the existing crisis in public dental facilities.

Finally, patient co-payments may also have a beneficial impact on access to private dental care, particularly in rural and remote areas. As noted previously in this submission, following the axing of the Commonwealth Dental Health Program in 1997, there were anecdotal reports of private practitioners in rural and remote areas in NSW closing up shop following the loss of income from the public scheme, demonstrating a link between fees for services provided to public patients and private practice viability in these areas.[48] These public patients were in effect guaranteeing access to dental services for private patients, many of whom only just fail to qualify as publicly eligible patients themselves.

The State government must act to ensure the ongoing viability of the OHFFSS. If there is no significant increase in funding for items on the OHFFSS Schedule of Fees, patient co-payments will be necessary to maintain the integrity of the system. The level of remuneration for

[48] Bragg, R. 'Primarily Pain Relief: Public Dental Services in NSW', Health Issues, No. 61, December 1999, p. 15-16

participating dental practitioners must be set at a level that adequately compensates them for their services and at the same time encourages the greatest number of dental practitioners to participate to maximize oral health outcomes in the community.

DENTAL WORKFORCE INCLUDING ISSUES RELATING TO THE TRAINING OF DENTAL CLINICIANS AND SPECIALISTS

Key Points

- **Current remuneration rates and the limited range of services and funding available make it increasingly difficult to recruit and retain dental officers in the public sector;**

- **Structured career pathways and/or vocational training will not alone overcome these problems;**

- **Governments at all levels must do more to ensure that university dental faculties are appropriately funded and that increasing student fees do not act as a barrier to entry into dentistry for talented young Australians.**

The inability to recruit and retain a sufficient number of public sector dentists is a significant barrier to the provision of a sufficient, sustainable and appropriately skilled labour force to meet the oral health needs of NSW. The following factors all contribute to discourage recruitment and retention in the public sector oral health workforce:

- failure to provide attractive remuneration commensurate with the private sector (as well as salary differences with dentists in other jurisdictions, i.e. particularly Queensland);
- staff frustrations with the funding base for public dental services and the implications for service delivery and oral health outcomes;
- lack of career structure as well as lack of incentives for post-graduate study and continuing professional education opportunities; and
- the nature of the patient base and long waiting lists resulting in a high proportion of emergencies and a limited range of treatments being offered.

Current rates of remuneration make it difficult to recruit and retain dental officers in the public sector

The following tables illustrate the significant salary differences that exist between dental officer and specialist positions in New South Wales and Queensland.

Table 10: Comparison of Dental Officer Salaries in New South Wales and Queensland

GRADE	NSW[49]*	QLD*
Dental Officer Grade 1		
Year 1	$ 48,797	$ 65,602
Year 2	$ 52,508	$ 67,282
Year 3	$ 56,223	$ 68,954
Year 4	$ 59,935	$ 72,166
Year 5	$ 63,646	$ 73,932
Year 6	$ 67,361	$ 75,703
Year 7	$ 71,071	$ 77,462
Dental Officer Grade 2		
Year 1	$ 73,857	$ 79,340
Year 2	$ 76,635	$ 81,219
Dental Officer Grade 3	$ 79,793	$ 83,835
		$ 86,648
Dental Officer Grade 4	$ 83,135	$ 89,458
		$ 91,766
Dental Officer Grade 5	$ 87,776	$ 95,823
		$ 99,580

Despite the fact that a rural incentive scheme of up to $20,000 per annum applies for all Dental Officers employed outside the metropolitan area, this appears to have done little to encourage dentists to take up these positions.

Table 11: Comparison of Dental Specialist salaries in New South Wales and Queensland

SPECIALIST	NSW[50]**	QLD
Year 1	$82,205	$95,823
Year 2	$85,361	$99,580
Year 3	$88,516	$103,342
Year 4	$91,856	$107,094
Year 5	$95,198	$110,859
		$114,613
		$118,372

** All specialists also receive the following allowances: 10% on call

15% in lieu of private practice

[49] Effective from first pay period commencing on or after 1 July 2004.
[50] Effective from first pay period commencing on or after 1 July 2004.

Salary differences between the private and public sector are even more extreme. For example, a job advertisement for the role of Dentist in a clinic run by a private health insurance fund in 2004 advertised the following package for a graduate with a 'minimum of two years post graduate experience:

Salary:

From $90,000+ per annum, commensurate with experience
Up to 12% superannuation
Up to $500 Health Insurance Subsidy
Rural Incentive Scheme (***Conditions Apply*)

Benefits:

Average 38 Hour work week, for full-time positions
Negotiable rostered days off
Great physical work environment
Corporate Health Program – Total Health
Superannuation benefits
Work/life balance programs
Employee Assistance Program
Supportive leave provisions
Continuing education and training

Although private health insurance clinics are still relatively small in comparison to the rest of the private sector, they are conceivably the single biggest competitor with the public sector for graduate dentist positions. Many graduates who would once have considered a role within the public sector now find similar conditions offered by private health insurance clinics only with much more attractive benefits and greater levels of job satisfaction. One can only speculate about what might happen to the public sector workforce if there was to be increased entry into the market by 'corporatised' dental clinics, from either existing private health insurance funds or new corporate players.[51]

In the private sector salary differences can be even greater. Although not typical, it is not unusual for a third or fourth year graduate to earn a salary of $130,000 or more. When this level of remuneration is compared to the public sector it is not difficult to understand why current graduates find employment in the public sector so unappealing. With a starting salary of less than $50,000 it takes almost seven years for a public sector dentist to earn over $70,000.

Current rates of remuneration for public sector dental officers are a significant barrier to the provision of a sufficient, sustainable and appropriately skilled labour force able to meet the oral health needs of eligible persons in NSW. As has been noted previously, the demand for dental services is expected to rise significantly in the coming decades. At the same time total workforce

[51] An outcome of National Competition Policy has been the 'deregulation' of dentistry in NSW. In 2004, changes to the *Dental Practice Act 2001* allowed non-dentist corporate players to own dental practices.

numbers are expected to remain static or to drop. The combination of increasing demand for services, together with shrinking workforce numbers will place upward pressure on the cost of dental services. This can only increase the wage differential between the public and private sectors making it even harder to recruit and retain dental officers in the public sector. Significant steps must be taken now to reduce the wage differential between the two sectors if NSW is to retain a sustainable oral health service. On a related point, if governments and health departments across the country are so concerned about the rising cost of health services (in this case dental services) they would be wise to act quickly to ensure that sufficient numbers of graduates are being trained to meet the expected increase in demand for services.

Funding public dentistry and implications for service delivery and oral health outcomes

Although current rates of remuneration are a significant barrier to the recruitment and retention of public sector dental officers, this is by no means the only factor effecting the recruitment and retention. Earlier this year the Branch distributed a survey in relation to member views on the NSW public dental system in the May edition of the *NSW Dentist*. Almost 250 responses were received, from Branch members.

The survey yielded valuable insights into the views of ADA NSW members concerning the functioning of the public dental system. Almost 88 per cent of respondents worked mainly in private practice (either completely or with some public patients), indicating that the views in the survey are broadly representative of the profession as a whole.

Some of the key insights from the survey include:

- For practitioners working in the public system, the key negatives of their work are the limited range of services and procedures that are conducted and the pressure of long waiting lists. The key positive is the satisfaction of helping patients in genuine need.

- The main reasons for practitioners leaving the public system were stated as being seeking better remuneration and financial security or to broaden their clinical experience and skills. The overwhelming factor that would attract more practitioners into the public system was stated as being a dramatic improvement in pay and conditions.

- In rating the NSW public dental system, funding levels and access to services were both rated heavily towards being poor or very poor.

- In rating the most important problems with the NSW dental system, respondents placed salaries and award conditions, understaffing, lack of facilities, lack of government leadership and lack of funding as all being very important.

- A wide range of solutions were suggested for improving dental services for low-income and special needs groups, including more government funding, more staff, a well-functioning voucher system and a system of co-payments.

- Providing better incentives for dentists living in rural areas, increasing funding and staff for rural areas and the introduction of an intern year or compulsory posting in a rural area upon graduation were all suggested as solutions to the problem of providing services to rural and regional areas.

The Branch strongly believes that the range of treatments provided to recipients of public dental services should be more comprehensive and directed towards ensuring long term oral health, which in turn, is a vital component of an individual's general health. This will have a direct and significant benefit for patients while also encouraging recruitment and retention to the public oral health workforce.

Lack of career structure as well as lack of incentives for post-graduate study and continuing professional education opportunities

A recent oral health workforce review identified several potential solutions to the problems effecting public sector dentistry. These included rectification of award disparities, increased ability to provide comprehensive care, enhanced professional support and structured career pathways. In response, the NSW Oral Health Workforce Committee (on which ADA NSW participates) has developed a proposal for clear, supported career pathways for public dentists linked to proposed amendments to the award structure.

The Workforce Committee proposal notes that:

> "The profession generally endorses the concept of a structured first year experience for dental graduates although there has been little progress made in the implementation of this concept. With the introduction of Bachelor of Oral Health programs at Newcastle and Sydney, there is the need for careers pathways for graduates of these programs. The need for clinical support and mentoring of new graduates has been well documented in a series

> of oral health reviews and reports. Many new graduates choose not to enter public sector employment, as they believe that clinical opportunities are restricted and there is little scope for career advancement. With the introduction of a structured career pathway with appropriate academic and clinical support, culminating in one of four areas, it might be reasonably expected that both recruitment and retention would be favourably influenced. Career progression opportunities would be facilitated by recognition of this experience and the qualifications obtained.[52]

ADA NSW supports the introduction of a structured career pathway for public sector oral health professionals. However, this support is heavily qualified by reiterating earlier Statements about the acute need to overcome problems associated with remuneration, limited services and procedures available in public dental facilities and the pressures created by long waiting lists. Unless and until these problems are dealt with effectively, planning for and implementing career pathways will have little if any impact upon recruitment and retention because the only career pathway graduates will sensibly opt for will be straight into private practice, bypassing the public sector altogether. It is the opinion of the Branch that this is already occurring.

Education and training of dental practitioners

It is the current policy of the Australian Dental Association that Australia should be largely self-sufficient with regard to training of the dental workforce. Governments must ensure adequate funding to achieve this. Dental assistants and dental laboratory technicians should be trained in the vocational system. Dental hygienists should be trained in a tertiary institution associated with the training of dentists.

Unfortunately it is now not uncommon for the dental profession to express significant concerns relating to the education of dentists in New South Wales. These concerns are not limited to this State alone however; rather, these issues affect the Australian dental profession as a whole.

In a recent message to Branch members, ADA NSW President, Dr Chris Wilson, talked about many of these concerns. An edited version of his message is set out below.

> "Recently I was part of the strategic planning process for the Faculty of Dentistry and one aspect of this was an interview with Professor Rory Hume a former Dean of the Faculty. In talking with him it was brought home to me how much the Faculty had changed.

[52] NSW Oral Health Workforce Committee: Careers Pathway Sub-group 'Oral Health Careers Pathway' (Draft 5) 28th May 2005

Like most members of ADA (NSW Branch), I graduated from Sydney University. I spent my years in lectures, tutorials, laboratory sessions and clinics being taught by a relatively large number of diverse individuals. In the first couple of years they were from several Faculties of the University but in later years they were all in the Faculty of Dentistry.

There were many characters. Most had individual quirks which ex-students still remember and talk about today. Some you related well to and others you 'survived'. Many were full-time academics engaged only in teaching and research while others were part-time teachers, part-time researchers and part-time private practitioners. There was a lot of experience and diversity in the Faculty.

In those days there were over 100 members of staff. Now I understand there are around 25. In those days the part-time staff members were all paid. Now I understand many of the part-time tutors and demonstrators are honorary. In those days there was a first year intake of 120. Now I understand it is around 70. In those days university was provided by the government free of charge. Now every student makes a significant monetary contribution through HECS or pays full fees for their tuition. In those days Sydney University had the largest Dental Faculty of any Australian University. Now I understand it would be number 3 or 4.

Looking at the above changes, you have to reach the conclusion that the Faculty is in decline. You have to wonder where it will all end and what sort of Faculty will be there after the strategic planning is complete and the changes made.

One of the possibilities is that there will be no Faculty. This was acknowledged by Professor Hume although it is fairly unlikely. After all you would then have the most populous State in the country relying on 'imported' dentists to provide services to the population. Surely this would be politically unacceptable to the 'Premier State' government who don't have a big influence on this or even to the Federal Government who do. But it is a possibility. There are attractions to both governments and the bureaucracies they support.

From a State point of view training dental students means providing facilities in an already cash strapped public dental service. Money the Health Department would probably see as better used for directly providing service.

From a Federal point of view dentistry is an expensive course to provide and there may be economics of scale to be achieved by having all the training concentrated in one place. They have already decided that the cost is too high. We asked Professor Hume why Sydney

University hadn't applied for any of the extra 78 HECS places in dentistry provided by the Federal Government last year and he said that had he been in charge he wouldn't have applied for these either! Each HECS place costs the Faculty money. In other words the government has already decided it won't fully fund dental places in Australia.

Perhaps with Federal Government policy the way it is, dentistry will become a full fee paying course only. The new dental school at Griffith University is already setting the precedent with the first couple of combined years being HECS supported but the last few years of their dentistry degree being full fee paying.

So where would that leave us? We are the most populous State in the country so commercial opportunities alone would probably continue to draw dentists in from other States like South Australia where they appear to be training more dentists than that State alone needs. We would probably draw in the bulk of any dentists immigrating to Australia. Already over the last few years graduates from the Australian Dental Council examination who have registered in NSW have outnumbered graduates from Sydney University and the State Health Department seems very keen on promoting recruitment of overseas trained dentists as a strategy for dealing with the shortage of dentists in the public sector.

Without a strong Dental Faculty however, the workforce shortages already evident in the public sector and rural regions will become even more acute and spread. If you look at those States which don't have a Dental Faculty they have even lower dentists to population ratios and worse distribution patterns than ours.

Without a strong Dental Faculty we have less access to the latest research and techniques. There will be less access to specialist training and fewer presenters available for continuing education. Our 'dental development' may not keep up with other parts of the developed world making us a less attractive working environment for those training elsewhere.

This scenario is very unlikely to give the public better access to dental services or make them more affordable.

Whatever the final shape is, it is important for us to maintain a viable Dental Faculty in NSW and your Association will do all we can to support this whilst looking after your interests. It would be wonderful if we lived in a world where the government and politicians in general understood the importance of dentistry. It would be wonderful if the Federal and State governments did not blame each other for the deficiencies in services but undertook to fix them. It would be wonderful if they would fully fund dental education so that an

> adequate number of practitioners and dental team members could be supplied to a public interested in maintaining their oral hygiene. It would be wonderful if dental services could be provided to all those who needed them with equal ease of access across the State."[53]

This submission has already discussed the fact that many dental graduates choose not to enter public sector employment as they believe that clinical opportunities are restricted. To overcome this problem, some oral health advocates have proposed implementing a vocational training year for graduates to be undertaken in the public sector, particularly in rural and regional areas. While the Branch supports vocational training in principle, once again we reiterate that there is a lack of infrastructure currently in place to support such a proposal. This State of affairs will continue until conditions in the public sector improve significantly or until there is greater public-private collaboration. On this point, there will be little progress until appropriate funding and indemnity issues are addressed by government. Finally, there is little incentive for graduates to support vocational training given their high levels of HECS and fee indebtedness and the possible diminution of skills that may result from such a program given that current mentoring and oversight capabilities are already limited in the public sector.

[53] Dr Chris Wilson, *The NSW Dentist*, Australian Dental Association (NSW Branch) Limited, July 2005, Vol 54 No 7

PREVENTIVE DENTAL TREATMENTS AND INITIATIVES, INCLUDING FLUORIDATION AND THE OPTIMUM METHOD OF DELIVERING SUCH SERVICES

Dental caries is Australia's most prevalent health problem, edentulism the third most prevalent, and periodontal disease the fifth most prevalent (compared to hearing loss (2nd), asthma (4th), iron-deficient anaemia, alcohol dependence/harmful use, osteoarthritis, chronic back pain, and depression which rate 6th to 10th).[54] Caries and periodontal disease account for 90 per cent of all tooth loss.[55] Caries is the second most costly diet-related disease in Australia, with an economic impact comparable with that of heart disease and diabetes.[56]

A number of health conditions and diseases are associated with oral symptoms and disease. In particular, periodontal disease (disease of the gums) may contribute to cardiovascular disease, preterm birth and low birth weight, while diabetes directly affects the periodontium (the tissues of the gum that support the teeth).[57] Oral disease is also associated with aspiration pneumonia, hepatitis C, HIV infection, infective endocarditis, otitis media, and nutritional deficiencies in children and older adults

Tooth decay, gum disease and oral cancer are all the major oral diseases that are amenable to prevention strategies. They also share risk factors with other major preventable diseases including cardiovascular disease, cancer, and diabetes. These shared risk factors include tobacco smoking, inappropriate diet, alcohol consumption, injuries, poor hygiene and exposure to ultraviolet radiation.[58]

Oral disease affects almost all members of the Australian community at some point in their lives. This should reinforce the need for new approaches to respond to the widening inequalities in oral health status, the inequitable access to services, and the rising costs of health care driven by medical and dental advances, community expectations, population ageing and the increasing numbers of older people who fall into lower socioeconomic groups, and the increasing prevalence of lifestyle-related diseases. A prevention and health promotion strategy needs to

[54] Australian Institute of Health and Welfare (AIHW) (2000) Australia's Health 2000: the seventh biennial health report of the Australian Institute of Health and Welfare. Canberra: AIHW
[55] Australian Health Ministers' Advisory Council (AHMAC) Steering Committee for National Planning for Oral Health (2001) Oral health of Australians: National planning for oral health improvement: Final report. South Australian Department of Human Services.
[56] Ibid.
[57] National Advisory Committee on Oral Health (NACOH). *Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013*
[58] Ibid.

address oral health at both individual and population levels, based on the identified needs of communities.

The National Oral Health Plan

In July 2004 the National Oral Health Plan, "*Healthy Mouths Healthy Lives"* was published by the National Advisory Committee on Oral Health (NACOH) and endorsed by the Australian Health Ministers Advisory Council (AHMAC). *Healthy Mouths Healthy Lives* built on the work of the AHMAC Steering Committee for National Planning and Oral Health, which in 2001, released *Oral health of Australians: National Planning for oral health improvement: Final Report.*

Healthy Mouths Healthy Lives has four broad themes underpinning it. These are:

- recognition that oral health is an integral part of general health;
- a population health approach, with a strong focus on promoting health and the prevention and early identification of oral disease;
- access to appropriate and affordable services – health promotion, prevention, early intervention and treatment – for all Australians; and
- education to achieve a sufficient and appropriately skilled workforce, and communities that effectively support and promote oral health.

A population health approach, with a strong focus on promoting health and the prevention and early identification of oral disease

The Plan recommends the adoption of a 'population health approach' which aims to systematically:

- promote health and prevent and intervene early in the pathway to disease through strategies that involve individuals, communities and whole societies;
- build individual and community capacity and provide enabling cultures and environments;
- provide a comprehensive range of high quality, integrated health care services; and
- reduce disparities in health status through equitable allocation of health resources and access to health services.

Only a population health approach can offer a way to manage the growing demand that is occurring for dental services, utilising both public and private resources as effectively as possible, and working across sectors and communities to maximise oral health gains and promote oral health across the community.

Prevention must be the focus of government policy. Without this, no amount of money or workforce can solve the dental problems in this State. This requires more effective utilization of dental auxiliaries; particularly targeting school aged children and the elderly. The ADA believes that the use of dental therapists is of limited value and that their training should be phased out in favour of dental hygienists. The expansion of the role of hygienists into the public sector would be more cost effective and increase the capacity of the system to provide preventative care and oral health promotion as well as to deliver services outside dental clinic settings. On this point we note that there is currently no role for dental hygienists within the existing award structure for the oral health workforce. This is an issue that must be dealt with as a matter of urgency.

Water fluoridation is safe, effective, efficient, cost-effective and equitable

One of the most successful and cost-effective oral health prevention programs has been water fluoridation.

The Australian Dental Association, peak public health bodies and dental academics and researchers around Australia have for a considerable time been confounded by the continuing opposition from a small but extremely vocal minority in relation to the adjustment of natural fluoride levels in drinking water supplies through the addition of fluoride to optimum decay-fighting levels.

There is universal agreement between all the major public health bodies throughout the world regarding the benefits of water fluoridation. However we are still seeing campaigns that oppose the measure and seek to influence decision-making at the local level, thereby denying communities vital decay protection. It is hardly surprising that these communities are more often than not the most disadvantaged in terms of oral health and oral disease.

The Australian Dental Association would remind all key community members that water fluoridation is:

- **SAFE** to be used in the fight against dental infection (decay)
- **EFFECTIVE** in that it delivers proven decay reduction
- **EFFICIENT** in that it reaches a high proportion of targets
- **COST-EFFECTIVE** in that its benefits far outweigh the costs
- **EQUITABLE** in that it transcends socio-economic barriers that might prevent the use of other decay preventing, fluoride-containing products

In line with the recommendation in the National Oral Health Plan, "*Healthy Mouths Healthy Lives*", ADA NSW calls upon the State Government to demonstrate leadership on this issue and make fluoridation mandatory for all communities with a population greater than 1000.

CONCLUSION: THE TIME FOR ACTION IS NOW

Recent media attention focusing public awareness on the litany of problems afflicting the public dental system - lengthening waiting lists, staff shortages and falling staff morale resulting in declining oral health outcomes for welfare recipients and low income earners – serves to highlight the concerns held by the Australian Dental Association (NSW Branch). Oral health has long been a neglected, although important issue for the people of New South Wales.

As a consequence, the capacity of the public system to provide treatment for eligible patients is at crisis point. Chronic under-funding has resulted in a system rapidly losing the capacity, infrastructure and staff to deliver critical dental services to those in need across the State.

In 2004-2005, the total budget allocation for oral health was $109.7 million; representing about 1 per cent of the total health budget. Public dental services are chronically under-funded to meet the growing demand for services, placing at risk the viability of the system to function effectively as demand increases. Per capita funding for oral health in Queensland and South Australia is approximately double that of New South Wales. Significant extra funding however will not be enough. The government and senior bureaucrats in the Health Department must ensure that oral health is accorded a much higher priority than is currently the case.

The success of the public system depends on attracting and retaining qualified dental staff, while at the same time making it feasible for private practitioners to service public patients. There must be a concerted effort to rebuild a system based on well-functioning public dental hospitals, clinics and services supported by private practitioners. It is often overlooked in the debate about public dental care that more than 85 per cent of all dental services occur within the private sector where the vast majority of dentists practice. Private practitioners provide governments with an established and extensive network of dentists able to service the significant (and increasing) unmet demand that exists amongst persons eligible for public dental care. In many rural and regional areas however, much more concerted efforts need to be made to attract practitioners, public and private to these same areas.

In recent years there has been an enormous volume of work published dealing with issues affecting oral health in New South Wales and across Australia more generally. In almost all respects, the problems identified in this State are the same problems identified in every other State and Territory. For many dental professionals it is lamentable to witness the countless

wasted opportunities as each new workforce report and oral health position paper simply reiterates the recommendations found in the reports that came before it without actually achieving any tangible results.

The Australian Dental Association (NSW Branch) is committed to a vibrant and well functioning public oral health sector with a primary role in providing quality care and services to the community across the State. Inextricably linked to this role however is the important role the public sector plays in conjunction with the tertiary education sector for training the future dental workforce. It would be fair to State that the public and tertiary education sectors rely on each other in order to function effectively. The time has now come for the New South Wales Government to demonstrate its own commitment to a well functioning public oral health sector before it loses the capacity and staff needed to deliver critical dental services to those most in need across the State.