The Senate

Select Committee into the Provision of and Access to Dental Services in Australia

Interim report

June 2023

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Contents

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Terms of reference

The Select Committee into the Provision of and Access to Dental Services in Australia to inquire into and report on:

(a) the experience of children and adults in accessing and affording dental and related services;
(b) the adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas;
(c) the interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services;
(d) the provision of dental services under Medicare, including the Child Dental Benefits Schedule;
(e) the social and economic impact of improved dental healthcare;
(f) the impact of the COVID-19 pandemic and cost-of-living crisis on access to dental and related services;
(g) pathways to improve oral health outcomes in Australia, including a path to universal access to dental services;
(h) the adequacy of data collection, including access to dental care and oral health outcomes;
(i) workforce and training matters relevant to the provision of dental services;
(j) international best practice for, and consideration of the economic benefit of, access to dental services;
(k) any related matters.

Chapter 1
Introduction and background

Referral and conduct of the inquiry

1.1 On 8 March 2023, the Senate resolved that the Select Committee into the Provision of and Access to Dental Services in Australia be established to inquire into matters relating to the nation's oral and dental health, and access to services. The committee was required to present an interim report by 20 June 2023, and a final report by 28 November 2023.[1] This is the committee's interim report.

1.2 Committee members were appointed on 9 March 2023, including Senators Askew, Cadell, Payman, Marielle Smith and Steele-John.[2] The committee called for submissions to be provided by 4 May. The date was later extended to 4 June to allow time for more people to participate in the inquiry.

1.3 The committee advertised the inquiry on its website and wrote to a number of relevant organisations and individuals to invite them to make a submission. As of 19 June 2023, the committee has received and published 62 submissions, which are available on the committee's website. The committee continues to process received submissions, and to accept late submissions. A list of submitters will be provided in the final report.

1.4 The committee decided to create an online survey to provide another way for people to communicate their experiences. The survey was launched on 17 April and closed on 4 June. The survey collected a total of 17 547 responses. A report outlining the findings of the survey is attached at Appendix 1.

1.5 A number of additional documents have also been received. These have been published on the committee's website and will be listed in the final report.

1.6 The committee has scheduled public hearings for later in the year. These will inform the committee's final report.

Acknowledgements

1.7 The committee thanks all of the individuals and organisations who have submitted to the inquiry so far. In particular, the committee wishes to thank people who have generously shared their personal stories, contributing to the committee's understanding of the real-world impacts of these matters.

1 *Journals of the Senate,* No. 35, 8 March 2023, pp. 1053–1055. Includes resolution of appointment.

2 *Journals of the Senate,* No. 36, 9 March 2023, p. 1087.

1.8 The committee also wishes to thank the Social Policy Research Team and Statistics and Mapping Section in the Parliamentary Library for the helpful and comprehensive research and mapping services provided to assist the committee.

Notes on terminology

1.9 While the inquiry was set up to consider the provision of and access to *dental* services, many submitters highlighted broader issues associated with *oral* healthcare. The Australian Institute of Health and Welfare (AIHW) defines 'oral health' as 'the condition of a person's teeth and gums, as well as the health of the muscles and bones in their mouth'. As well as causing tooth decay, poor oral hygiene can lead to gum disease and periodontitis (a bacterial infection that causes inflammation), and cause functional and wellbeing impacts.[3]

1.10 The terminology used in this report is 'oral health/oral healthcare'. However, submitters have used a variety of other terms, including 'dental health' and 'dental disease'. While the terms 'oral' and 'dental' may be used interchangeably in this report, the committee recognises that oral healthcare is much broader than just the teeth.

Structure of the report

1.11 The interim report contains three chapters. This first chapter introduces the inquiry, provides background information, and outlines the structure of the report. It summarises the current status of dental service provision across Australia, provides a history of Commonwealth involvement in the provision of dental services, and discusses previous inquiries into dental services.

1.12 Chapter 2 outlines the unmet need for dental services. This chapter presents the committee's survey results, alongside research and data from established sources. It looks at the economic costs and social impacts associated with poor oral health, and considers service gaps for specific groups of people.

1.13 Chapter 3 looks at emerging issues for the inquiry and provides a high-level summary of key proposals raised in submissions received. The chapter also poses key questions for the committee to consider as it conducts public hearings, and deliberates around its final report.

Background

1.14 The World Health Organization (WHO) defines 'oral health' as:

> …the state of the mouth, teeth and orofacial structures that enables individuals to perform essential functions, such as eating, breathing and speaking, and encompasses psychosocial dimensions, such as

[3] Australian Institute of Health and Welfare (AIHW), *Oral health and dental care in Australia*, last updated: 17 March 2023.

> self-confidence, well-being and the ability to socialize and work without pain, discomfort and embarrassment.[4]

1.15 The most common oral health problems worldwide are untreated caries (cavities) of deciduous (primary) and permanent teeth, severe periodontal disease, edentulism (total tooth loss) and cancer of the lip and oral cavity.[5]

1.16 According to the WHO, oral diseases are 'the most widespread noncommunicable diseases' in the world, affecting 45 per cent of people worldwide. People experiencing poverty, prisoners, refugees, disabled people, Indigenous peoples, and those who live in rural and remote areas face a higher burden of disease compared with the general population. The WHO reports a 'direct and proportional association' between socioeconomic status and the prevalence and severity of oral diseases.[6]

Status of Australia's oral health

1.17 Oral and dental health in Australia have improved over the last 25 to 30 years, especially as a result of the addition of fluoride to drinking water. However, Australian Government dental health statistics indicate there are still significant problems:

- 3 in 10 people delay or avoid seeing a dentist because of the cost
- 1 in 4 children (aged 5 to 10) have untreated decay in their baby teeth
- 1 in 25 people (aged 15 and over) have no natural teeth left.[7]

1.18 According to the AIHW, poor oral health is common among Australian children and adults and contributes 4.5 per cent of the burden of non-fatal disease in the community (2022 figure). People's oral health deteriorates over time. Australians between 35–54 years old have, on average, 10.3 'decayed, missing or filled teeth'. By the time they are 75 years old, *most* of the average Australian's teeth are missing, decayed or have been treated/filled.[8]

1.19 Key factors contributing to poor oral health include:

- consumption of sugar, tobacco and alcohol
- a lack of good oral hygiene and regular dental check-ups
- a lack of fluoridation in some water supplies
- inadequate access to and availability of services, including:

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4 World Health Organization (WHO), *Global oral health status report: towards universal health coverage for oral health by 2030*, 2022, p. 1 (accessed 24 May 2023).

5 WHO, *Global oral health status report: towards universal health coverage for oral health by 2030*, 2022, p. 6.

6 WHO, *Global oral health status report: towards universal health coverage for oral health by 2030*, 2022, pp. 1–2 and p. 22.

7 Department of Health and Aged Care, *Dental Health* (accessed 24 May 2023).

8 From the *National Study of Adult Oral Health 2017–18* quoted in AIHW, *Oral health and dental care in Australia*, 17 March 2023.

- the cost of private dental care, and
- long waiting times to access public dental care.[9]

1.20 In 2020, the Australian Dental Association (ADA) and the Australian Health Policy Collaboration (AHPC) published *Australia's Adult Oral Health Tracker*. This national review found that tooth decay and gum disease have both *increased* since previous national studies were conducted in 2004–06:

- 32.1% of adults (aged 15+) have untreated tooth decay, a 6.6% increase from 25.5% in 2004/06.
- 28.8% of adults (aged 15+) have periodontal pockets (>4mm), a 9% increase from 19.8% in 2004/06.[10]

1.21 The Oral Health Tracker also found that less than half of Australia's adults had a dental check up in the last 12 months, one in five reported experiencing toothache, and almost half do not brush twice daily. The proportion of adults with 'severe tooth loss' (less than 21 teeth) was one in ten.[11]

1.22 The effects of poor oral health can be profound and impact the whole body, decreasing a person's general health. Because it destroys tissues in the mouth, dental disease can lead to 'lasting physical and psychological disability'. Tooth loss reduces functionality in the mouth, making it harder to chew and swallow. This can compromise nutrition and 'exacerbate existing health conditions'. AIHW notes that poor oral health 'is also associated with a number of chronic diseases, including stroke and cardiovascular disease'. It can impact pregnancy outcomes, is associated with lung conditions, and can contribute to oral cancers.[12]

1.23 Oral disease is linked to diabetes, with periodontitis contributing to complications, such as end-state renal disease, in diabetics. Type 2 diabetes is also a risk factor for periodontitis. Large international studies have linked loss of teeth with 'coronary heart disease, acute myocardial infarction, diabetes, and early death'; even accounting for other factors, such as smoking. The National Advisory Council on Dental Health (2012) reported that poor oral health affects people's mental health, contributing to anxiety, depression and poor self-esteem.[13]

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9 AIHW, *Oral health and dental care in Australia*, 17 March 2023.

10 Australian Dental Association (ADA) and Mitchell Institute, Victoria, University, Melbourne, *Australia's Adult Oral Health Tracker 2020,* [p. 3] (accessed 11 May 2023).

11 ADA and Mitchell Institute, *Australia's Adult Oral Health Tracker 2020,* [p. 6].

12 AIHW, *Oral health and dental care in Australia*, 17 March 2023.

13 Grattan Institute, *Filling the gap: A universal dental scheme for Australia*, 2019, p. 24 (accessed 30 May 2023). See also: National Advisory Council on Dental Health, *Final report*, 2012.

1.24 Poor oral health also costs Australia's healthcare system significantly. According to the Grattan Institute:

- there are an estimated 750 000 general practitioner (GP) consultations each year for dental problems, primarily for pain relief and antibiotics; and
- this costs taxpayers up to $30 million per year, for the consultations alone, with further costs for subsidising prescribed medications.[14]

1.25 Dental and oral health problems also impact the hospital system, with AIHW estimating that in 2020–21, there were about 83 000 hospitalisations for preventable dental conditions. Hospitalisations are most prevalent among children, people in remote areas and Indigenous Australians:

- In 2020–21, the rate of potentially preventable hospitalisations due to dental conditions (per 1,000 population) was highest in those aged 5–9 years (10.9 per 1,000 population).
- In 2020–21, the rate of potentially preventable hospitalisations due to dental conditions (per 1,000 population) generally increased as remoteness increased, ranging from 3.0 per 1,000 population in Major cities to 4.8 per 1,000 population in Very remote areas.
- In 2020–21, the rate of potentially preventable hospitalisations due to dental conditions (per 1,000 population) was higher for Indigenous Australians (5.4 per 1,000 population) than for Other Australians (3.0 per 1,000 population).[15]

1.26 Dental and oral disease costs the economy, reducing productivity and workforce participation. Australians take an estimated 2.4 million days or half days off work or study because of oral disease, and the estimated 'total economic cost of reduced workforce participation due to dental conditions [is] $556 million per year' (2010 data).[16]

1.27 In Australia, dental disease and oral health problems disproportionately affect those on low incomes, Aboriginal and Torres Strait Islanders peoples, people in rural and remote areas, prisoners, disabled people, and those with specialised healthcare needs. A discussion of unmet need for dental services, and service gaps for vulnerable cohorts, is included in Chapter 2 of this report.

Overview of dental services in Australia

1.28 Australia has a universal health care system (Medicare), which provides free or subsidised health services for Australians, and some overseas visitors. When the first iteration of Medicare was introduced in 1974, the Whitlam Government

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14 Grattan Institute, *Filling the gap: A universal dental scheme for Australia*, 2019, p. 25.

15 AIHW, *Oral health and dental care in Australia*, 17 March 2023.

16 Grattan Institute, *Filling the gap: A universal dental scheme for Australia*, 2019, p. 26.

chose to exclude dental services to avoid inflating the cost of the scheme and, reportedly, to avoid conflict with the dental profession.[17]

1.29 Australia spent an estimated $220.9 billion on healthcare in 2020–21. Governments funded the majority of this expenditure (around 70 per cent). In comparison, around $11.1 billion was spent on dental services that year:

- almost 60 per cent (around $6.5 billion) was paid directly by individuals;
- around 20 per cent ($2.2 billion) was financed through private health insurance providers; and
- the remaining 20 per cent was funded by the Commonwealth (around $1.3 billion) and state and territory governments (around $946 million).[18]

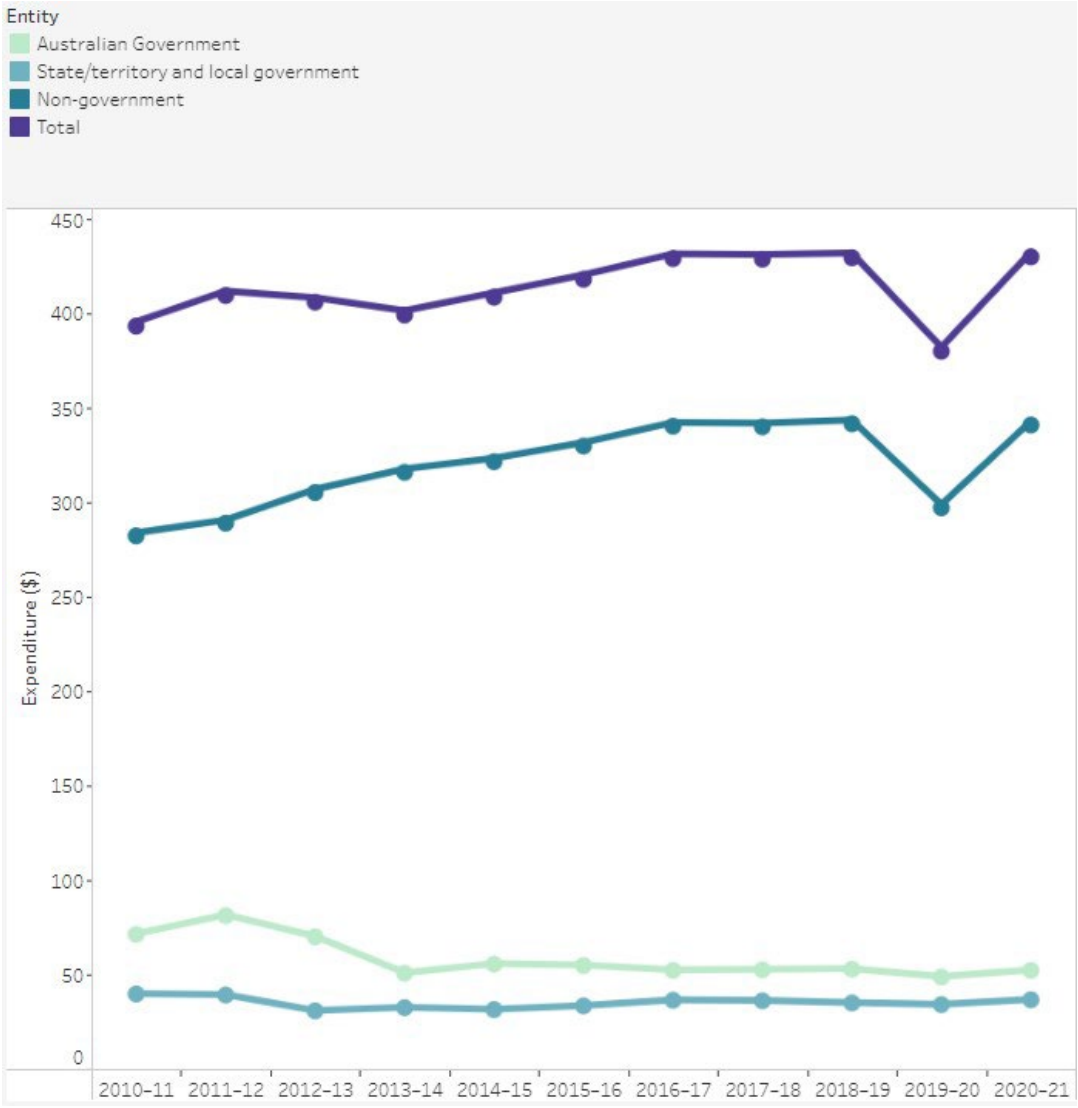
1.30 According to AIHW data, Australia's total per capita spend on dental services in 2020-21 was $432. **Figure 1.1** shows the breakdown of expenditure on a per capita basis by source of funding from 2010–11 to 2020–21.[19]

[17] John Menadue, *Why dental care was excluded from Medicare and why it should now be included (an edited repost)*, 8 March 2021 (accessed 11 May 2023).

[18] AIHW, *Health expenditure Australia 2020–21*, last updated: 23 Nov 2022 (accessed 5 May 2023). Note: Expenditure data derived from the AIHW Health Expenditure Database. It is important to note that the COVID-19 pandemic affected every aspect of the health system in 2019–20 and in the years following. AIHW, 'Costs', *Oral health and dental care in Australia*, 17 March 2023.

[19] AIHW, 'Costs', *Oral health and dental care in Australia*, 17 March 2023.

Figure 1.1 Expenditure on dental services per capita by source of funds, constant prices, 2010–11 to 2020–21



Source: AIHW, Oral health and dental care in Australia, 17 March 2023. Note: Constant prices adjust current prices for the effects of inflation.

1.31 The Commonwealth currently supports public dental service provision through:

Child Dental Benefits Schedule (CDBS)—The CDBS allows eligible children aged 0 to 17 years to claim up to the benefit cap every two years for basic dental services. The program is means tested; children must be eligible for Medicare and they and/or their family/carer should receive an eligible Australian Government payment at least once in the calendar year.

Federation Funding Agreement (FFA) for adult public dental services—The Commonwealth offers top-up funding to states and territories to provide adult public dental services. This funding is dependent on achieving activity levels above a baseline level, set in 2013-14. The current 2022-23 FFA agreement ends on 30 June 2023. In the 2023-24 Budget the government announced funding of $215.6 million over two years as an interim measure while decisions on future funding arrangements for dental

service provision are finalised through an inter-governmental senior officials working group.

National Health Reform Agreement (NHRA)—The Commonwealth provides funding for public hospital admitted and outpatient dental services.

Private Health Insurance (PHI) rebates—The Commonwealth provides an income-tested private health insurance rebate. The rebate applies to hospital, general treatment (including dental), and ambulance policies.

Grants to the Royal Flying Doctors Service (RFDS)—The Commonwealth funds grants to the RFDS which provides dental outreach services through provision of fly-in/fly-out or drive-in/drive-out outreach dental services, where there are no other private or public dental services in classified areas.

Research—The Department funds population health dental research studies conducted by the Australian Research Centre for Population Oral Health (ARCPOH) at the University of Adelaide. The National Health & Medical Research Centre (NHMRC) and the Medical Research Future Fund (MRFF) also provide other funding opportunities for dental research through competitive processes.

The Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP)—Since 2007, the Commonwealth Government has helped fund oral health services for Aboriginal and Torres Strait Islander children aged under 16 in the Northern Territory through various iterations of National Partnership Agreements (NPA) since the Northern Territory Emergency Response (NTER).[20]

[20] Department of Health and Aged Care, *Submission 18*, pp. 1–2.

Figure 1.2 Summary of Commonwealth funding for dental services

	2020-21 ($m)	2021-22 ($m)	2022-23 ($m)	2023-24 ($m)	2024-25 ($m)	2025-26 ($m)	Total ($m)
CDBS^	336.5	281.2	343.7	349.7	357.7	259.2	**1928.0**
NHRA - Acute Admitted Dental Services	44.3	40.6	n/a	n/a	n/a	n/a	**84.9**
NHRA - Specialist Outpatient Procedure Clinics	134.5	84.8	n/a	n/a	n/a	n/a	**219.3**
NPA/FFA	107.8	107.8	107.8	107.8	107.8	-	**539.0**
Child Oral Health Study	-	-		0.7	-	-	**0.7**
National Dental Care Survey (NDCS)				0.8	0.6	0.2	**1.6**
Developmental work to support dental funding reform (costing study & NMDS)^^	-	-	-	1.3	0.7	0.03	**2.1**
Royal Flying Doctor Service Grant – Dental Services	5.6	5.7	5.8**	5.8**	5.8**	5.8**	**34.5**
Private Health Insurance Rebates*	775.0	n/a	n/a	n/a	n/a	n/a	**775.0**
Total	**1403.7**	**520.1**	**457.3**	**466.1**	**472.6**	**265.2**	3585.1

Source: Department of Health and Aged Care, Submission 18, pp. 2-3.

*^ Estimated actuals as per relevant Budget Portfolio Statements. Figures for 2023-24 onwards as per Budget 2023-24. ** From 2022-23 onwards, the RFDS grant allocates funding flexibly across all primary care service delivery, which includes dental services. This figure is the indicative amount for dental services and may be used flexibly to provide other primary care services. * PHI Rebates – estimated contribution of PHI rebates being paid out in dental claims. Data from 2021-22 is not available. Source: AIHW. ^^ Additional funding of $0.02m will be provided in 2026/27. #The Indigenous Australians' Health Programme Primary Health Care Funding Model provides funding ($34.1m from 2020-21 to 2023-24) to the Wurli-Wurlinjang Aboriginal Corporation which provides a range of primary health care activities, including a dental program. Funding for the dental services cannot be disaggregated.*

1.32 Limited support is also available under Medicare for certain items related to oral surgery, and benefits are paid for eligible children and young people under the Cleft Lip and Cleft Palate Scheme, which is administered by Services Australia.[21]

Legislation

1.33 The CDBS represents the majority of Commonwealth spending on dental services, budgeted at almost $350 million in 2023–24. The statutory mechanism for Commonwealth funding is the *Dental Benefits Act 2008* (cth) (the Act). The only program currently administered under the Act is the CDBS. The Act, and associated Dental Benefits Rules 2014, provide a mechanism by which state and territory public sector dental providers can claim for children's services until 31 December 2026. Section 68 of the Act stipulates that the Minister for Health must instigate an independent review of the operation of the Act after one year,

[21] Department of Health and Aged Care, *Submission 18*, pp. 13–14.

then every three years thereafter.[22] Review reports were published in 2009, 2011, 2015 and 2019, and examined the attainment of the purposes of the Act and its administration.

1.34 The Fifth Review of the Act was underway at the time of writing and seeks to review the CDBS more broadly. The review is being undertaken by an independent panel of experts, guided by specific Terms of Reference.[23] The department called for stakeholder input in mid-2022 and the report is expected to be tabled in Parliament sometime in 2023.

1.35 The committee's final report will consider the legislative architecture, programs and grants provided by the Commonwealth in support of dental services in more detail.

International comparison

1.36 Government support for dental and oral health care varies across countries but is generally lower than government support for general health care. According to the Organisation for Economic Co-operation and Development (OECD), on average 'less than one-third of dental care costs are borne by government schemes or compulsory insurance', and only three OECD countries provide universal coverage for oral health care (Japan, Germany and the Slovak Republic).[24] Deakin Health Economics reported that Scandinavian countries, Japan, South Korea, Thailand, and Taiwan 'have funded universal oral healthcare', but evidence on outcomes is patchy.[25]

1.37 As **Figure 1.3** demonstrates, the government contribution to spending on dental care in Australia is low by international standards. In 2019, only eight out of 38 OECD countries reported a lower share than Australia and, at approximately 16 per cent, Australia's public proportion of spending was around half the OECD average.

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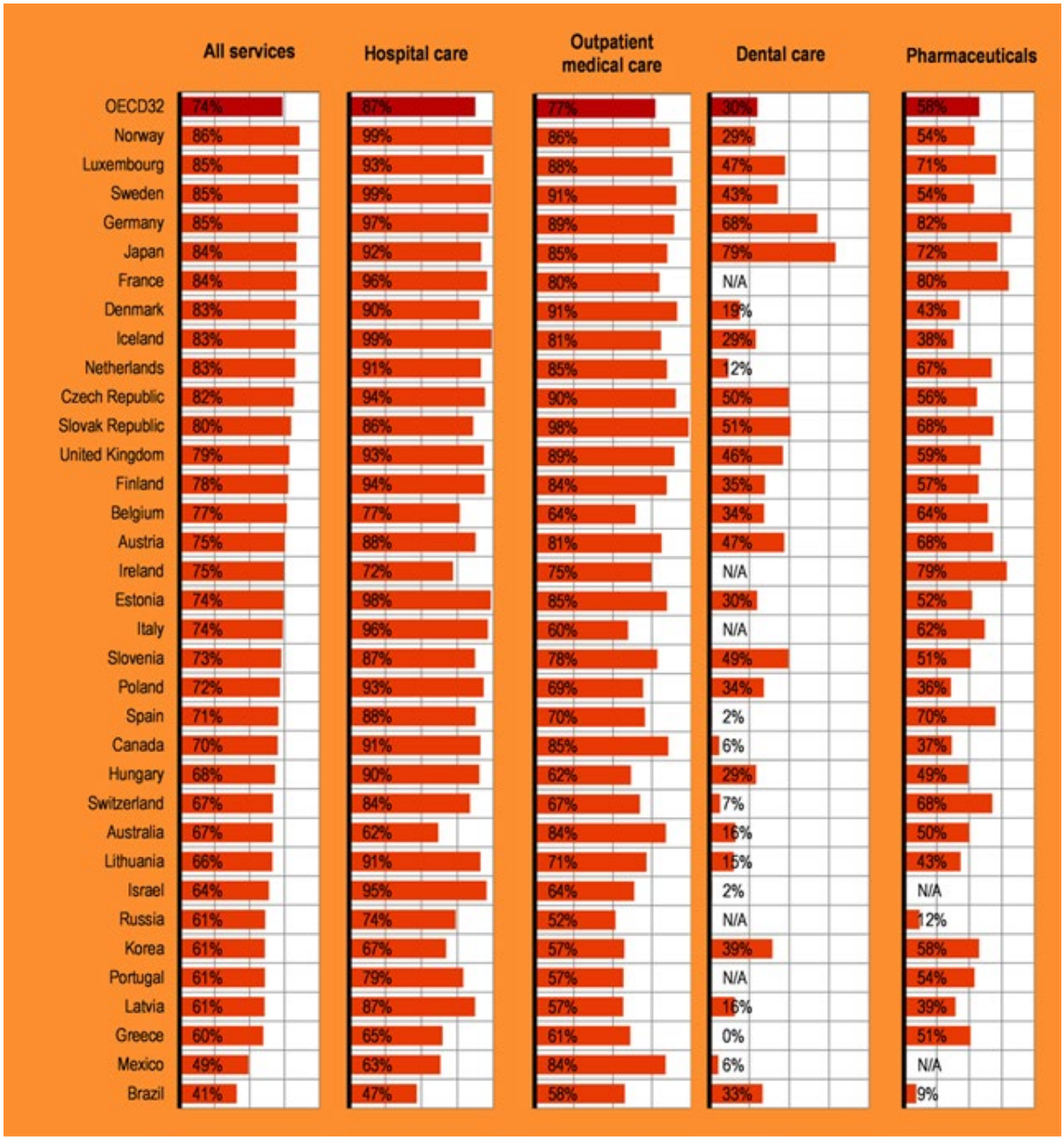
22 *Dental Benefits Act 2008,* Section 68 (1) and (2); Department of Health and Aged Care, *Submission 18*, pp. 10–11.

23 The Terms of Reference and membership of the committee are available from the Health Department's consultations website.

24 Organisation for Economic Co-operation and Development (OECD), 'Extent of health care coverage', *Health at a Glance 2021: OECD Indicators*, OECD Health Statistics 2021.

25 Deakin Health Economics, *Submission 10*, [p. 6].

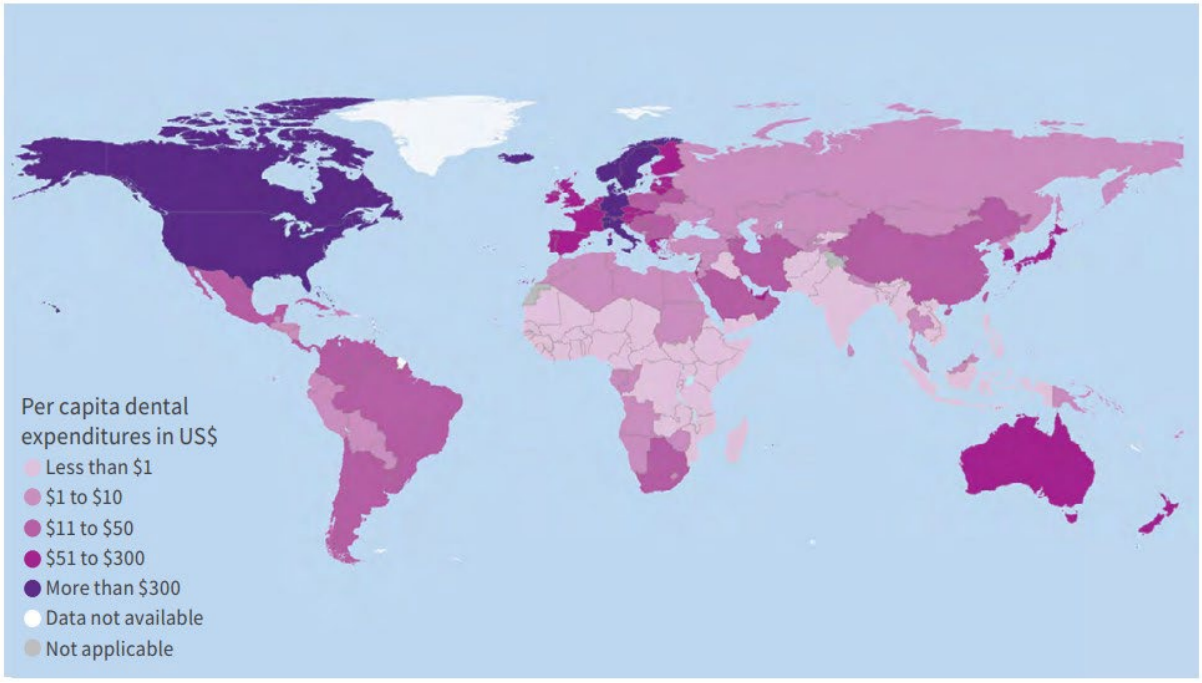
Figure 1.3 Government and compulsory insurance spending as proportion of total health spending by type of care



Source: 'Extent of health care coverage', OECD. See also: AIHW, Oral health and dental care in Australia, 17 March 2023.

1.38 While government contribution is comparatively low by global standards, members of the Australian community spend a lot on dental care, being in the second highest category of annual spending per capita:

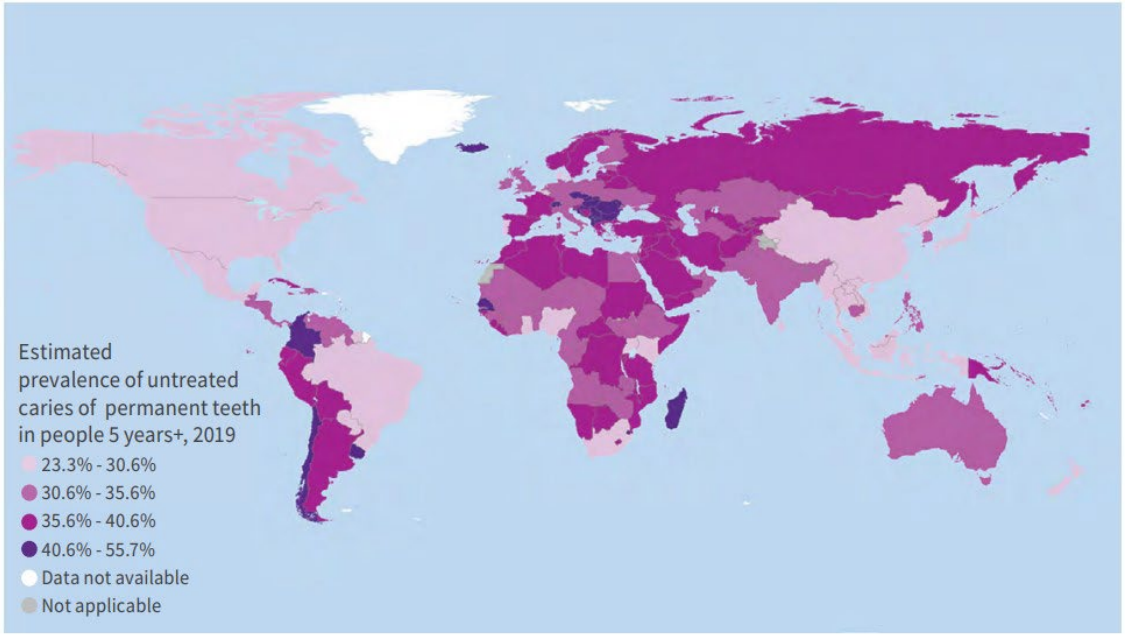
Figure 1.4 Per capita dental expenditures in US$ per country, 2019



Source: WHO, Global oral health status report: towards universal health coverage for oral health by 2030, 2022, p. 28. Data Source: Jevdjevic & Listl 2022. Economic impacts of oral diseases in 2019. Map Production: WHO NCD/MND unit. Map Creation Date: 30 August 2022. Note: N = 194 countries.

1.39 In Australia, higher per capita spending does not necessarily translate to better outcomes. **Figure 1.5** and **Figure 1.6** below indicate that Australians experience a similar level of dental tooth decay, and a much higher level of edentulism (total tooth loss), as people in a number of countries where individuals spend a lot less on dental care per capita.

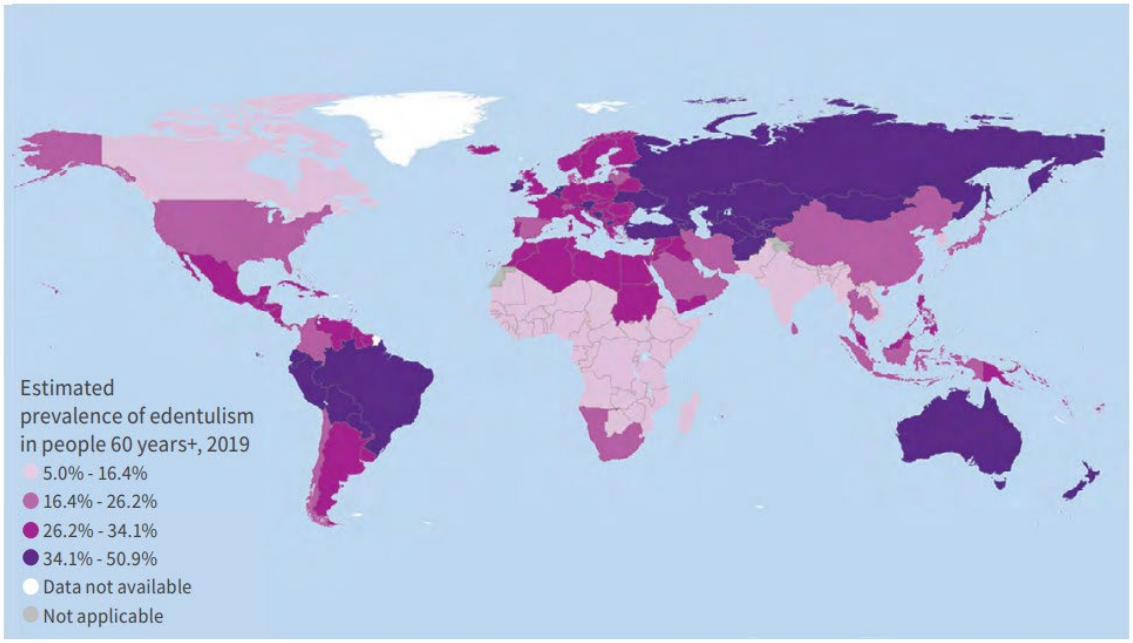
Figure 1.5 Estimated prevalence of caries of permanent teeth per country



Source: WHO, Global oral health status report: towards universal health coverage for oral health by 2030, 2022, p. 35. Data source: Global Burden of Disease Collaborative Network. GBD 2019. Seattle: IHME; 2020. Map

Production: WHO NCD/MND unit. Map Creation Date: 30 August 2022. Note. N = 194 countries; data are age standardized, for ages greater than 5 years, both sexes, from GBD 2019 (4).

Figure 1.6 Estimated prevalence of edentulism



Source: WHO, Global oral health status report: towards universal health coverage for oral health by 2030, 2022, p. 44. Data source: Global Burden of Disease Collaborative Network. GBD 2019. Seattle: IHME; 2020. Map Production: WHO NCD/MND unit. Map Creation Date: 30 August 2022. Note. N = 194 countries; data are for ages greater than 60 years, both sexes, from GBD 2019 (4).

1.40 Australians also have higher out-of-pocket costs compared with many comparable countries. The department reported that, at almost 60 per cent, Australia's out-of-pocket expenses for dental care are significantly higher than Canada (38 per cent) and the United States of America (40 per cent).[26]

1.41 The committee's final report will include a more detailed comparison of international dental care schemes.

Private dental services

1.42 Over 85 per cent of dental care in Australia is provided through private, for-profit dental clinics. These businesses are run by a mix of large companies, private health insurance providers, and individual dentists. The fees charged are not regulated, and treatment costs vary greatly across Australia. While most fees are paid by individuals or private health insurers, government pays for eligible services provided through the CDBS at participating private dental clinics.[27]

1.43 Dental practitioners have to be registered with the Australian Health Practitioner Regulation Agency (AHPRA) to practise in Australia. According to

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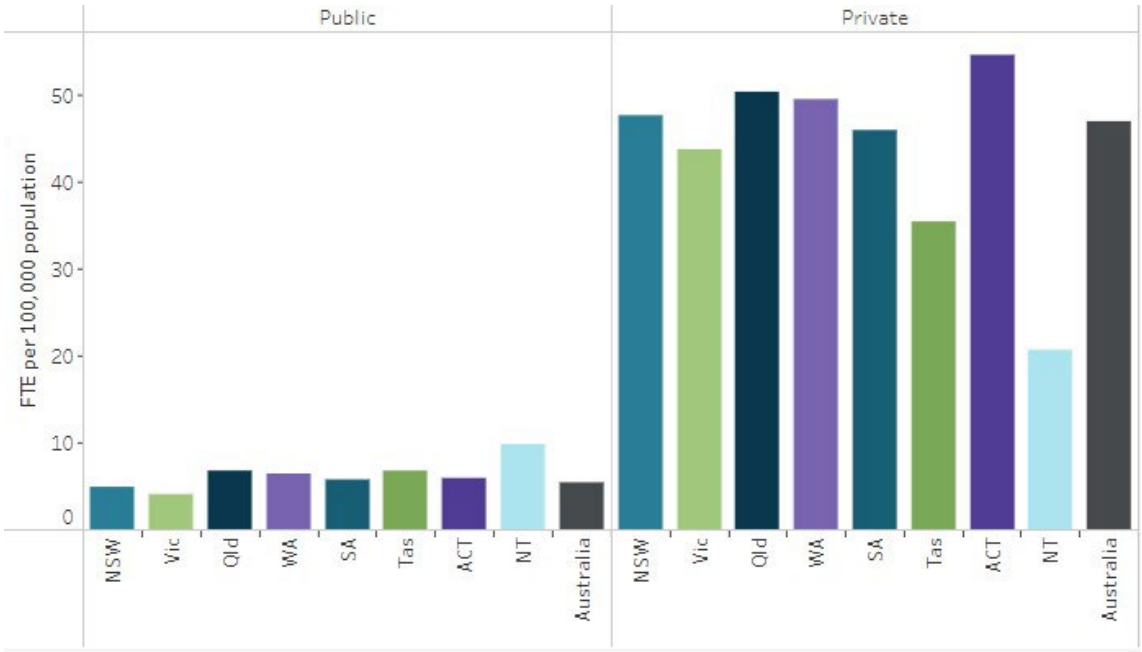
26 Department of Health and Aged Care, *Submission 18*, p. 26.

27 ADA, Private Dental Clinics, 26 April 2023 (accessed 24 May 2023).

AIHW, in 2020 there were 18 383 registered dentists in Australia, which equated to 57.9 dentists per 100 000 population. Around 95 per cent of dentists worked in private practice.[28] The proportion is higher in major cities, where 52.1 dentists per 100 000 population were employed in the private sector. Remote and very remote areas have the highest proportion of dentists employed in the public sector, at 9.5 dentists per 100 000 (2020 data).[29] In 2023, there are 26 563 registered dental practitioners, of which 19 795 are dentists.[30]

1.44 **Figure 1.7** below provides a state-by-state comparison of dentists employed in the public and private sectors in 2020.

Figure 1.7 Full-time equivalent dentists per 100 000 population, public and private sectors, states and territories, 2020



Source: AIHW, Oral health and dental care in Australia, 17 March 2023. Data from the National Health Workforce Dataset.

Cost of dental care

1.45 The cost of private dental care can vary significantly depending on where you live, with average prices higher in the Australian Capital Territory (ACT) and Tasmania, and lower in South Australia and Queensland.[31]

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28 Australian Health Practitioner Regulation Agency (AHPRA), *Annual report 2021–22*, p. 17 (accessed 30 May 2023).

29 AIHW, *Oral health and dental care in Australia*, 17 March 2023.

30 Dental Board of Australia, *Registrant data 2023*, Reporting period: 1 January 2023 to 31 March 2023, 26 April 2023 (accessed 2 June 2023).

31 COTA Australia, *Submission 11*, p. 8.

1.46 Almost 40 per cent of adults avoid or delay visiting a dentist due to cost, almost a quarter experience 'a lot of difficulty' paying a $200 dental bill, and around 23 per cent of Australians who visit the dentist cannot afford the recommended treatment and do not complete it. Australians with private health insurance are significantly more likely to access dental care than those who are uninsured.[32]

1.47 To address these inequities, state and territory governments provide some public dental care, which is partly funded by the Commonwealth.

Public dental services

1.48 State and territory governments run public dental clinics for eligible adults, which are partly funded by the Commonwealth through the National Partnership Agreement on Public Dental Services (NPA). Less than 5 per cent of registered dentists work in public practice. In 2020, this was just 787 dentists across all of Australia.[33] At the same time the ADA estimates that the public system provides around 15 per cent of dental care.[34]

1.49 An overview of the eligibility requirements, and fees (if any) for public dental services, in each jurisdiction is provided at Appendix 2 of this report.

1.50 Due to funding and workforce limitations, public services tend to focus on emergency dental care, rather than preventative treatment, and clinics prioritise patients who are in significant pain, have swelling, significant bleeding, difficulty swallowing, or have an infection.[35]

1.51 Consumer surveys indicate that Australians 'overwhelmingly attend private services' for dental care, even though they consider private services 'unaffordable'. Surprisingly, this also applies to people who do not have private health insurance, and people who are eligible for public or subsidised care. This is due to factors including:

- a lack of awareness about public dental services;
- accessibility issues, including an absence of public services in the area;
- failure to meet eligibility requirements; and
- long waiting lists for public clinics, which drive people to attend a private provider to have their issues dealt with sooner.[36]

1.52 While there is no national data set on public dental clinic waiting times, data from individual states and territories was collected by the AIHW and published

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32 COTA Australia, *Submission 11*, pp. 8–9.

33 AHPRA, *Annual report 2021–22*, p. 17; AIHW, *Oral health and dental care in Australia*, 17 March 2023.

34 ADA, Private Dental Clinics, 26 April 2023.

35 COTA Australia, *Submission 11*, pp. 10–11. See also: NSW Health, *Information for patients,* last updated: 30 March 2023 (accessed 31 May 2023).

36 Consumers Health Forum of Australia, *Submission 13*, p. 16.

in January 2018. This data shows average wait times for treatment that are 'excessively long' in most jurisdictions—up to two years, and sometimes longer.[37] In 2022, the government reported that wait times had reduced as a result of Commonwealth-state funding agreements beginning in 2012. Over 10 years of investment, wait times had dropped from an average of 20 months to 12 months.[38] However, submitters also note wait times vary dramatically from state to state and by geography, with patients waiting much longer in Tasmania and the Northern Territory.[39] Wait times are discussed in more detail elsewhere in this report, and will be addressed in the committee's final report.

1.53 Access to oral healthcare is not equitable across the states and territories and this is reflected in outcomes. For instance, national surveys indicate dental decay is higher among children in Tasmania, Queensland and the Northern Territory, than in other states and territories. These differences can be attributed to demographic factors, but may also be 'partly explained by differences in individual state and territory oral health care funding, service models and eligibility requirements'.[40]

1.54 There is extensive evidence that adult public dental services are underfunded and overstretched. COAG Health Council data suggests less than 25 per cent of eligible adults access public dental treatment, with some states and territories performing better than others (**Figure 1.8**).

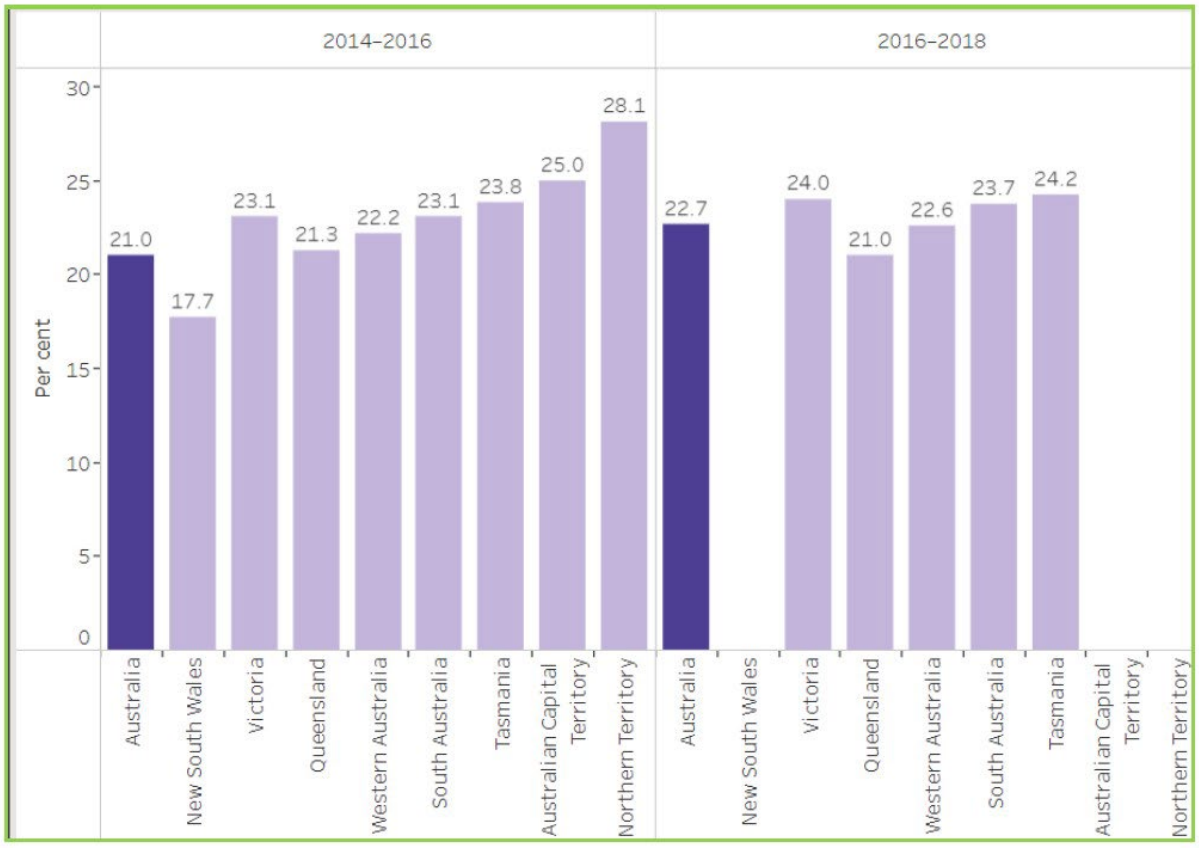
37 COTA Australia, *Submission 11*, pp. 11–12. For detailed data, see: AIHW, *A discussion of public dental waiting times information in Australia: 2013–14 to 2016–17*, January 2018 (accessed 30 May 2023).

38 Department of Health, *Budget 2022-23 fact sheet: Primary Health Care 10 Year Plan – Supporting access to dental care* (accessed 31 May 2023).

39 Dental Board of Australia, *Submission 8*, p. 3.

40 AIHW, *Oral health and dental care in Australia*, 17 March 2023.

Figure 1.8 Proportion of eligible adults, by jurisdiction, accessing public dental care services 2014–16 and 2016–18

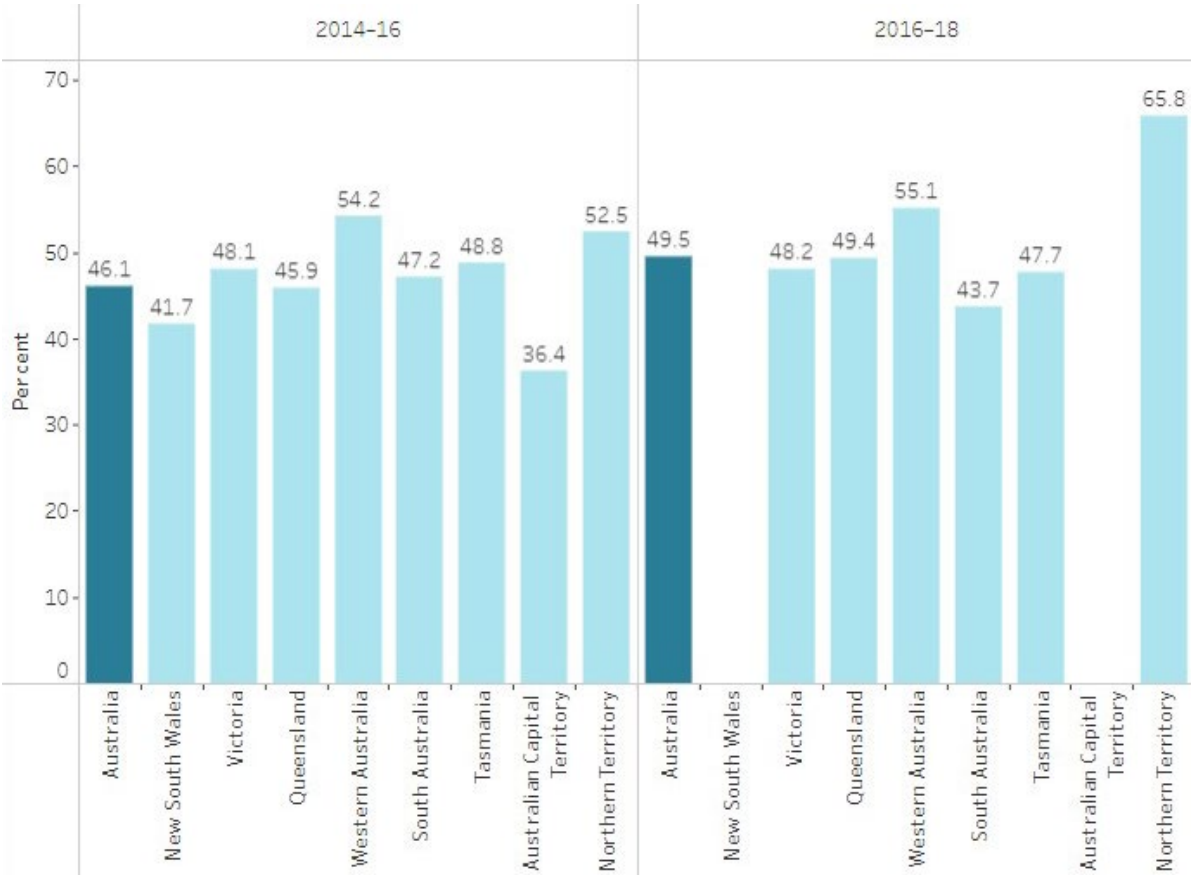


Source: COTA Australia, Submission 11, p. 11. AIHW data from state and territory health departments. Note data for NSW, ACT and NT unavailable for 2016-18.

1.55 Children are more likely to have accessed a public or subsidised dental service. For instance, just under 50 per cent of all children accessed oral healthcare through a government funded program or service in 2016–18 (**Figure 1.9**).[41]

[41] Note: This indicator measures the total number of children accessing government-funded oral health care, either through state and territory funded public dental services or the Australian Government funded Child Dental Benefits Schedule, as a proportion of the total child population.

Figure 1.9 Proportion of children accessing oral health care through a government funded oral health program, 2016–18



Source: AIHW, National Oral Health Plan 2015–2024: performance monitoring report, 3 December 2020.
Note: data for ACT and NT not available for 2016-18.

1.56 However, data from the Department of Health and Aged Care (the department) indicates public services for children are also underutilised. In 2021, the Australian Government paid benefits of around $300 million under the CDBS, for almost five million dental services provided across Australia. While up to three million children are eligible for the CDBS each year, less than 40 per cent of eligible children participate.[42]

History of Commonwealth involvement in the provision of dental services

1.57 The Australian Government gained the constitutional power to legislate with respect to dental services in 1946, following the success of the referendum on inserting Section 51 (xxiiiA).[43] The amendment explicitly mentioned dental services alongside pharmaceutical and hospital benefits and medical services. The Commonwealth did not directly fund dental services until the 1970s. Dental

[42] Department of Health and Aged Care, *Submission 18*, p. 5.

[43] Note: the terms 'Commonwealth' and 'Australian Government' are both used in this report. Both terms refer to Australia's National Federal Government.

programs funded since that time have included the Australian School Dental Program (1973–80s); a Commonwealth Dental Health Program (1993–97); the Private Health Insurance Rebate Scheme (1997–present); two iterations of a Medicare-funded chronic disease program (2004–07 and 2007–12); the Medicare Teen Dental Plan (2008–13); and most recently the Child Dental Benefits Schedule (2014–present).[44]

1.58 Compared with the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme—which have existed in their current forms since 1984 and 1948 respectively—Commonwealth dental schemes have been patchy and inconsistent. Commentators have noted that Australian governments have had trouble placing oral health 'within a health framework, and dental services within a medical services framework'.[45]

Previous inquiries and reports

1.59 A number of significant inquiries have been conducted that looked at oral and dental healthcare since 1998, when the Senate Community Affairs References Committee published its *Report on Public Dental Services*. The full list, including links, is provided at Appendix 3. A Parliamentary Library analysis of progress made in implementing key recommendations from these reports is provided in a table at Appendix 4. The following paragraphs are drawn from that table, which provides links to the original sources.

1.60 The 1998 Senate report recommended:

- better promotion of oral health;
- programs to encourage practitioners to work in rural and remote areas;
- greater use of 'dental auxiliaries such as therapists and hygienists';
- a national oral health training strategy;
- pilot programs to address priority groups including 'pre-school age children, young adult Health Card holders (18-25 years), aged adult Health Card holders (65+ years), the homebound, rural and remote, and Indigenous communities';
- the introduction of a national oral health policy which would include 'minimum service targets' and 'monitoring of goals through national data collection';
- resources for a national oral health survey; and

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44 FAC Wright and PF List, 'Reforming the mission of public dental services', *Community Dentistry and Oral Epidemiology*, vol. 40, no. s2, 2012, pp. 102–109; Australian National Audit Office, *Administration of the Child Dental Benefits Schedule*: ANAO Report No. 12 2015-16, 2015; Jane Harford and A John Spencer, 'Government subsidies for dental care in Australia', *Australian and New Zealand Journal of Public Health*, vol. 28, no. 4, 2004, pp. 363–368.

45 FAC Wright and PF List, 'Reforming the mission of public dental services', *Community Dentistry and Oral Epidemiology*, vol. 40, no. s2, 2012, pp. 102–109.

- creation of a dedicated section for oral health within the Department of Health and Family Services.

1.61 The government response to the committee's report was not supportive. It identified public dental services as a state responsibility, and suggested the states needed to 'resolve the structural, management and financial problems in their dental services'.[46] While the committee recommended a national oral health strategy be developed, this was not supported by government at the time. As such, a national strategy was not implemented until 2015, when *Healthy mouths, healthy lives—Australia's National Oral Health Plan 2015–2024* was released.

1.62 Submitters, including veteran dentist and academic, Dr Peter Foltyn, commented that, despite 'considerable goodwill' at the time, Australia has made 'little progress' in the 25 years since the Senate report. Deakin Health Economics said this approach has meant 'recommendations from previous reviews of the dental program have not been fully implemented in [a] systematic and comprehensive manner'.[47]

1.63 In 2003, the Senate Select Committee on Medicare recommended the government recommit to a Commonwealth contribution towards public dental health services and work with the states and territories to implement targets. The recommendation was not supported by the then Coalition government, which reiterated its view that public dental services were the responsibility of the states.

1.64 The next five years saw the introduction and amendment of schemes that provided some dental coverage under Medicare for people with chronic conditions. Then, in 2008, in response to a Senate report on cost of living pressures for older Australians, the then Labor government outlined a plan to provide $290 million to the states and territories to reduce public dental waiting times.

1.65 Shortly after, the National Health and Hospital Reform Commission (June 2009) recommended:

- the establishment of a 'Denticare Australia' scheme to be funded by a 0.75 per cent increase in the Medicare levy;
- expanding coverage for children; and
- providing funding for oral health promotion.

1.66 The government did not provide a systematic response to the Commission's report, and neither the Australian Labor Party, nor the Coalition, expressed support for a Denticare Australia scheme, as proposed in the report.

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46 Government Response to the Senate Inquiry into Public Dental Services, February 1999, p. 1.

47 Dr Peter Foltyn, *Submission 12*, [p. 1]; Deakin Health Economics, *Submission 10*, [p. 3].

1.67 In 2012, the National Advisory Council on Dental Health recommended an integrated national oral health system that would provide equitable access to oral and dental healthcare. The government welcomed the report, which likely informed subsequent Commonwealth dental health policies, such as the CDBS and the National Partnership agreement with states and territories to alleviate pressure on adult public dental waiting lists.

1.68 In 2013, the House Standing Committee on Health and Ageing published *Bridging the Dental Gap: Report on the inquiry into adult dental services*, which made recommendations to inform a new Commonwealth funding agreement with states and territories. It proposed a commitment to long-term funding of public dental services, a national framework led by a Chief Dental Officer, and the introduction of performance indicators for public dental care. It also proposed that an implementation plan be established for the National Oral Health Plan, and that governments begin a phased process towards a universal dental scheme.

1.69 While some of these recommendations have been actioned, the most significant have not. There is currently no long-term plan for funding public dental services, though work on this is underway. There is no Chief Dental Officer, and governments have yet to express support for any type of universal access scheme for oral and dental healthcare.

1.70 In 2015, Australia's first (and current) National Oral Health Plan was then developed under the auspices of the Council of Australian Governments (COAG) Health Council. The plan, which expires in 2024, identified national goals and priority populations, but did not contain any recommendations for substantive policy reform. A December 2020 performance monitoring report found there had been a favourable trend in improvement for seven indicators, an unfavourable trend for nine indicators, and no change or no new data for the others.

1.71 A number of reports followed that considered the performance of the CDBS. The next significant proposals for reform were contained in the Productivity Commission's 2018 report into reforming human services, which recommended:

- measures to increase choice and competition in the system, including the introduction of a new consumer-directed public dental care scheme, utilising private providers and a blended payment model;
- adoption of outcome measures;
- introduction of a digital oral health record; and
- allocation of public funding based on a risk-based model.

1.72 There does not appear to be a formal government response to the Productivity Commission's report.

1.73 In 2021, the Royal Commission into Aged Care Quality and Safety recommended the establishment of an Australian Senior Dental Benefits Scheme

(SDBS). This recommendation is being considered by government as it works to develop a longer-term approach to funding public dental services.

1.74 The most recent relevant report was completed by KBC Australia (2022) and considered strategies to increase dental and oral health training in rural and remote Australia. The government has yet to respond to this report.

Chapter 2
Unmet need for dental services

2.1 This chapter outlines unmet need for dental services in Australia by exploring the following topics:

- barriers that impact access to dental services;
- service gaps for specific cohorts of people;
- the economic costs and social impacts associated with poor oral health; and
- comparison of the committee's survey results against official research and data.

2.2 In order to better facilitate the involvement of a diversity of members of the public with lived experience of dental health service access and issues, the committee agreed to conduct an online survey. The survey was held between 17 April 2023 and 4 June 2023, and recorded a total of 17 544 responses.

2.3 The survey was circulated by members of the committee, other members of parliament, community members, dental and other organisations.

2.4 The committee notes that the sample size is large, participants self-selected and that results are presented in their primary format—independent statistical analysis on the data has not been conducted.

2.5 A selection of results has been analysed and presented throughout the chapter and a full list of the questions and results is available in Appendix 1.

Barriers to accessing care

2.6 Many Australians experience barriers when trying to access dental services, and this section will expand on the following barriers: cost, workforce availability, and long waiting times.

Cost

2.7 The cost of dental care is a barrier to many Australians when accessing dental services. The Australian Institute of Health and Welfare (AIHW) reports that 39 per cent of people aged 15 and over avoided or delayed visiting the dentist due to cost reasons.[1] This barrier is more pronounced for people in lower socioeconomic positions.[2]

2.8 The committee's survey results indicated a higher proportion of people delayed going to the dentist due to costs, compared to the AIHW. 61 per cent of

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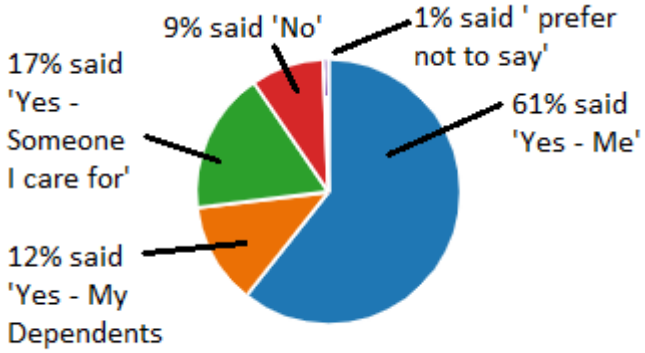
1 Australian Institute of Health and Welfare (AIHW), *Oral health and dental care in Australia- Costs*, last updated: 17 March 2023 (accessed 2 June 2023).

2 Department of Health and Aged Care, *Submission 18*, p. 15.

individuals who completed the survey delayed going to the dentist because of the cost (**Figure 2.1**).

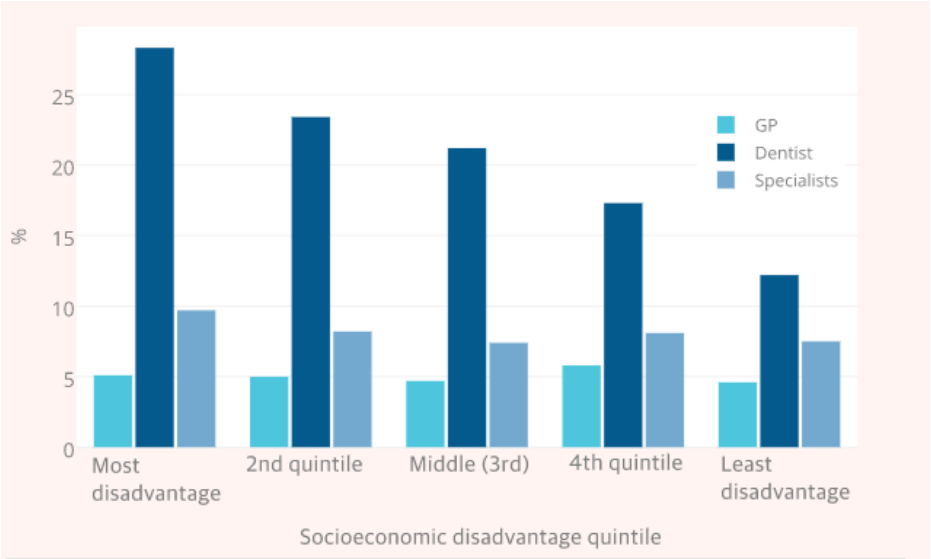
Figure 2.1 Have you, or someone you care for, delayed going to the dentist because of cost?



Source: Committee's Survey: Question 19 (Appendix 1)

2.9 The Australian Bureau of Statistics reported (2021–22) that people delayed seeing dental professionals due to cost at a higher rate compared to general practitioners (GPs) and other medical specialists (**Figure 2.2**).[3]

Figure 2.2 Delayed or did not make healthcare visit where cost was a factor by socioeconomic disadvantage



Source: The Guardian, Cost of medical and dental care a barrier to Australians – survey, 13 November 2015.

2.10 The average household out of pocket expenditure for dental services is $240, which is the second highest household expenditure on health, following non-subsidised medications ($429). Approximately a quarter of Australia's

[3] Australian Bureau of Statistics (ABS), *Patient Experiences 2021–22*, 18 November 2022 (accessed on 2 June 2023).

population would have trouble paying a $200 bill for dental services.[4] Over 4000 people reported in the committee's survey that they went without basic necessities to pay for necessary dental services.[5]

2.11 Adults aged 25–34 years were the most likely to delay or avoid dental care compared to any other age group. The AIHW reported in 2017-18, 50 per cent of people in this age group delayed or avoided dental care due to cost.[6]

2.12 Having private health insurance can help alleviate the costs, however private health insurances have a gap, on average, of 54 percent of dental expenses. This still leaves people paying significant out of pocket costs in addition to their premiums.[7]

2.13 The committee's survey indicated that over half (57 per cent) of those who completed the survey do not have private health insurance,[8] and would therefore be paying for dental services completely out-of-pocket or relying on public dental if eligible.

2.14 If people cannot pay for dental services, they will either delay, miss out on dental care, or rely on the public system if they are eligible. For those eligible for the public system, there are long waiting lists.

2.15 The committee's survey indicated that cost was the largest barrier affecting peoples' access to dental services (**Figure 2.3**), when compared to accessibility, cultural and/or language barriers, wait times, and fear of the dentist. 98 per cent of survey respondents indicated that the Government should make more dental healthcare free.[9]

4 Deakin Health Economics, *Submission 10*, p. 2.

5 See Appendix 1, Question 17.

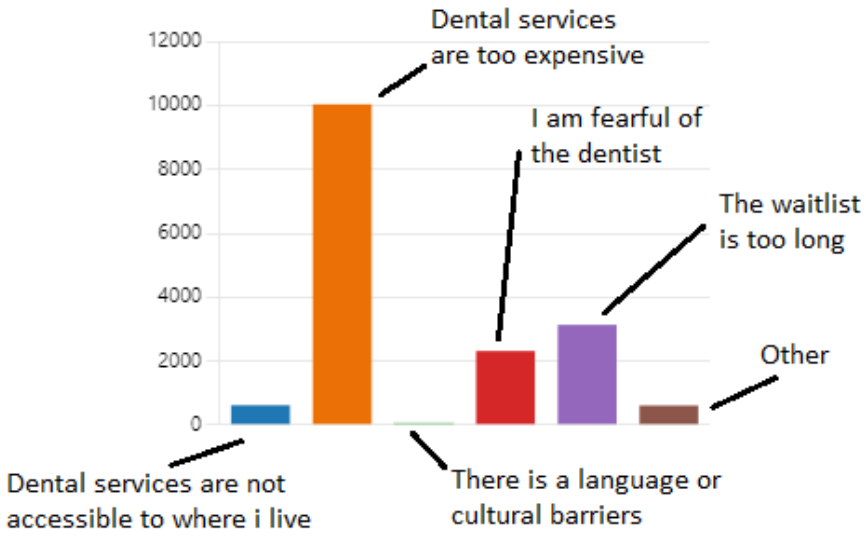
6 AIHW, *Oral health and dental care in Australia- Costs*, 17 March 2023 (accessed 2 June 2023)

7 Grattan Institute, *Filling the gap: A universal dental scheme for Australia*, 2019, p. 11.

8 See Appendix 1, Question 11.

9 See Appendix 1, Question 28

Figure 2.3 What factors impact your access to dental services?



Source: Committee's Survey: Question 21 (Appendix 1)

Workforce availability

2.16 The Australian Health Practitioner Regulation Agency reports that there are over 26000 registered dental practitioners across Australia.[10] Dentists employed in Australia predominantly work in the private sector, with only five per cent of dental practitioners practicing in the public dental system.

2.17 Similarly, to other health professionals, there is a maldistribution of dental practitioners between regional and remote Australia compared with major cities. The AIHW reports in 2020 the rate of full-time equivalent dentists ranged from 26.3 in remote and very remote areas to 63.8 per 100000 population in major cities.[11] Similarly, the rates of both dental hygienists and oral health therapists also decreases with remoteness.[12] There are currently no workforce initiatives to support recruitment or retention of dental health practitioners in rural, regional and remote Australia.[13]

2.18 La Trobe University notes in their submission, that despite the establishment of rural dental schools, the rural oral health workforce is still a considerable concern. The following issues impact rural schools to train practitioners that would potentially continue to practice in rural and remote locations:

- a shortage of dental educators to sustain rural placements;

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10 Department of Health and Aged Care, *Submission 18*, p. 23.

11 AIHW, *Oral health and dental care in Australia- Dental workforce*, last updated: 17 March 2023 (accessed 2 June 2023).

12 La Trobe University, *Submission 17*, p. 1.

13 Department of Health and Aged Care, *Submission 18*, p. 23.

- the increasing cost to maintain clinical placements; and
- the reliance on community health services, as university dental schools are unable to run their own clinics.[14]

2.19 To assist with providing dental care to regional and remote Australia, the Royal Flying Doctor Service (RFDS) established a dental service designed to support communities in country Australia. The RFDS provide services using fly-in, fly-out or drive-in, drive-out services. In 2021-22, the RFDS delivered 58 976 dental services over 507 locations.[15]

2.20 There are significantly fewer dental practitioners in rural and remote Australia; however, there are more dental practitioners who practice publicly compared to major cities.

2.21 The Productivity Commission reported that the rate of full-time public dentists was higher in remote and very remote areas (6.7 per 100 000 people) of Australia compared to other areas (4.9 to 5.4 per 100 000 people) of Australia (**Figure 2.4**).[16] The highest rate of dentists employed in the public sector per 100 000 people was in the Northern Territory, and the lowest rate was in Victoria.[17]

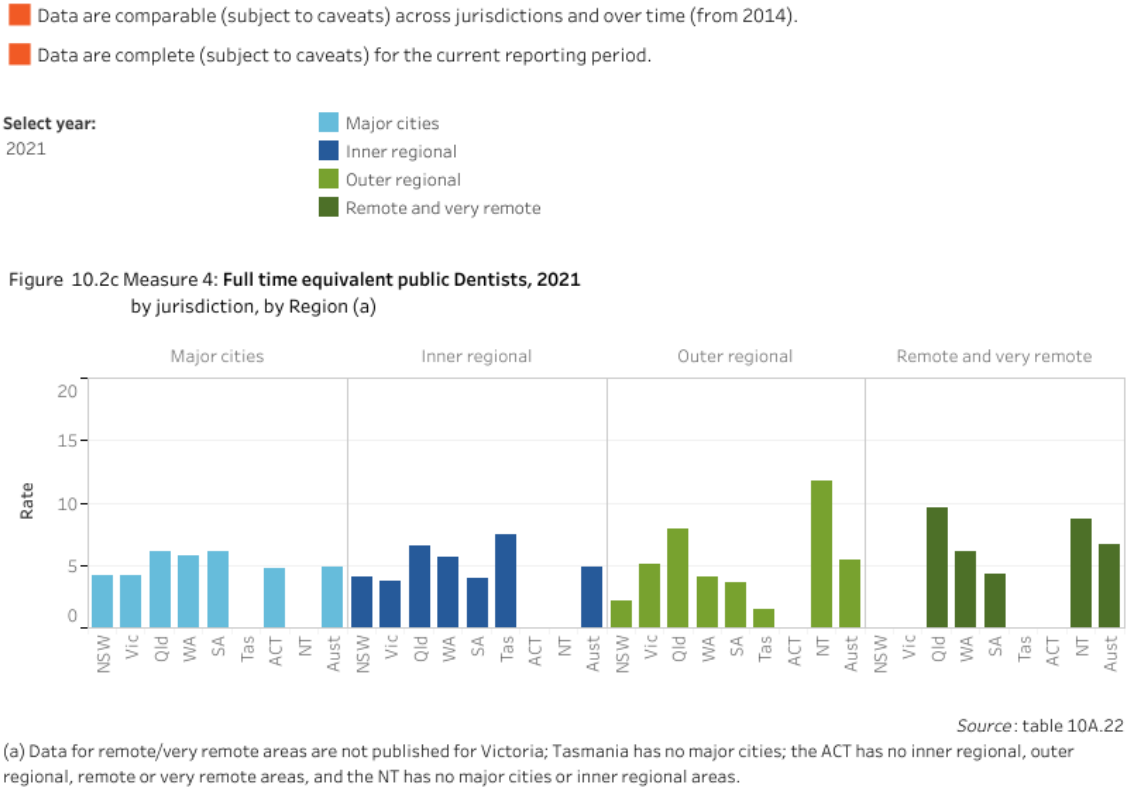
[14] La Trobe University, *Submission 17*, p. 6.

[15] Department of Health and Aged Care, *Submission 18*, p. 8.

[16] Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, 27 October 2017 (accessed 30 May 2023).

[17] AIHW, *Oral health and dental care in Australia- Dental workforce*, 17 March 2023 (accessed 6 June 2023).

Figure 2.4 Full time equivalent public dentists by jurisdiction and remoteness



Source: Productivity Commission, Report on Government Services 2023, Part E, Section 10, 2 February 2023.
Rate = dentists per 100 000 people.

2.22 There are 13 approved dental specialities in Australia, and in 2020 it was reported that only 9.8 per cent of dentists were specialists. The most common speciality is orthodontics, which accounts for 35 per cent of all specialist dentists. The least common specialities are special needs dentistry, oral pathology, and dento-maxillofacial radiology.[18]

2.23 The Dental Board of Australia reports that there are currently no special needs dentists in the Australian Capital Territory, Northern Territory, and Tasmania.[19]

Waiting times

2.24 The committee's survey indicated that long wait times to access dental services was the second largest barrier for those who competed the survey (**Figure 2.3**).

2.25 Only five per cent of dental professionals practise in the public dental system, leading to high levels of demand for public dental services. Due to the demand, the focus is placed on treating the most urgent cases first and placing the remaining patients on a waiting list. These waiting lists (depending on which

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18 AIHW, *Oral health and dental care in Australia- Dental workforce*, 17 March 2023 (accessed 2 June 2023).

19 Dental Board of Australia, *Registrant data 2023*, Reporting period: 1 January 2023 to 31 March 2023, 26 April 2023, p. 8.

state or territory) can have adult patients waiting up to three years to receive care.[20] Competition with the private sector makes it challenging for the public sector to meet demand and to attract sufficient dentists.

2.26 These waiting times preclude patients from accessing timely dental services, resulting in adults being unable to receive regular care based on their oral health needs.

2.27 Once general care is completed (a full course of dental treatment), eligible adults typically have to be placed back onto the waiting list to receive follow-up appointments for ongoing oral health care.[21]

2.28 Without timely access to dental services, patients end up seeking care from alternative health care professionals –GPs, pharmacists, and hospitals.[22]

Service gaps for specific populations

2.29 There are populations who are at a greater risk of poor oral health, due to barriers to accessing oral health care in either the private or public sector. The National Oral Health Plan identifies four priority population groups that experience poor oral health at higher rates than other sectors of the population: people who are socially disadvantaged or on low incomes; Aboriginal and Torres Strait Islander Australians; people living in regional or remote areas; and people with additional and/or specialised health care needs.[23]

2.30 The committee's survey indicated that approximately 61 per cent of respondents had average, poor or very poor access to dental services (**Figure 2.5**).

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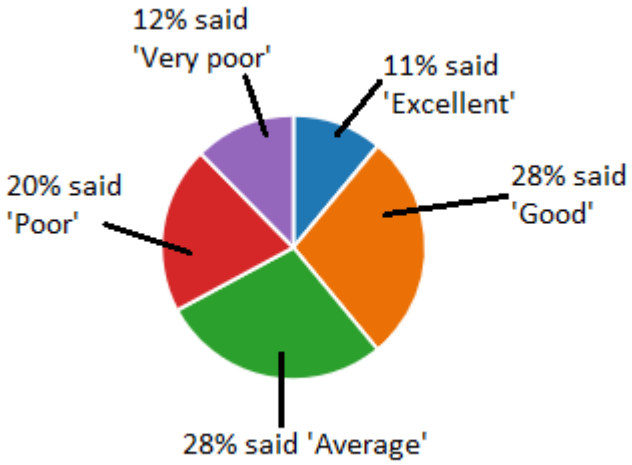
20 Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, 27 October 2017 (accessed 30 May 2023).

21 Deakin Health Economics, *Submission 10*, [p.2].

22 AIHW, *Oral health and dental care in Australia- Disease Expenditure,* 17 March 2023 (accessed 30 May 2023).

23 Council of Australian Governments (COAG) Health Council 2015, *Healthy Mouths Health Lives - Australia's National Oral Health Plan 2015–2024*, 17 February 2016 (last updated 8 May 2023), pp. 50– 68 (accessed 30 May 2023).

Figure 2.5 How would you rate your current level of access to dental services?



Source: Committee's Survey: Question 20 (Appendix 1)

2.31 This section expands on these populations of Australia that have reduced access or barriers to accessing dental services.

People who are socially and economically disadvantaged

2.32 This group has traditionally been identified as those on a low income and/or receiving some form of government income assistance. This priority group now extends to include people experiencing other forms of disadvantage, including refugees, homeless people, some people from culturally and linguistically diverse backgrounds, and people in institutions or prisons.[24]

2.33 Adults with low incomes are less likely to purchase private health insurance, leaving them reliant on public dental services (if eligible), or required to pay for private dental services completely out-of-pocket.

2.34 Public dental care is only available for limited sections of the population. It differs by state and territory, but generally adults must have a healthcare card or pensioner concession card to be eligible.[25]

2.35 As indicated in the committee's survey, 37 per cent of respondents were unaware that public dental care was available in Australia (**Figure 2.6**). Those who rely on public dental services have little choice on who provides their care, when they can access this care, and where it will be provided.[26]

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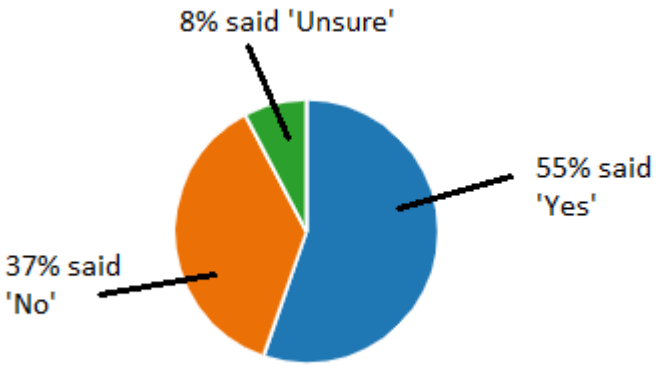
[24] COAG Health Council 2015, *Healthy Mouths Health Lives - Australia's National Oral Health Plan 2015–2024*, 17 February 2016, pp. 50–54 (last updated 8 May 2023).

[25] Australian Dental Association (ADA), *Government dental care*, 13 June 2023 (accessed 1 June 2023).

[26] Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, 27 October 2017, pp. 357–359 (accessed 16 June 2023).

Figure 2.6 Did you know that some people are eligible for public, or government funded dental services in Australia?



Source: Committee's Survey: Question 25 (Appendix 1)

2.36 Mitigating factors also contribute to poor oral health services in this population. Individuals in prisons/correctional facilities have higher rates of tobacco smoking and high-risk alcohol consumption compared to the general public.[27] These behaviours have been linked to increased risk of oral disease. This means prisoners often need higher levels of dental care and more intensive treatments.

2.37 Despite the need for dental care in prisons, there are significant barriers to accessing this care. The Office of the Inspector of Custodial Services in Western Australia noted the following issues in its submission:

- shortage of dentists;
- long waitlists;
- onsite dental suites are not available at every facility; and
- dental care is focused on extractions and has little preventative services.[28]

2.38 Prisoners do have the option to seek and pay for private dental services, however they are required to cover the staffing and vehicle costs to escort them to and from the appointment. This adds on average $700 to their appointment costs, which few prisoners can afford.[29]

Aboriginal and Torres Strait Islander Australians

2.39 Aboriginal and Torres Strait Islander Australians suffer from higher rates of oral disease, have more untreated dental problems, and have more tooth extractions

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27 AIHW, *Oral health and dental care in Australia - People who are socially disadvantaged or on low incomes,* 17 March 2023 (accessed 1 June 2023).

28 Office of the Inspector of Custodial Services, *Submission 4*, pp. 5–7.

29 Office of the Inspector of Custodial Services, *Submission 4*, pp. 5–7.

than the general population. They are also less likely to receive essential dental care when required.[30]

2.40 Key barriers to accessibility of dental care for Aboriginal and Torres Strait Islander Australians include the disproportionate burden that the socioeconomic determinants of health have on health outcomes, lack of access to public preventative dental services, and inadequate oral health education.

2.41 Private dental practices are often unaffordable for many Aboriginal and Torres Strait Islander people, and public dental services are not meeting their oral health needs. Public dental services are often hard to access without transport, incur a cost, have no facilities for parents or carers with babies and young children, and there is a lack of culturally appropriate services.[31]

2.42 Accessibility of dental services is a big factor contributing to the poor oral health of Aboriginal and Torres Strait Islander populations compared to the rest of the population. The *National Oral Health Plan 2015–2024* reports that 43 per cent of Aboriginal and Torres Strait Islander people live in regional Australia, and 21 per cent live in very remote areas.[32] Regional and remote areas have limited local availability for dental services and limited transport options to travel to receive care.

2.43 The Office of the Inspector of Custodial Services in Western Australia noted the importance of culturally safe access to dental services for Aboriginal and Torres Strait Island people in prisons. With a high representation of Aboriginal and Torres Strait Islander Australians in adult and youth custody, combined with an already increased risk for oral diseases, they are disadvantaged without culturally safe dental services.[33]

2.44 The dental and oral health needs of Aboriginal and Torres Strait Islander people are unmet due to inadequate dental services in a culturally safe environment.

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30 COAG Health Council 2015, *Healthy Mouths Health Lives - Australia's National Oral Health Plan 2015–2024*, 17 February 2016 (last updated 8 May 2023), p. 55 (accessed 2 June 2023).

31 Derbal Yerrigan Health Service, *Submission 29*, p. 2.

32 COAG Health Council 2015, *Healthy Mouths Health Lives - Australia's National Oral Health Plan 2015–2024*, 17 February 2016 (last updated 8 May 2023), p. 55 (accessed 2 June 2023).

33 Office of the Inspector of Custodial Services, *Submission 4* p. 9.

Box 2.1 Barriers experienced when accessing dental services – Testimonies from members of the public

The committee received evidence directly from disadvantaged members of the public regarding barriers they face accessing dental services in Australia. Referenced quotes are from submissions to the inquiry and can be found on the committee's website.

Gum disease at 30

> I began my apprenticeship in 2016, and like many adult apprentices, I struggled to make ends meet. The meagre income I received barely covered my living expenses, leaving me with no room for additional costs such as dental care. During this time, I neglected my dental health, as I simply could not afford regular check-ups or treatments… Those years of forced neglect have now culminated in a diagnosis of Advanced Late-Stage Gum Disease, I am only 30 years old… The cost of treating my gum disease is staggering. Restoration of the gum is expected to cost upwards of $2,500 for just one area that has gum recession. Facing this reality, I have come to the heartbreaking realization that I cannot afford this treatment. My front tooth will eventually fall out, and as the disease progresses, I will lose the rest of my teeth with it. – Name withheld, *Submission 47.*

Severe tooth decay at 6 years old

> Alison was screened by a Kimberly Dental Team (KDT) dentist which she saw in class at her local school. Alison has substantial decay in various teeth in both her upper and lower archers. She has been in a lot of pain and has been on the waitlist to receive treatment via General Anaesthetic by public dental health services for over a year.
>
> Multiple extractions would be required to relieve Alison of pain and minimise risk of further infection. Due to her age, Alison would need to receive GA to tolerate this level of treatment. Therefore, the KDT could not carry out any treatment to support Alison. – Supplied by the Kimberley Dental Team, *Submission 46*.

People living in regional and remote Australia

2.45 People living in regional and remote areas in Australia have poorer oral health compared to those living in major cities, and people's oral health status generally decreases as remoteness increases.[34]

2.46 Factors influencing poor oral health in regional and remote Australia are related to higher rates of tobacco and alcohol use, reduced access to fluoridated drinking water, lack of service availability, high cost of healthier food options, and increased cost of oral hygiene products.[35]

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34 COAG Health Council 2015, *Healthy Mouths Health Lives - Australia's National Oral Health Plan 2015–2024*, 17 February 2016 (last updated 8 May 2023), p.59 (accessed 2 June 2023).

35 AIHW, *Oral health and dental care in Australia- People living in regional and remote areas,* 17 March 2023 (accessed 2 June 2023).

2.47 The *National Oral Health Plan 2015–2024* states that all communities with populations over 1000 should have access to fluoridated water supplies. However, a recent study in the Australian Journal of Rural Health found that 33 per cent of rural towns in Victoria with more than 1000 people did not have access to fluoridated water. Over 50 per cent of children under 12 years living in these non-fluoridated communities had increased rates of decayed, missing or filled teeth.[36]

2.48 The RFDS reports that approximately 119 000 people in rural and remote Australia do not have access to general dental services within a 60-minute drive time.[37] A 60-minute drive in rural and remote Australia can be a significant undertaking, with difficult terrain, weather, condition of roads, and a person's ability to access transport impacting the accessibility.

2.49 In rural and regional areas of Australia, there are significant gaps in dental services for complex or specialised services. Tertiary referral services (like orthodontics), dental hospitals and specialised clinics are primarily located in major cities, making it difficult for people living in regional and remote Australia to access them.[38] In many cases there are no options for accessing these specialised services due to the high cost of travel to a major city, along with treatment and accommodation required.

2.50 For children, early oral health education is an essential preventative measure against poor oral health. In rural and remote Australia, there is limited school screening, toothbrush programs, and restricted oral health educational programs.[39]

People with additional and/or complex health care needs

2.51 This group includes people living with mental illness, disabled people, people with complex medical needs, and older people. People with additional health care requirements often receive fragmented care, resulting in poor oral health.

2.52 The factors that lead to suboptimal care for this priority group are as follows:

- a shortage of dental health professionals with special-needs dentistry expertise;
- difficulties in physically accessing suitable dental services; and

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36 Virginia Dickson-Swift, Leonard Crocombe, Silvana Bettiol and Stacey Bracksley-O'Grady, 'Access to community water fluoridation in rural Victoria: It depends where you live…', *The Australian Journal of Rural Health*, Vol. 31, no. 3, 2023.

37 Royal Flying Doctor Service of Australia, *Submission 31*, p. 2.

38 Grattan Institute, *Filling the gap: A universal dental scheme for Australia,* 2019, p. 20.

39 Royal Flying Doctor Service of Australia, *Submission 31*, p.3.

- the cost of dental services.[40]

2.53 COTA Australia conducted a survey in 2023, which showed that dental services were the most difficult health or medical service for older people to access.[41] This is coupled with the risk that many oral diseases tend to increase with age (**Figure 2.7**).

Figure 2.7 Prevalence of oral health conditions among older Australians

COMPLETE TOOTH LOSS AFFECTS:	• 8% of people aged 55- 74 years • 20% of people aged 75+ years
UNTREATED TOOTH DECAY AFFECTS:	• 32% of people aged 55- 74 years • 25% of people aged 75+ years
PERIODONTAL (GUM DISEASE) AFFECTS	• 51% of people aged 55- 74 years • 69% of people aged 75+ years
INADEQUATE DENTITION AFFECTS:	• 22% of people aged 55- 74 years • 46% of people aged 75+ years

Source: COTA Australia, Submission 11, p. 5

2.54 Residents of aged care facilities have been identified as a particularly vulnerable subpopulation of older Australians who have high-risk oral health needs and limited access to dental care.

2.55 As most dentists in Australia operate in private dental practices, it is difficult for older Australians to access them for regular care. There are few organised programs that target people in aged care, and those that do, do not have the capacity to care for the high number of aged care residents.[42]

2.56 Oral health was one of the issues raised in the Aged Care Royal Commission, and it was recommended (recommendation 60) to create a new dental benefits scheme for seniors.[43]

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40 AIHW, *Oral health and dental care in Australia- People with additional and/or specialised health care needs,* 17 March 2023 (accessed 5 June 2023).

41 COTA Australia, *Submission 11*, p. 5.

42 F.A. Clive Wright, Garry Law, Steven K.-Y. Chu, John S. Cullen, and David G. Le Couteur, 'Residential age care and domiciliary oral health services: Reach-OHT – The development of a metropolitan oral health program in Sydney, Australia', *Gerodontology*, vol. 41, no. 4, 2017, pp. 1–2.

43 Royal Commission into Aged Care Quality and Safety, *Final Report: Care Dignity and Respect – List of Recommendations*, 1 March 2021, p. 249.

Disabled people

2.57 Barriers affecting access to dental services for disabled people can include long wait times, cost of services, accessibility of dental suites, and communication barriers.

2.58 Some disabled people cannot verbally communicate their pain and may rely on non-verbal communication to express their discomfort. This can lead to communications barriers between the individual and the dental professional, leading to suboptimal care.[44]

2.59 The AIHW reported in 2018, that 32 per cent of disabled people between the ages of 15 and 64 did not see a dental professional due to cost.[45] In the committee's survey, 74.5 per cent of respondents who identified as a disabled person said that the cost of dental services impacts their access to those services.[46]

2.60 Disabled people often require extra support to access dental services. For people who require general anaesthesia (GA) to be able to access basic dental services, there is funding available under the National Health Reform Agreement for public hospital in-patient dental services. However, most states and territories have strict eligibility criteria and long wait times.[47]

2.61 The Dental Board of Australia reports that there are currently only 26 practising special needs dentistry specialists across Australia. This is equivalent to one per cent of dental specialists in Australia.[48] Although disabled people can be treated by a general dentist, it can be difficult to find one happy to treat them without referring them to a specialist. An article published by the ABC states that one third of general dentists would be unwilling to treat people with disabilities, mostly due to a lack of confidence and training in how to treat disabled people.[49]

2.62 The AIHW reported that 70 per cent of disabled people wait more than a year on the public dental waiting list before receiving dental care.[50] The Department

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44 Geelong Parents Network, *Submission 2*, p. 2.

45 AIHW, *People with a disability: Access to health services*, last updated: 5 July 2022 (accessed 6 June 2023).

46 See Appendix 1, Questions 5 and 21.

47 Department of Health and Aged Care, *Submission 18*, p. 7.

48 Dental Board of Australia, Registrant data 2023, Reporting period January 2023 to 31 March 2023, 26 April 2023, p. 8.

49 Zalika Rizman, 'Millions of Australians live with a disability, but dental care remains out of reach by many', *ABC News*, 13 March 2023 (accessed 6 June 2023).

50 AIHW, *People with disability in Australia Report*, July 2022 (accessed 5 June 2023).

of Health in Western Australia reported that the current waitlist for Special Needs Dental Clinics is 2 years 8 months for recall, and 3 years for GA.[51]

2.63 To access GA through the private system for dental services, patients could be out-of-pocket between $3500 and $5000.[52]

Box 2.2 Barriers experienced when accessing dental services – Testimonies from members of the public

A 6-to-10-hour car journey

The oral health story of the Yolgnu people who live in our communities is distressing. Many adults suffer ongoing pain and discomfort. They are unable to make appointments to see a dentist unless they go to town (Darwin), most times this is either a flight or a 6-to-10-hour car journey. The Yolgnu people are totally reliant on a service attending the community they live in. – Supplied by the Northern Territory Department of Health, *Submission 27.*

Mouth cancer

Elderly lady. Mentally competent. Supportive family. Pensioner. Wheelchair bound. Travelling well. Denture wearing. Advised she had a mouth ulcer. Ulcers are frequent. Last about 10-14 days with removal of denture and local analgesic application. This one didn't. When I saw her 2 months later the ulcer was not an ulcer but an aggressive mouth cancer and needed IMMEDIATE treatment. She was now bed bound, lost a lot of weight, on morphine, and sleep deprived. A biopsy was needed, but no one would do it. I couldn't because I was a dentist (policy), it needed a specialist. DHS didn't have one. Private didn't do domiciliary. Eventually I contacted a colleague at the dental school in Oral Medicine. He did the biopsy gratis. It confirmed my diagnosis. She was referred to RPH and assessed for surgery. Being a public patient, she had to wait. If she was private, it could have been done next day. To facilitate treatment, I approached the Health Insurance Commission. Not possible (legislation 1973), the health funds not possible. They required 3 months waiting period(policy). She died in pain shortly afterwards. Her family was very upset. This is not a rare event. – Supplied by Dr Patrick Shanahan, *Submission 1.*

Impacts of poor oral health on individuals and families

2.64 Poor oral health has substantial impact on individuals, the health system and society. Poor oral health can affect both an individual's physical and mental health, and have social impacts such as poor appearance, low self-esteem, and

[51] Western Australia Department of Health, *Submission 42*, p. 6.

[52] Department of Health and Aged Care, *Submission 18*, p. 7.

decreased quality of life. The impact of poor oral health on the health system causes direct and broader economic costs.

Social impacts associated with poor oral health

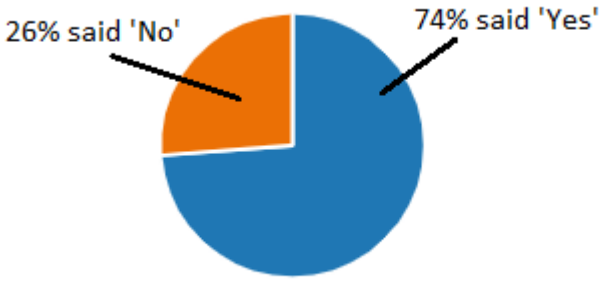
2.65 People who have access to appropriate and quality dental care are more likely to visit the dentist.[53] Improving the pattern of dental visits would have a positive impact on the population's oral health through earlier access to prevention, earlier diagnoses, and increased education on oral hygiene measures.

2.66 Good oral health contributes positively to physical, mental and social wellbeing and enables people to speak, eat and socialise unhindered by pain, discomfort, oral disease and embarrassment. On the other hand, poor oral health can negatively affect speech, sleep, mental health, self-esteem, relationships, and a person's general wellbeing. Improved oral health has the following positive effects:

- improved general health;
- decreased absences from work and school;
- improved self-esteem and improved mental health;
- improved nutrition;
- decreased dental hospitalisations and a reduced need for acute care; and
- improved oral health care knowledge.[54]

2.67 In the committee's survey, 74 per cent of respondents reported they had dental problems or concerns that impacted their health or quality of life (**Figure 2.8**).

Figure 2.8 Have you ever experienced dental problems or concerns that have impacted your health or quality of life?



Source: Committee's Survey: Question 16 (Appendix 1)

2.68 Poor oral health can cause bad breath, missing, decoloured and/or crooked teeth, which can negatively impact a person's self-esteem and/or mental health. The AIHW reports that one-in-three people felt uncomfortable with their dental

53 Western Australia Department of Health, *Submission 42*, p. 11.

54 Royal Flying Doctor Service of Australia, *Submission 31*, [p. 5].

appearance over the last 12 months.[55] Over 7500 people in the committee's survey stated that their oral health negatively impacted their confidence and self-esteem. Secondly, over 3500 reported that their oral health negatively impacted their social life, relationships and community participation.[56]

2.69 The association between low socioeconomic status and poor oral health is well established. Oral diseases disproportionally affect poor and socially disadvantaged populations, which causes further social disadvantages.[57] Poor oral health can result in time off from work and school, which affects disadvantaged groups disproportionately.

Economic costs associated with poor oral health

2.70 The economic cost to Australia of poor oral health is not identified in Australia's National Oral Health Plan, and there are limited Australian studies that provide costing estimates. Existing studies are generally neither current nor comprehensive in scope.

2.71 The Australian Research Centre for Population Oral Health reported in 2012 that the estimated cost of reduced workforce participation due to dental conditions was approximately $556 million per year.[58] This is a result of individuals taking time off from work or school due to dental problems.

2.72 These long wait times have serious impacts on people's oral health and can put people at a higher risk of developing or worsening oral health diseases. Without timely access to public dental care, patients end up seeking care from GPs and from hospitals (Figure 2.9). The AIHW reported that: 'In 2020–21, about 83,000 hospitalisations for dental conditions could potentially have been prevented with earlier treatment.'[59]

2.73 Seeking alternative care options often results in larger cost for the patient and the government for largely preventable conditions.

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55 AIHW, *Oral health and dental care in Australia- Healthy Lives*, 17 March 2023 (accessed 2 June 2023).

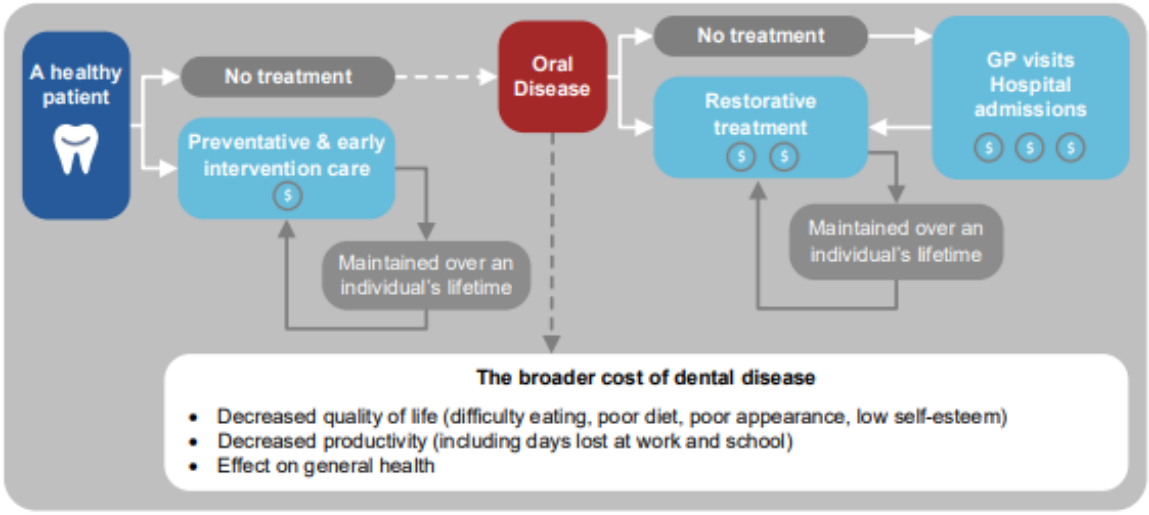
56 See Appendix 4, Question 17.

57 La Trobe University, *Submission 17*, p. 5.

58 Australian Research Centre for Population Oral Health, 'Productivity losses from dental problems', *Australian Dental Journal*, vol. 57, no. 3, 2012, p. 396.

59 AIHW, *Oral health and dental care in Australia- Hospitalisations,* 17 March 2023 (accessed 30 May 2023).

Figure 2.9 A stylised pathway of dental health care and the costs



Source: Productivity Commission, Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, 27 October 2017, p. 360.

2.74 The AIHW reported that in 2019–20, expenditure in hospitals on oral disorders was $639 million and $438 million on other oral disorders. Noting that $208 million of expenditure on other oral disorders was spent on private hospital services. It was also reported by the AIHW that $65.7 million was spent during 2019–20 on GP services for oral disorder conditions.[60]

2.75 Another impact of delayed dental care and worsening oral health is the need for further treatment. For example, once a tooth experiences decay, it enters a restorative cycle. This results in a filling that will need to be replaced periodically, which may require a crown or root canal, all resulting in an increased cost to save the tooth. Even a tooth which is extracted can have a lasting economic burden if the patient chooses to restore the gap left from removal. On a population level, this would have significant economic impact.[61]

Committee view

2.76 Australia is a wealthy country by global standards and people in Australia enjoy a relatively high standard of living. While there are certain inequalities in the system, healthcare is widely available and relatively affordable for most Australians—dental care is not.

2.77 The prohibitive cost of dental care means simple, treatable dental problems turn into medical emergencies, leading to preventable hospitalisations and the costs associated with that. The committee believes that moving to a preventative

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60 AIHW, *Oral health and dental care in Australia- Disease Expenditure,* 17 March 2023 (accessed 30 May 2023).

61 Western Australia Department of Health, *Submission 42*, p. 12.

based approach will improve Australia's oral health status and have substantial social and economic impacts.

2.78 The committee is concerned that dental decay and gum disease are *increasing* in Australia, and that dental services remain unaffordable and inaccessible to around half of the population. The committee heard consistently that people who are socially disadvantaged or who have low incomes, Aboriginal and Torres Strait Islander Australians, people living in regional and remote Australia, and people with additional and/or specialised health care needs. The committee believes that prioritising accessibility for these subpopulations is critical in addressing the unmet need for dental services in Australia.

2.79 Public dental services, provided by state governments with some funding support from the Commonwealth, are woefully inadequate to meet the needs of eligible populations. They are understaffed and under resourced, serving only a quarter of those who are eligible and in need. By expanding the public dental system, training more dental professionals, and supporting a more diverse distribution of services, significant benefits could be achieved in Australia's oral health.

2.80 Australia's oral and dental health system is broken. 25 years' worth of inquiries and reports have illuminated the problems, and recommended solutions. However, reforming the way in which oral and dental health services are funded and coordinated is a huge task, and one that governments across the political spectrum have been reluctant to take on.

2.81 This inquiry will test suggested models for reform while looking to outline a realistic and achievable pathway towards universal access to oral and dental healthcare in Australia.

Chapter 3
Looking forward - key questions for the inquiry

3.1 Evidence to this inquiry, and many more before it, indicates that Australia's public dental and oral healthcare is fragmented, under-resourced and overstretched. Australians are paying more for dental care than people in many other countries, but with poorer health outcomes, and access to dental services remains deeply inequitable. People experiencing poverty, disabled people, prisoners, Indigenous Australians, older Australians and those in care are most impacted by deficiencies in the current system.

3.2 The problems are clearly defined and well understood, and a number of possible solutions have been articulated over recent decades. Despite this, very little has changed.

3.3 This chapter explores key proposals for reform that are emerging in the submissions received so far, and outlines questions arising from these proposals. Noting the committee's evidence is preliminary and incomplete at this stage, this report does not draw conclusions or make recommendations. It is the committee's intent to interrogate a variety of options and present its findings in the final report.

3.4 Preliminary proposals explored in this chapter include:

- integrating essential oral healthcare and preventative care into existing health assessment and care settings;
- expanding the scope of public subsidies under Medicare for dental and oral healthcare, using the current Child Dental Benefits Schedule (CDBS) as a model;
- implementing an Australian Senior Dental Benefits Scheme;
- national administrative reforms, including establishing a Chief Dental Officer to coordinate a national approach;
- improved national data and evaluation;
- addressing the disparity of dental care between metropolitan, rural, regional and remote areas;
- education, training and workforce initiatives;
- increasing funding for state-run public dental services and addressing the low proportion of dentists working in public practice; and
- initiatives to ensure services reach priority populations, in particular aged and disabled people, prisoners, and Indigenous Australians.

3.5 This list is not exhaustive. Other important issues have and will be raised over the course of the inquiry. The committee will explore a wider range of issues and proposals as the inquiry progresses.

Integrate oral healthcare

3.6 Submitters noted with concern that oral and dental healthcare in Australia are 'divorced from the rest of the body'.[1] Former member of the Australian Dental Association (ADA) expert working panel advising the Commonwealth, Dr Patrick Shanahan, argued that oral healthcare—as distinct from dentistry—should be integrated into general healthcare:

> Problems in the mouth are usually seen exclusively as dental problems because teeth are very visible and important for appearance and function. But what about health? The mouth has more than teeth in it. Blood vessels, nerves, salivary glands, tongue, soft tissues, and soft palate. Who looks after them?[2]

3.7 Research indicates many serious medical conditions are linked to poor *oral health*, rather than dental decay. Even those without teeth can be affected by oral health conditions, which can then lead to serious and sometimes fatal broader health complications. Dr Shanahan explained:

> Dentists practice independently of medicine and outside health care. This is one of the reasons why we have problems in the health system. Preventing infection is a MEDICALLY NECESSARY service and therefore ESSENTIAL HEALTH CARE. Medicare is legislated to cover essential health care but has excluded oral and dental health from health care and allied health. It failed to make the distinction between essential health care and dentistry.[3]

3.8 Dr Shanahan suggested oral hygienists should be funded to work in healthcare, 'under a medical umbrella as members of the medical allied health team'. He proposed a pilot be conducted 'to develop an evidence based (microbiology and radiography) operational model'. This would involve using oral hygienists *instead* of dentists in many contexts, integrating their services 'within medical management'. Oral hygienists could also provide 'intermediate' restorations, which are 'much more affordable' than permanent fillings. Dr Shanahan concluded:

> Unlike dentists [oral hygienists and therapists] are prevention, education, and maintenance. The priority is to reduce the medical risk in high risk groups through infection control not restorative dentistry. They have the right to practice independently now. This is a different dental patient, in a different setting, with different needs, different outcomes, different practices, and different abilities. The cost of this is minimal against what is presently spent. It will save more than it costs.[4]

3.9 The Australian Dental and Oral Health Therapists' Association (ADOHTA) put forward a number of suggestions for increasing the use, scope and availability

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1 Dr Peter Foltyn, *Submission 12*, [p. 4].

2 Dr Patrick Shanahan, *Submission 1*, [p. 1].

3 Dr Patrick Shanahan, *Submission 1*, [p. 2].

4 Dr Patrick Shanahan, *Submission 1*, [p. 5].

of oral health therapists, particularly to address unmet need in regional and remote communities.[5]

3.10 Dental health lecturer, Dr Peter Foltyn, observed that, while 'sexual health, mental health, disability health, [and] senior's health' are all supported under the Commonwealth Medicare Benefits Schedule, oral and dental health conditions are excluded for the majority. This is the case even when the condition is impacting a person's 'systemic health', or needs to be treated before a patient can have surgery or other necessary treatment.[6]

3.11 Dr Foltyn recommended that oral and dental health services that are necessary before medical treatment be urgently integrated into the Commonwealth's Medicare Benefits Schedule. He also suggested medical undergraduate training should include education on 'the important relationship [of oral health] to systemic health':

> Because oral health care has not been seen as a priority nor fully appreciated by the medical profession and government, many doctors have a limited working knowledge of oral and dental anatomy and the close relationship between oral health and general health. … Education and prevention strategies in oral and dental health care must be put in place now for all medical undergraduate students, doctors and nurses in order to limit a disaster amongst our medically compromised, aged and disabled.[7]

3.12 Submitters noted missed opportunities where oral health assessment, education and basic treatment could be incorporated into existing health interventions. For instance, government-funded Aged Care Assessment Teams (ACATs)—which assess the eligibility of older people for care services and make health referrals—look at 'physical, social and psychological needs' of older people, but do not consider oral health. Dr Foltyn submitted that assessing oral health needs at this crucial juncture would be an easy way to integrate oral healthcare into general healthcare for older people. He also suggested adding oral health assessments to government-funded 'over 75s' general practitioner (GP) health assessments—which are available free to anyone over 75.[8]

3.13 Medical academics, Dr John Rogers and Dr Jamie Robertson, from the University of Melbourne, argued for a similar approach. They recommended governments:

- Create oral health promoting environments in pre-school, school, and aged care settings;

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5 Australian Dental and Oral Health Therapists' Association (ADOHTA), *Submission 28*, p. 6.

6 Dr Peter Foltyn, *Submission 12*, [p. 4.]

7 Dr Peter Foltyn, *Submission 12*, [p. 4.]

8 Dr Peter Foltyn, *Submission 12*, [pp. 5–6.]

- Extend preventative value-based dental care by employing minimal intervention approaches such as fissure sealants, Hall crowns, silver diamine fluoride and community-based fluoride varnish programs; and
- Trial the involvement of other health professionals in applying fluoride varnish.[9]

3.14 Seniors Dental Care Australia argued 70 per cent of the work that dentists do 'can be performed by oral health therapists, dental therapists and dental hygienists' effectively, and at lower cost.[10] The ACT Government observed that recent regulatory changes (2022) allowing these professionals to 'opt in' to claim under the CDBS have had low uptake so far. It suggested government considers 'whether this will achieve greater availability and affordability for consumers nationally'.[11]

3.15 Some submitters, including Deakin Health Economics, suggested 'non-dental health professionals' could be trained to deliver preventative care, such as early assessment of problems and the application of fluoride varnishes.[12] The Australian Dental Association (ADA) agreed that 'physicians, nurses, and pharmacists, could play a helpful role in early detection, prevention, and referral of oral health issues', noting limitations in their capacity.[13]

3.16 Dr Rogers and Dr Robertson advocated integrating oral health into 'all relevant policies and public health programs', enhancing the skills and knowledge-base in the Department of Health and Aged Care (the department) to improve national planning, and including oral health promotion in the remit of the new Australian Centre for Disease Control.[14] They argued that oral health research is 'inadequately funded in Australia', with less than 1 per cent of National Health and Medical Research Council research funds going towards oral health research.[15]

3.17 The ADA suggested the government support and extend existing oral health promotion activities, such as its annual 'Dental Health Week':

> Government funding and support in publicising the event and increasing awareness will create an even more impactful campaign. Current reach is significant but necessarily constrained by the budget limitations of the ADA.

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9 John Rogers and Jamie Robertson, *Submission 16*, pp. 5–6.

10 Seniors Dental Care Australia, *Submission 3*, p. 4.

11 ACT Government, *Submission 21*, p. 2.

12 Deakin Health Economics, *Submission 10*, [p. 5].

13 Australian Dental Association (ADA), *Submission 19*, pp. 9–10.

14 John Rogers and Jamie Robertson, *Submission 16*, p. 4. For information on the establishment of the new Australian Centre for Disease Control, see: https://www.health.gov.au/our-work/Australian-CDC.

15 John Rogers and Jamie Robertson, *Submission 16*, p. 8.

> As the assets already exist, we would be able to rapidly scale to further provide preventative oral care advice to target demographics should Government support become a reality.[16]

3.18 Dr Rogers and Dr Robertson advocated the creation of 'compatible dental and medical record systems', that are linked to Medicare, along with other reforms to embed oral health into primary healthcare.[17] While progressing reforms to current structures would require 'substantial discussion [on] priorities and timelines, funding and implementation responsibilities', Dr Rogers and Dr Robertson contended it is necessary:

> Universal oral health care for all individuals and communities would enable Australians to enjoy the highest attainable state of oral health and contribute to healthy and productive lives. The tattered safety net needs repair. The mouth should be brought back into the body.[18]

Committee questions

3.19 How can Australian governments better integrate oral health within general health?

3.20 Is there a distinction between 'essential oral healthcare' and dentistry?

3.21 Should 'essential oral healthcare' be funded under Medicare, while some dental services remain in the private sector?

3.22 How can existing medical, disability and aged care programs better integrate oral health?

3.23 Is there scope to better fund and promote the use of dental therapists and dental hygienists *within* the existing health system, under Medicare?

Extend coverage under Medicare

3.24 Most health and dental organisations, peak bodies, think tanks, and individuals who have submitted to the inquiry advocated for systemic reform. These stakeholders are urging the Commonwealth to work with states and territories to implement radical reforms to the way oral and dental healthcare is funded, coordinated and administered.[19] In line with the 2021 World Health Assembly resolution to embed oral health within universal health coverage,[20] submitters

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16 ADA, *Submission 19*, p. 7.

17 John Rogers and Jamie Robertson, *Submission 16*, p. 7.

18 John Rogers and Jamie Robertson, *Submission 16*, pp. 7–9.

19 See for example: Northern Territory Health, *Submission 27*, [p. 7]; Community and Public Sector Union/Civil Service Association (CPSU/CSA), *Submission 30*, p. 4; John Rogers and Jamie Robertson, *Submission 16*, p. 7.

20 The World Health Assembly approved a Resolution on oral health in 2021 at the 74th World Health Assembly. The Resolution recommends a shift from the traditional curative approach towards a preventative approach; timely, comprehensive and inclusive care within the primary health-care

including the NT Health, the WA Department of Health, and the National Health Alliance (NOHA) argued for bringing dental into Medicare, with a view to 'putting the mouth back in the body'.[21]

3.25 Submitters outlined various proposals, ranging from extending existing Medicare coverage (the CDBS) to seniors and/or other groups, to full universal coverage of dental services for all Australians. Many submitters recommended a phased approach.

3.26 In 2019, the Grattan Institute proposed a full universal dental scheme, estimating the scheme would cost around $5.6 billion per annum. The Grattan Institute updated its report for the inquiry, finding the need is now even greater, and many indicators have worsened **(Figure 3.1)**.

system. Also that oral health-care interventions should be included in universal health coverage programs. World Health Organisation, *Oral Health*, 14 March 2023 (accessed 6 June 2023).

[21] NT Health, *Submission 27*, [p. 7]; Western Australia Department of Health, *Submission 42*, p. 15; National Oral Health Alliance (NOHA), *Submission 15*, p. 5.

Figure 3.1 Most problems have become worse since 2019

Measure	*Filling the gap* report, 2019	Most recent evidence	Change in performance
Funding and access			
Total government expenditure on dental care, per person	$90 (2017-18)	$81 (2020-21)	↓
Proportion of total dental care funding provided by patients	58 per cent (2016-17)	58 per cent (2019-20)	→
Proportion of people who skipped or delayed needed dental care	30 per cent (2016-17)	32 per cent (2021-22)	↓
Proportion of people who skipped or delayed needed dental care because of the cost	18 per cent (2016-17)	16 per cent (2021-22)	↑
Waiting times (years, median) for public dental care	Vic: 1.6, Qld: 1.4, WA: 0.2 (2017-18)	Vic: 2.2, Qld: 1.8, WA: 0.9 (2021-22)	↓
Oral health problems			
Proportion of Australians with untreated dental decay	26 per cent (2004-2006)	33 per cent (2017-18)	↓
Proportion of Australians concerned about their dental appearance	27 per cent (2012-13)	35 per cent (2017-18)	↓
Proportion of Australians who avoided some food due to teeth	21 per cent (2012-13)	24 per cent (2017-18)	↓
Proportion of Australians who suffer toothache	16 per cent (2012-13)	20 per cent (2017-18)	↓

Notes: For brevity, waiting times are included only for the three largest states where data is available for both time periods. In all cases, expenditure is as 2020-21 dollars.

Sources: Grattan analysis of various sources, and Duckett et al (2019).

Source: Grattan Institute, Submission 41, p. 4.

3.27 The Grattan Institute reiterated its call for universal coverage, suggesting:

> It would be impractical to move to a universal scheme overnight. The cost would be large – in 2019 Grattan estimated it to be about $5.6 billion in extra spending per year – and the oral health workforce would need to be expanded. So, the federal government should announce a roadmap to a universal scheme, including plans to expand the workforce, followed by incremental steps towards a universal scheme.
>
> …

> The first step is for the federal government to takeover funding of existing public dental schemes, fund them properly, and enable private-sector providers to deliver publicly-funded care. Coverage should then be expanded – first to people on Centrelink payments, then all children. After that, the federal government should take the final step to a universal scheme, ideally within a decade.[22]

3.28 NT Health advocated moving towards full universal coverage using an 'incremental approach', based on 'the principles of value based health care'. NT Health acknowledged that 'achieving this vision will be challenging amidst ageing populations, increasing chronic diseases and escalating healthcare costs'.[23]

3.29 Dr Rogers and Dr Robertson suggested a 'phased integration of basic dental care into Medicare', starting with seniors. This should be implemented with 'monitoring, evaluation and adjustments', and then extended to those on low incomes and 'people with certain chronic health conditions such as endocrine and cardiovascular disorders'.[24]

3.30 Similarly proposing a focus on seniors, Dr Shanahan noted that, when Medicare was introduced, life expectancy was around 70 and most older people had 'full dentures'. With life expectancy now around 85, and many seniors having 'some of their own teeth and increasingly dental implants', the need for seniors' dental care has changed and increased.[25]

3.31 Submitters who supported the implementation of an Australian Senior Dental Benefits Scheme (SDBS) included: Seniors Dental Care Australia; COTA Australia; NOHA; the Public Health Association of Australia (PHAA); and many others. These submitters also argued for the full implementation of the oral health recommendations made by the Royal Commission into Aged Care Quality and Safety:

> NOHA views the SDBS as a priority to support people living in [residential aged care] homes, those receiving aged care community packages or those who receive the full rate of aged pension—this would ensure some of Australia's most at-risk populations receive timely and affordable, oral healthcare. The Royal Commission recommended the SDBS should focus on essential oral healthcare to maintain a functional dentition, and to maintain and replace dentures. … The SDBS is the next step towards a unified healthcare system that does not separate oral health from the rest of the body.[26]

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22 Grattan Institute, *Submission 41*, p. 9.

23 NT Health, *Submission 27*, [p. 7].

24 John Rogers and Jamie Robertson, *Submission 16*, p. 7.

25 Dr Patrick Shanahan, *Submission 1*, [p. 3].

26 NOHA, *Submission 15*, p. 5. See also: Public Health Association (PHA), *Submission 26*, p. 5.

3.32 In implementing a seniors' dental scheme, COTA Australia argued that governments must ensure:

> (a) Each dental/oral care practitioner group's scope of practice is pragmatically and fully utilised.
> (b) Dental and oral health practitioners are encouraged to take up positions outside of metropolitan and large regional cities.
> (c) A robust financial model is developed and agreed upon which has the capacity to sustainably underpin the Scheme and enable the delivery of a comprehensive range of oral and dental treatments aimed at optimising older people's health outcomes.[27]

3.33 The department submitted that it has completed 'preliminary analysis of options for a Seniors Dental Benefit Program', and these are 'being considered as part of the inter-governmental officials working group on long term dental reform'. Outcomes of the inter-governmental process are 'expected to be presented to Health Ministers for consideration and an initial discussion in June 2023'. At this time, officials 'intend to seek Health Ministers' views on next steps' in relation to the National Oral Health Plan.[28]

3.34 Many submitters see seniors dental as the first step on a road to universal access. NOHA—whose membership includes a number of Australia's most significant health organisations—submitted a 'Roadmap to Universal Access to Affordable Oral Healthcare' which starts with the development of Australia's next National Oral Health Plan 2025–34:

> Universal access to affordable oral healthcare should be embedded within Australia's healthcare system and reflected in the next ten-year National Oral Health Plan for 2025–34. It should be aligned with the [World Health Organisation] WHO's *Global Oral Health Action Plan 2023–2030*. Prevention, early detection, and interventions for managing oral diseases need to be the cornerstone of universal access to affordable oral healthcare.[29]

3.35 Ms Anne Shea proposed the CDBS be used as a 'blue print to improve the oral health of financially disadvantaged adults'. Ms Shea highlighted the 'enormous amount of work' done over the last decade on developing a pathway towards better oral healthcare, saying 'there would seem to be little reason to prevent

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27 COTA Australia, *Submission 11*, p. 4.

28 Department of Health and Aged Care, *Submission 18*, pp. 7 and 10.

29 NOHA, *Submission 15*, pp. 5–6. NOHA members who supported *Submission 15*: Australian Council of Social Service; Australian Dental Association; Australian Dental and Oral Health Therapists' Association; Australian Dental Prosthetists Association; Australian Healthcare and Hospitals Association; Consumers Health Forum of Australia; COTA Australia; Dental Hygienists Association of Australia; National Rural Health Alliance; and Public Health Association of Australia.

discussion and agreement on a staged implementation action plan for the next 5–7 years'.[30]

3.36 The ACT Government also noted Australia's 'strict eligibility criteria and limited scope of service' for public dental. It suggested governments consider 'all the aspects of the "coverage cube"' when adopting a new model.[31]

3.37 This approach was widely supported in submissions. However, some submitters did not agree. Dr Shanahan argued against full coverage of dental services under Medicare, saying it would not be affordable:

> In 2019–20, the DIRECT costs of dental services were $11.1 billion for 50% of the population. The INDIRECT costs are unknown as there is no data available. It could be anything from $1–3 billion recurrent annually. If you had universal Medicare coverage adding the other 50% with all their problems and accumulated need it would probably be 1.5–2 times more. It is just not affordable. The way forward is to address the health care issue. It is the best option, most affordable, and will markedly improve everything for everyone, and in time things would improve.[32]

3.38 The ADA advocated for initiatives to provide universal *access* to dental services, as opposed to a 'universal dental scheme', which it said could cost in the region of $11 billion annually. The ADA claimed that universal dental schemes have failed to produce better outcomes, with 'disparities in oral health' remaining in countries like the United Kingdom and Germany. The ADA recommended 'targeted schemes, subsidised by public funding', including:

- schemes to improve access to oral care for Australians 'more susceptible to oral disease such as those in aged care, or those with a disability';
- a health levy on sugary drinks; and
- utilising private clinics to provide public dental services via voucher schemes.[33]

3.39 In contrast, the Community and Public Sector Union/Civil Service Association (CPSU/CSA) in Western Australia recommended 'shifting away from a "voucher" model', favouring direct investment in dedicated public dental health services and infrastructure.[34]

Committee questions

3.40 Should oral and dental healthcare be part of Australia's universal healthcare system, Medicare?

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30 Ms Anne Shae, *Submission 6*, [pp. 3–4].

31 ACT Government, *Submission 21*, p. 5.

32 Dr Patrick Shanahan, *Submission 1*, [p. 5].

33 ADA, *Submission 19*, pp. 3 and 23.

34 CPSU/CSA, *Submission 30*, p. 4.

3.41 Is now the right time to implement radical reforms in the provision of oral healthcare to Australians?

3.42 What is the best way to improve access to oral and dental health services for all Australians, and particularly for those on low incomes and in other priority groups?

3.43 Should public dental care be universal or means tested?

3.44 If dental coverage under Medicare is expanded, how should this be progressed?

3.45 Should *all* services be covered, or only those deemed medically necessary, along with preventative care?

Policy and administrative reform

3.46 Submissions from peak dental and healthcare bodies, and academics, consistently argued for wholescale reform to the way oral and dental healthcare are administered at the Commonwealth level. This included proposals for greater national coordination and a new Chief Dental Officer.[35]

3.47 NOHA argued that the current treatment of oral health policy as 'allied health' policy is inappropriate. Oral health should be embedded within *primary* healthcare policy, and should have 'a dedicated branch' in the department. The role of Chief Dental Officer should be created to lead the branch and 'support oral healthcare reform that integrates oral health within the wider healthcare system'. A Commonwealth Chief Dental Officer would work with State and Territory Chief Dental Officers and sector stakeholders to implement a national approach.[36]

3.48 The need for national coordination was also identified by the Productivity Commission in its 2017 report on introducing competition and choice into human services. In this report, the Productivity Commission proposed governments work together to develop an 'oral health outcomes framework' to 'improve accountability, and provide the basis for more comprehensive reforms to promote targeted preventive care'.[37]

3.49 Submitters also noted the fragmented nature of oral health and dental services data collection, and the need for more effective evaluation of dental services and programs.[38] According to the department:

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35 See for instance: PHA, *Submission 26*, p. 4; ADOHTA, *Submission 28*, pp. 4–6.

36 NOHA, *Submission 15*, p. 5.

37 Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, Report No. 85*, October 2017, p. 35.

38 See for instance: John Rogers and Jamie Robertson, *Submission 16*, p. 8; Australian Commission on Safety and Quality in Health Care, *Submission 23*, p. 3; Department of Health and Aged Care, *Submission 18*, pp. 20–23.

- variability in data scope between states and territories makes it impossible 'to gain an understanding of [public dental] wait lists at the national level';
- data from private providers is limited, leaving a large gap;
- data on individually-funded treatment is difficult to obtain; and
- Medicare data on geographic location and Indigenous status can be unreliable or out of date.[39]

3.50 The department suggested a 'bottom up' approach to improving data collection:

> …commencing first with what each jurisdiction is already capturing and reporting internally. Over time, reporting may converge in some areas, but in other areas may continue to reflect the differing priorities/models that apply in each jurisdiction. Nevertheless, more consistent availability of data would enable better monitoring of the provision of and access to dental services by populations eligible for public dental care.[40]

3.51 Deakin Health Economics argued that funding oral and dental healthcare under distinct legislation (the *Dental Benefits Act 2008*) makes it vulnerable to being de-funded. Instead, it recommended cost-effective dental services be funded under Medicare's *Health Insurance Act 1973*, and 'subject to review in accordance with the Medical Services Advisory Committee'.[41]

3.52 The department submitted that work is well underway on national reforms, with the inter-governmental working group having 'agreed several objectives for reform'. These include 'increased equity of access, interface and alignment with the broader health system, financing certainty, transparency, and flexibility'. Health Ministers received an options paper on 18 November 2022, 'based on these objectives'. Health Ministers are due to meet in June 2023 and are expected to consider further options.[42]

3.53 Submitters also noted a need for better and more up-to-date data and research to inform national reforms and ensure investment is targeted to achieving the best outcomes.[43] The department acknowledged the lack of reliable national data sources, and suggested options for improving this may include:

- working with states and territories and other stakeholders to standardise data collection about 'characteristics of all clients and all services provided by public dental providers'; and

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39 Department of Health and Aged Care, *Submission 18*, pp. 20–22.

40 Department of Health and Aged Care, *Submission 18*, p. 23.

41 Deakin Health Economics, *Submission 10*, [p. 3].

42 Department of Health and Aged Care, *Submission 18*, p. 19.

43 Deakin Health Economics, *Submission 10*, [p. 5].

- working with private sector stakeholders to 'encourage them to report on' costs and services provided.[44]

3.54 It also reported that the government has provided funding of $442 000 over two years in the 2023–24 Budget for the development of 'a new public dental National Minimum Data Set (NMDS) to collect nationally consistent activity and waiting times data'.[45]

Committee questions

3.55 Is it the role or responsibility of the Commonwealth government to support and coordinate a national approach to improving access to dental services? What is the role of the states?

3.56 Why is oral healthcare situated within allied health at the Commonwealth level? Should oral and dental healthcare be reclassified as 'primary healthcare', and funded through primary healthcare frameworks and legislation?

3.57 Are the current Commonwealth arrangements, staffing and resourcing for oral health policy and administration appropriate and/or adequate?

3.58 What are the optimal administrative arrangements to ensure success of the next National Oral Health Plan?

3.59 What is the role for the Commonwealth in funding and coordinating nationally consistent, comprehensive oral health and dental services data and research?

Improve rural and remote dental care

3.60 A number of options for improving access to oral and dental healthcare in rural and remote areas have been put forward by submitters, including: increasing student-led services and mobile dental services; training more practitioners from rural and regional Australia; and expanding water fluoridisation in remote areas.[46]

3.61 La Trobe University recommended including dental and oral health 'within the health workforce scope of the Australian Government and within the scope of the Office of the Rural Health Commissioner'. It also suggested:

- enabling rural communities to access student-led public dental services;
- working with state governments to fund university-led dental clinics which would treat public patients; and

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44 Department of Health and Aged Care, *Submission 18*, p. 22.

45 Department of Health and Aged Care, *Submission 18*, p. 23.

46 Dental Board of Australia, *Submission 8*, p. 4; Australian Dental Council (ADC), *Submission 7*, p. 4; John Rogers and Jamie Robertson, *Submission 16*, p. 5.

- incentivising and funding 'an increase in the intake of rural students in the dental schools', and prioritising students from rural areas.[47]

3.62 The ADC reported that it has produced guidance notes to support dental education providers to implement a revised set of 'competencies', including some specific to rural and remote communities. This means educators must train professionals in 'improved models of care, the utilisation of the broader health care team, telehealth, and cultural safety'.[48]

3.63 The ADA proposed government direct funding in a way utilises 'already established dental clinics' in remote and very remote regions:

> In some cases, a practice may have reached capacity with dental demand in the area not being able to be met. The provision of capital assistance to such a practice to provide an additional dental chair (surgery) and the recruitment of an additional practitioner may be the most expeditious utilisation of funding to achieve improved dental care delivery in that community.[49]

3.64 Dr Rogers and Dr Robertson suggested governments invest in innovation in 'modalities and programs' to increase availability of mobile services for those who are remote or cannot travel. This suggestion was echoed by the Australian Dental Foundation.[50]

Committee questions

3.65 What are the barriers for rural and remote students in studying to qualify as a dental practitioner?

3.66 What role can other health professionals play in education, prevention and the provision of basic oral health treatments in remote areas? What role can other service providers play?

3.67 How much would it cost to expand fluoridisation across remote communities?

3.68 What is the role of mobile oral health services and should these be increased or modified?

Address workforce and training

3.69 Submitters from the dental industry identified a number of workforce and training issues, including difficulty attracting and retaining oral health academics, especially in regional areas, and a lack of supervisors for trainees. The Dental Board of Australia and the Australian Dental Council (ADC) said

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47 La Trobe University, *Submission 17*, p. 2.

48 ADC, *Submission 7*, p. 5.

49 ADA, *Submission 19*, p. 9.

50 John Rogers and Jamie Robertson, *Submission 16*, p. 7; Australian Dental Foundation, *Submission 14*, pp. 2–3.

discussions are 'ongoing' with health, dental and academic stakeholders to identify solutions.[51]

3.70 Acknowledging that there are currently 'no workforce initiatives to support recruitment or retention of dental practitioners in rural and remote areas', the department identified some existing rural health workforce and training initiatives; but noted that these often exclude dental professions.[52]

3.71 The Community and Public Sector Union/Civil Service Association (CPSU/CSA) recommended the Commonwealth fund a National Dental Workforce Plan.[53]

Committee questions

3.72 Is the current oral and dental health workforce sufficient to meet Australia's needs?

3.73 How can the geographic distribution of dental practitioners be improved?

3.74 Is there a role for the Commonwealth in coordinating a national approach to the oral and dental health workforce?

Boost resources for public dental

3.75 Submitters, including the department, universally agreed that state and territory public dental services are 'incapable [of] responding to the current needs of eligible persons in their state/territory', due to underfunding and understaffing. Seniors Dental Care Australia said, for those in residential care and people with disabilities, 'saying "you should go to the dentist" is like telling a person to fly to the moon'. Referral 'pathways' are inadequate or unclear, and waiting lists act as a major deterrent.[54]

3.76 In light of this, NOHA recommended an initial increase to the funding of $500 million per annum 'to support the immediate urgent needs of priority populations'.[55] The CPSU/CSA made a similar suggestion.[56]

3.77 The ADA proposed a review of public dental program waiting list criteria, which would 'consider the clinical appropriateness and equity implications of "priority access" arrangements'. This could feed into the development of 'nationally consistent essential and medically urgent dental care criteria'. The ADA also suggested a voucher system to enable 'overflow patients from the

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51 Dental Board of Australia, *Submission 8*, p. 4; ADC, *Submission 7*, p. 4.

52 Department of Health and Aged Care, *Submission 18*, pp. 23–26.

53 CPSU/CSA, *Submission 30*, p. 4.

54 Seniors Dental Care Australia, *Submission 3*, p. 5; Department of Health and Aged Care, *Submission 18*, p. 8.

55 NOHA, *Submission 15*, p. 5. See also: PHA, *Submission 26*, p. 5.

56 CPSU/CSA, *Submission 30*, p. 4.

public system to attend private practitioners'.[57] This recommendation was echoed by ADOHTA.[58]

3.78 The Productivity Commission has previously suggested developing a 'risk-based allocation model' which would see public dental care patients triaged 'according to their risk of developing or worsening oral disease', rather than simply added to a waitlist.[59]

Attract dental professionals to public practice

3.79 NOHA said Australia's National Oral Health Plan 2025–2034 'should articulate a readily implementable oral health workforce strategy', including initiatives to boost the public dental workforce.[60]

3.80 The CPSU/CSA proposed: increased wages for public sector staff to bring them into line with the private sector; higher wages and allowances for dental professionals 'living and working in regional, rural and remote areas' in the public sector; and improved access to 'affordable, appropriate housing' for rural and remote public dental professionals.[61]

Committee questions

3.81 How should the Commonwealth government approach reforming the way it funds and supports public dental services in the states and territories?

3.82 Is there a need for nationally consistent criteria for determining 'urgency' and 'priority' in relation to public dental waiting lists?

3.83 Are there evidence-based initiatives that could boost attraction and retention in the public dental workforce, including pay and conditions?

Better target priority groups

3.84 As discussed in Chapter 2, *Australia's National Oral Health Plan 2015–2024* identified the following groups of people as 'priority populations':

- people who are socially disadvantaged or on low incomes;
- Aboriginal and Torres Strait Islander people;
- people living in regional and remote Australia; and

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57 ADA, *Submission 19*, p. 7.

58 ADOHTA, *Submission 28*, p. 3.

59 Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services, Report No. 85*, October 2017, p. 36.

60 NOHA, *Submission 15*, pp. 5–6

61 CPSU/CSA, *Submission 30*, p. 5.

- people with additional and/or specialised health care needs.[62]

3.85 The Australian Dental Foundation (ADF) identified older Australians, disabled people, and children as key cohorts, and proposed:

- more resources for oral healthcare and training in care homes;
- better use of existing networks and providers to offer on-site preventative and emergency services in residential aged care;
- improved access to routine and preventative services under the National Disability Insurance Scheme (NDIS);
- initiatives to train more special needs dentists;
- better promotion of the CDBS; and
- extending the CDBS to provide funding for anaesthetic services for those with complex needs.[63]

3.86 The committee is aware that people in Australia's prisons have significant unmet need for dental care. A submission from the Office of the Inspector of Custodial Services (WA) offered valuable insights into this additional priority population.[64] Rather than detailing suggested approaches in this interim report, the committee has communicated its intent to hear more evidence on this issue at a public hearing, and report its conclusions in the final report.

3.87 While not exhaustive, this section provides a brief introduction to some of the proposals made in submissions to address the needs of particular priority groups.

Disabled people and those with complex needs

3.88 Seniors Dental Care Australia noted that, for adults, 'dental treatment is not part of aged care, home care or the NDIS', despite the fact that these cohorts have greater need and poorer access to services. They argued the exclusion of oral and dental healthcare from many of these programs should be removed, so persons receiving care or support can readily access quality oral healthcare.[65]

3.89 The Geelong Parent Network argued 'crisis driven access to dental services' for people with intellectual disabilities had led to a 'lack of ongoing care planning'. It recommended individualised oral healthcare plans be developed 'between the

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62 Australian Institute of Health and Welfare (AIHW), *Oral health and dental care in Australia*, last updated: 17 March 2023.

63 ADF, *Submission 14*, pp. 2–3. See also: Australian and New Zealand Association of Paediatric Dentistry, *Submission 45*, pp. 4–5.

64 Office of the Inspector of Custodial Services, *Submission 4*, pp. 2–4.

65 Seniors Dental Care Australia, *Submission 3*, p. 11.

person with intellectual disability, their families and carers and their dentist', as a priority.[66]

3.90 NSW Council for Intellectual Disability (CID) drew the committee's attention to the 2021 *National Roadmap for Improving the Health of People with Intellectual Disability.* This roadmap includes oral health as one of seven priority areas for improvement and recommends:

- better promotion of the CDBS and oral health services for people with intellectual disability, and research into utilisation of the service;
- a feasibility study into introducing Medicare items that can 'better support complex and difficult services, such as in hospital services under general anaesthetic';
- expanded workforce training and capacity building measures; and
- nationally-coordinated work, in conjunction with the National Centre of Excellence in Intellectual Disability Health, to implement 'hub and spoke models of care' to connect centralised special needs dentists and community dental clinics.[67]

3.91 In relation to coverage for anaesthetic services, the department acknowledged there is a problem. The Commonwealth provides funding under the National Health Reform Agreement (NHRA) 'for public hospital in-patient dental services'. However, few people can access these services, as there are 'strict eligibility restrictions and waiting lists' in most states and territories.[68] The department did not indicate that there are any measures under consideration to address this issue.

3.92 The Geelong Parent Network said calls for better data on this poorly-served cohort have not been answered, leaving people with intellectual disabilities essentially 'invisible' in national planning. The government is currently establishing a National Centre of Excellence in Intellectual Disability Health, which will aim to 'meaningfully' include people with lived experience of intellectual disability in its structure. The Geelong Parent Network highlighted the role the centre will have in improving data and research to 'inform practice', including in the provision of dental care.[69]

3.93 The experiences of disabled people, including those with intellectual disabilities, will be further explored during the committee's upcoming hearings.

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66 Geelong Parent Network, *Submission 2*, pp. 3–4.

67 Council for Intellectual Disability (CID), *Submission 20*, p. 4.

68 Department of Health and Aged Care, *Submission 18*, p. 7.

69 Geelong Parent Network, *Submission 2*, pp. 3–4. See also: https://www.health.gov.au/our-work/national-centre-of-excellence-in-intellectual-disability-health

Aboriginal and Torres Strait Islander people

3.94 Submitters to the inquiry observed with disappointment that the oral and dental health status of Indigenous Australians remains significantly worse compared with other Australians. The Kimberley Dental Team submitted that, while Aboriginal and Torres Strait Islander peoples were recognised as a priority population in Australia's Oral Health Plan, there has been 'little change in improving the poor oral health experienced by our First Nations peoples' under the plan.[70]

3.95 Improving oral healthcare in Indigenous communities is a 'wicked problem', complicated by demographic, structural, linguistic and cultural, and economic factors. NT Health outlined the barriers to accessing oral and dental healthcare for remote communities, in particular. It recommended the Australian Government:

- support an 'oral health scheme' for remote communities in the Northern Territory;
- establish a Remote Community Oral Health Strategy;
- increase Commonwealth funding and leadership;
- improve the CDBS for Aboriginal and remote children; and
- implement the oral health recommendations of the Royal Commission into Aged Care.[71]

3.96 Commenting on the low uptake of the CDBS in Indigenous communities, the department said that the Fifth Review of the Dental Benefits Act has 'looked at the uptake of the program for vulnerable cohorts'. This report is 'currently being finalised and is expected to be tabled in the Parliament later in 2023'.[72]

3.97 Kimberley Dental Team argued that, while attracting dental professionals to work in regional and remote areas 'is essential', these staff must also be 'suitably trained and equipped to work with Aboriginal children and adults in ways that feel supportive, understanding and considerate of cultural protocols and ways of being'. Sometimes residents are not made aware that a dentist is visiting their community and miss out on treatment. Services are often delivered by different people every time and provided by appointment, which may not be 'a model that works well in remote communities'.[73]

3.98 Based on its many years of successful service provision, Kimberley Dental Team made a number of recommendations, including that:

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70 Kimberley Dental Team, *Submission 46*, p. 3.

71 NT Health, *Submission 27*, [pp. 2–4].

72 Department of Health and Aged Care, *Submission 18*, p. 8.

73 Kimberley Dental Team, *Submission 46*, pp. 3–4.

- state-wide models of care should be reviewed and made more appropriate for Aboriginal people;
- more investment be directed from the states and the Commonwealth to Aboriginal oral health programs; and
- the model used by Kimberly Dental Team be adopted more widely.

The team generously offered its 'data, knowledge and expertise' to support the proposed reforms.[74]

3.99 Derbarl Yerrigan Health Service Aboriginal Cooperation in Western Australia recommended that access for Aboriginal patients to dental care be 'enabled through dedicated funding of dental services [to be delivered by] Aboriginal community Controlled Health Services', and that dental services be 'integrated in a culturally secure setting is integral to a holistic model of care'.[75]

3.100 The Royal Flying Doctor Service made similar recommendations around community-centred care, expanded eligibility in remote areas, and the need to support the delivery of culturally-appropriate care.[76]

3.101 The ADC noted recent changes to the national accreditation scheme incorporate 'a new objective' which 'aims to build the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander peoples'. Education providers are also now required to demonstrate that they include cultural safety as a core competency for future professionals.[77]

3.102 The committee intends to further interrogate the barriers to service for Indigenous Australians, and possible solutions, during its upcoming hearings.

Committee questions

3.103 Should oral and dental healthcare services be better supported under the National Disability Insurance Scheme (NDIS), and aged care packages?

3.104 How can residential care facilities and support workers be trained and supported to provide oral health education, prevention, basic care and referral services?

3.105 How much would it cost to extend the CDBS to support patients with intellectual disabilities and other complex needs?

3.106 Are there evidence-based initiatives that could be adopted to encourage more dental professionals to train and work in special needs oral healthcare?

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74 Kimberley Dental Team, *Submission 46,* p. 8.

75 Derbarl Yerrigan Health Service Aboriginal Cooperation, *Submission 29*, p. 3.

76 Royal Flying Doctor Service, *Submission 31*, p. 8.

77 ADC, *Submission 7*, p. 5.

3.107 How can the CDBS be better promoted to key cohorts, including Indigenous Australians, migrants and disabled people?

3.108 How can the cultural safety and capacity of oral and dental healthcare services be improved?

3.109 What is the most effective way to deliver oral and dental healthcare to very remote communities?

Senator Jordon Steele-John
Chair

Appendix 1
Survey results

1.1 In order to better facilitate the involvement of a diversity of members of the public with lived experience of dental health service access and issues, an online survey was conducted.

1.2 The survey asked quantitative questions, seeking to collect de-identified data on participants' oral health and its impacts, demographic information, and data on individuals' access to and use of dental services.

1.3 The survey was hosted on the committee's website and conducted from 17 April 2023 to 4 June 2023. The survey was circulated by members of the committee, other members of parliament, community members, dental and other organisations.

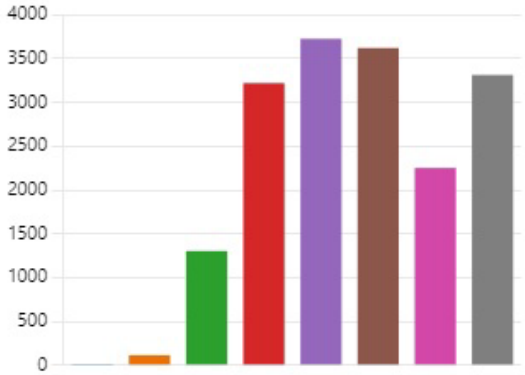
1.4 The committee notes that the sample size is large, participants self-selected and that results are presented in their primary format—independent statistical analysis on the data has not been conducted.

1.5 The committee recorded 17 547 survey responses over 34 questions. Please note that questions 31 to 34 were administrative details such as respondents' names and emails and have been excluded from the survey results below.

Results

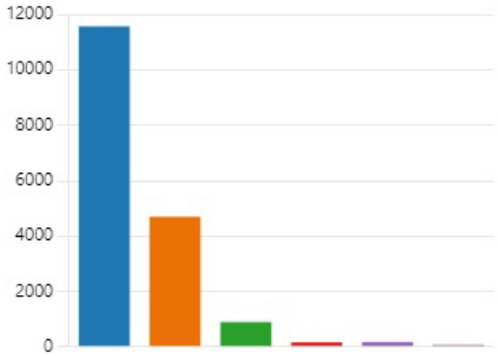
Question 1: Your age

Under 14	3
14-18	115
19-23	1304
24-30	3219
31-40	3725
41-55	3620
56-64	2251
65 and over	3312



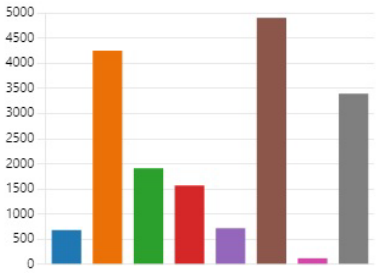
Question 2: Your gender

Female	11572
Male	4693
Non-Binary	890
Gender Fluid	161
Prefer not to say	172
Other	61



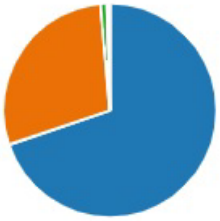
Question 3: Your location

ACT	682
NSW	4250
WA	1911
SA	1569
TAS	718
VIC	4903
NT	121
QLD	3395



Question 4: Urban/regional status

I live in an urban area or major city	12254
I live in a rural or regional area	5050
I live in remote area	165
Unsure/prefer not to say	80



Question 5: Do you identify as any of the following?

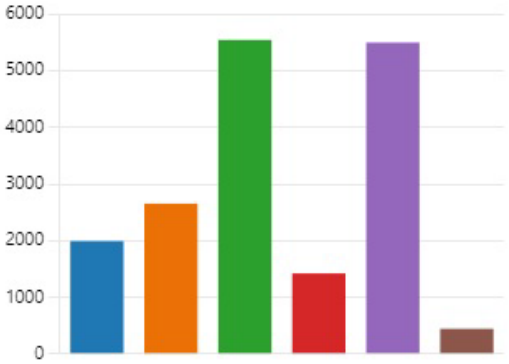
A disabled person	3304
A First Nations person	487
A member of the LGBTIQA+ community	4587
A person of colour	753
None	10591

Question 6: Is English your first language?

Yes	16715
No	792
Prefer not to say	42

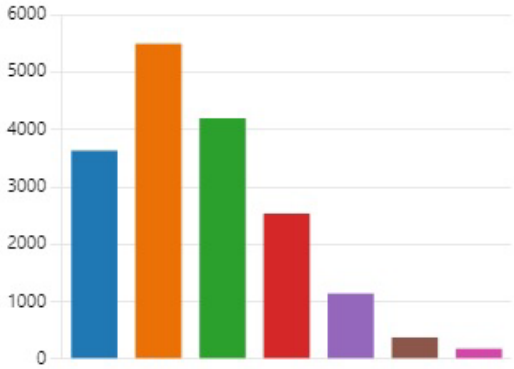
Question 7: Employment status

Casual	1991
Part-time	2653
Full-time	5544
Self-employed	1421
Not currently working	5497
Prefer not to say	443



Question 8: Income bracket

Less than $20,000	3631
$20,000 to $49,999	5494
$50,000 to $79,000	4196
$80,000 to $109,999	2533
$110,000 to $149,999	1141
$150,000 to $200,000	375
Over $200,000	179

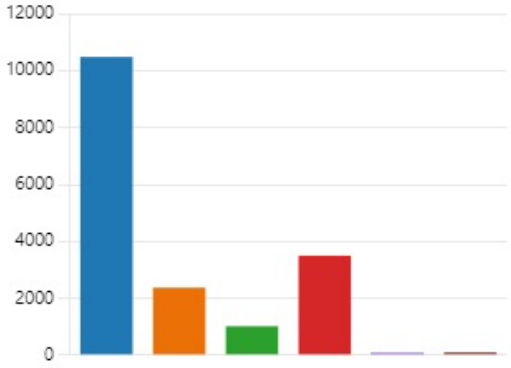


Question 9: Caring status

Parent	4678
Carer	1820
No caring responsibilities	11000
Prefer not to say	625

Question 10: Do you hold a commonwealth concession card?

None	10483
Health Care Card	2370
Seniors Card	1015
Pensioner Concession Card	3495
DVA White/Gold Card	83
Other	103



Question 11: Do you have private health insurance?

Yes	7355
No	10021
Prefer not to say	173

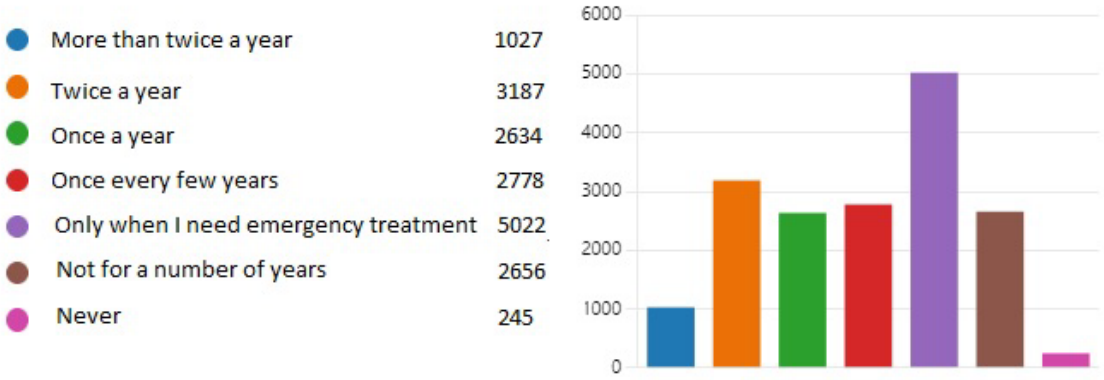
Question 12: Do you work in the dental care industry?

Yes	205
No	17327
Prefer not to say	17

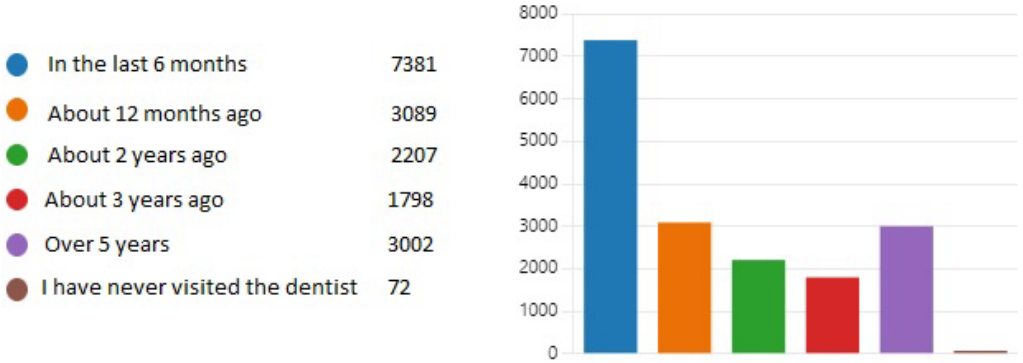
Question 13: How would you rate your oral health?

Excellent	1055
Good	4814
Average	6379
Poor	4059
Very poor	1242

Question 14: How often do you visit the dentist?



Question 15: When did you last visit the dentist?

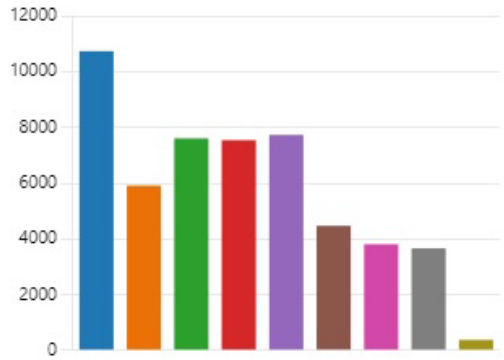


Question 16: Have you ever experienced dental problems or concerns that have impacted your health or quality of life?

1.6 Respondents who answered 'No' were directed straight to question 19.

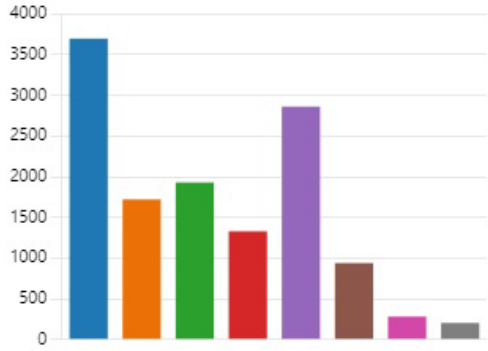
Question 17: How have these problems impacted you?

Negatively impacted my oral health	10739
Negatively impacted my general health	5910
Negatively impacted my mental health/wellbeing	7608
Negatively impacted confidence/self-esteem	7545
Negatively impacted financial or economic wellbeing	7734
I had to go without necessities to pay for dental services	4470
I missed work, classes or other career/study impacts	3809
Negatively impacted social life, relationships or community participation	3662
Other	374



Question 18: Which of these impacts was the most significant for you?

Negatively impacted my oral health	3696
Negatively impacted my general health	1721
Negatively impacted my mental health/wellbeing	1929
Negatively impacted confidence/self-esteem	1329
Negatively impacted financial or economic wellbeing	2861
I had to go without necessities to pay for dental services	939
I missed work, classes or other career/study impacts	282
Negatively impacted social life, relationships or community participation	204



Question 19: Have you, or someone you care for, delayed going to the dentist because of cost?

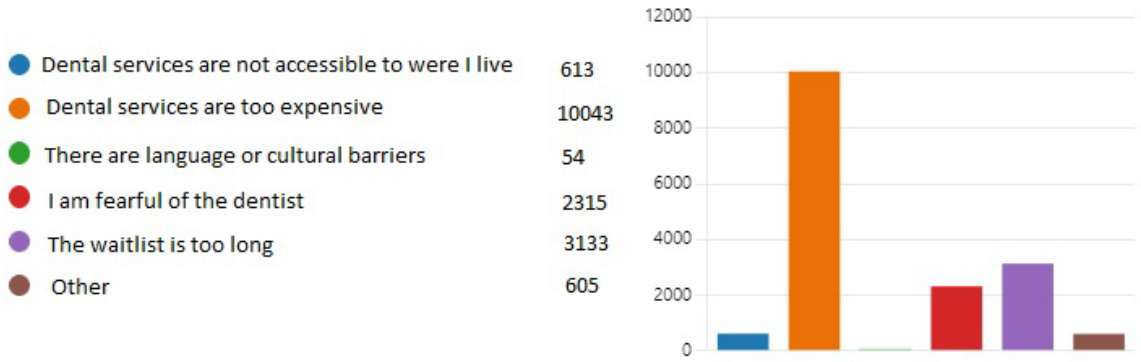
Yes - Me	14003
Yes - My dependents	2863
Yes - Someone I care for	4005
No	2055
Prefer not to say	150

Question 20: How would you rate your current level of access to dental services?

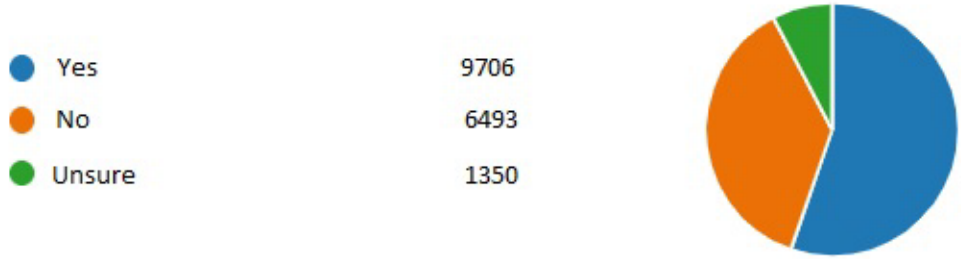
Excellent	1934
Good	4912
Average	4938
Poor	3592
Very poor	2173

1.7 Respondents who answered 'Excellent' or 'Good' were directed straight to question 22.

Question 21: What factors impact your access to dental services?



Question 22: Did you know that some people are eligible for public, or government funded dental services in Australia?

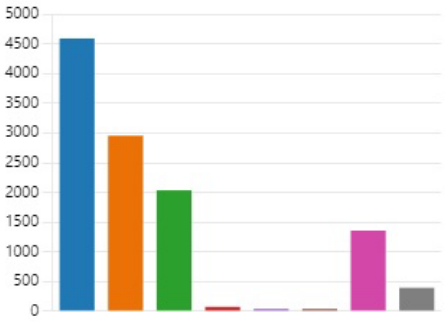


Question 23: Have you, or people you provide care for, ever accessed public or government services in Australia?

1.8 Respondents who answered 'Yes' were directed to the next questions and skipped question 25, and the respondents who replied 'No' were directed straight to question 25.

Question 24: Government funded dental services

Free dental health services for children, including school dental programs	4592
Free emergency dental care concession care/health care card/Pension card/White or Gold DVA Card	2955
Free or subsidised non-emergency adult dental care provided at a government facility	2036
Care through Cleft Lip Palate Scheme	72
Free remote dental care in Northern Territory	38
Care through the Country Patients Subsidy Scheme in WA	38
Care through the Medicare Child Dental Benefits Scheme	1357
Other	394

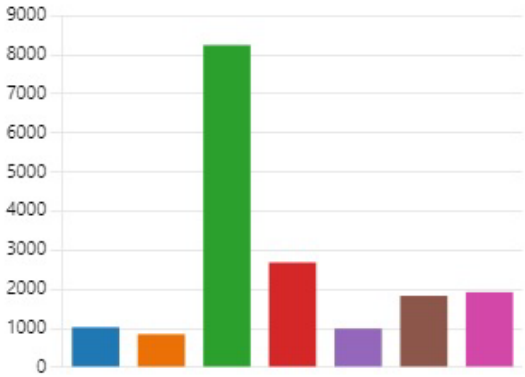


Question 25: Government funded dental services

Not needed	685
Not eligible	3045
Not accessible to me	873
Didn't know about them	4731
Other	729

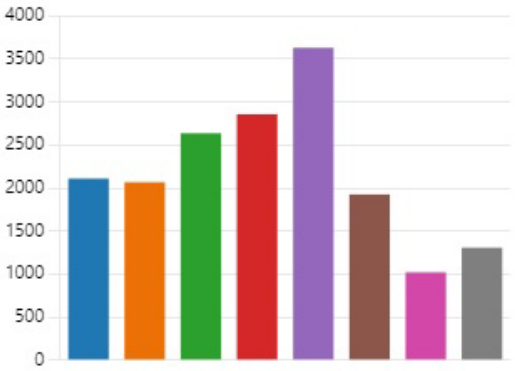
Question 26: How much was your most recent dental bill?

$0	1025
Less than $99	848
Between $100 and $499	8245
Between $500 to $999	2683
Between $1000 and $1499	993
Over $1500	1830
Unsure	1925



Question 27: How much would you estimate you have spent on dental services in the past five years?

$0	2109
$1 to $500	2067
$501 to $1000	2636
$1001 to $2000	2856
$2001 to $4000	3629
$4001 to $8000	1925
More than $8000	1020
Unable to estimates	1307

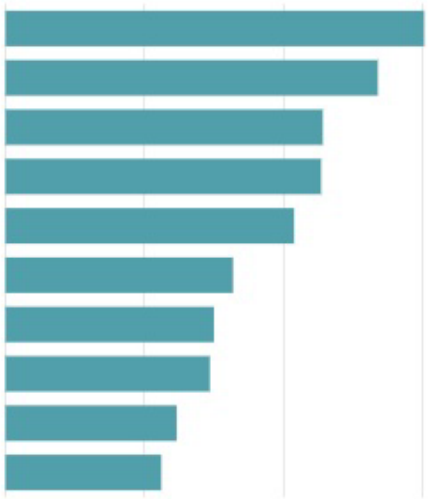


Question 28: The Government should make more dental healthcare free?

Agree	17171
Disagree	86
Unsure	292

Question 29: What dental services would most benefit you if they were free or subsidised?

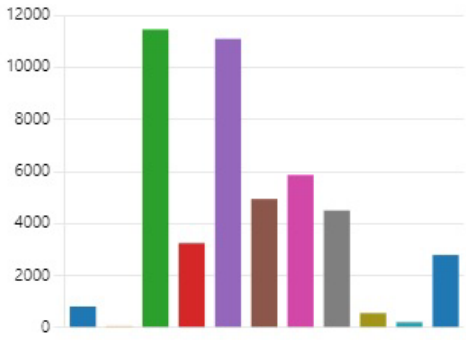
1	Regular check-up and clean
2	Fillings
3	X-Ravs
4	Tooth extractions (including wisdom teeth)
5	Root canals and crowns
6	Oral surgery
7	Bridges or implants
8	Braces and orthodontics
9	Dentures
10	Mouth guards



Ranked in order of highest priority (1) to lowest priority (10)

Question 30: How would increased access to free or affordable dental services impact your life?

No Impact	807
Negative impact	46
I would go to the dentist more often	11458
I would be able to get treatment I have been putting off (for me or someone I care for)	11098
I would take my children or people I care for to the dentist more often	3242
I would use money currently spent on dental care for other things	4940
I would be able to reduce or eliminate pain or other health impacts	5865
I would improve my mental health and wellbeing	4499
I would improve my work, study, or social engagement	555
It would improve my relationship	204
I would improve my self-esteem and self-confidence	2788



Appendix 2
Public dental services - eligibility and fees by jurisdiction

This overview of eligibility and fees for public dental services, by jurisdiction, was compiled by the Parliamentary Library.

Adults	*Children*
New South Wales	
Adult NSW residents must be eligible for Medicare and be listed on one of the following Australian Government concession cards: • Health Care Card • Pensioner Concession Card • Commonwealth Seniors Health Card Additional eligibility criteria may apply for dental specialist services or dental services provided in a hospital. *In addition to services provided in public dental clinics, vouchers may be offered to eligible patients under the **Oral Health Fee For Service Scheme** (OHFFSS). This is used in emergency cases or when the public dental service cannot provide the required treatment*	All children (under 18 years of age) who are NSW residents are eligible for public dental services in NSW. Children can access dental services at public dental clinics. NSW Health also works with public primary schools to deliver the NSW Health Primary School Mobile Dental Program to children in five local health districts: Western Sydney, South Western Sydney, Mid North Coast, Nepean Blue Mountains and the Central Coast. *Hunter New England, Murrumbidgee and Western NSW local health districts have recently commenced an outreach program that may include school visits*
NSW Health assists 21 Aboriginal Community Controlled Health Services (ACCHS) to provide dental care for their patients.	
Victoria	
Adults living in Victoria are eligible for public dental services if they: • hold a Centrelink-issued Health Care Card or Pensioner Concession Card or • hold a Department of Veteran's Affairs issued Veteran Gold Card or Veteran Pensioner Concession card • are a refugee or asylum seeker or	Children and young people living in Victoria are eligible for public dental services if they: • are aged 0-12 years of age, irrespective of family income or • are aged between 0–17 and are eligible for the Child Dental Benefits Schedule or

• are Aboriginal or Torres Strait Islander. Community dental clinics and Royal Dental Hospital of Melbourne provide General dental care. *A **fee** of $30.50 per visit is payable for those holding a Pensioner Concession Card. The most a complete general course of care will cost is $122. See below for list of people who do not pay fees.*	• are aged between 13-17 with a Health Care card or Pension Card or whose parents hold a Health Care card or Pension Card or • are a youth justice client in custodial care, regardless of age, or • are aged up to 18 years of age and are in out-of-home care, provided by the Children Youth and Families Division of the Department of Human Services General and emergency dental care is available at local community dental clinics and at the Royal Dental Hospital of Melbourne. Specialist dental services are only available at the Royal Dental Hospital of Melbourne (referral required). For children aged 0-12 general treatment is free if free if they or their parent holds a Concession card, or if they are eligible for Child Dental Benefit Schedule. Otherwise a fee of $36 per child applies; the most a family will pay is $140. See list below of people who do not pay fees. For young people aged 13-17 years, treatment is free if they (or their parents) hold a concession card or they are eligible for the Child Dental Benefit Schedule. *In addition, **Smile Squad** is Victoria's free school dental program. The program is free for all Victorian government school students. It is delivered to students during school hours and includes all required treatment (excluding orthodontics). **From 2026**, Smile Squad will begin offering services to students enrolled in primary and secondary low fee non-government schools.*

*The following groups have **priority access** to public dental services:*

- Aboriginal and Torres Strait Islander peoples
- children (0-12 years) and young people
- homeless people and people at risk of homelessness
- pregnant people
- refugees and asylum seekers
- people registered with mental health or disability services, who have a letter of recommendation from their case manager or a special developmental school.

The following people do not pay fees for dental treatment:

- Refugees and asylum Seekers
- Aboriginal and Torres Strait Islander peoples except for Specialist treatment
- Homeless people and people at risk of homelessness
- Children and young people up to 18 years of age, who are in out-of-home care provided by the Department of Human Services
- All youth justice clients (regardless of age)
- People registered with mental health or disability services, who have a letter of recommendation from their case manager or a special developmental school
- People experiencing financial hardship
- Children and young people aged 0-17 years who are health care or pensioner concession card holders or dependents of concession card holders except for specialist dental services.

Queensland

Adults residing in Queensland are eligible for free public dental care when they receive benefits from any of the following concession cards:

- Pensioner Concession Card issued by the Department of Veterans' Affairs
- Pensioner Concession Card issued by Centrelink
- Health Care Card
- Commonwealth Seniors Health Card
- Queensland Seniors Card

For children to be eligible for free public dental care they must:

- be a Queensland resident or attend a Queensland school; and,
- be eligible for Medicare; and,
- meet at least one of the following criteria:
  - be aged four years or older and have not completed Year 10; or,
  - be eligible for the Medicare Child Dental Benefits Schedule; or,
  - hold, or be listed as a dependent on, a valid Centrelink concession card

Public dental care for children may be provided on-site at schools through fixed or mobile dental clinics or at larger community dental clinics.

Western Australia

Western Australian adults with a current health care card or pension concession card

Children aged 0 to 4 whose name appears on their parent's health care or pension

are eligible for general public dental services. Dental Health Services uses the Commonwealth Department of Veterans' Affairs schedule of dental fees. Dental treatment provided at a Public Dental Clinic is subsidised by the Western Australian Government (either 50% or 75% of the cost of the treatment). The level of dental subsidy a person receives is based upon the income received from Centrelink.	concession card are eligible to attend a general dental clinic for care. The level of subsidy is as per adults. *Children and teenagers aged 5 to 16 attending school are eligible for the free **School Dental Service**.*
The Country Patients Dental Subsidy Scheme supports those without access to a public dental clinic to go to a private dentist who has agreed to provide treatment at the same cost as at a public dental clinic. In addition to the routine dental services, Dental Health Services provide special services to the following groups: • Patients who are physically unable to attend a Dental Clinic (Domiciliary Patients) • Aged Care Facilities who participate in the Aged Care Programme • Disability Services Commission Clients • Prisoners • In-Patients at Graylands Hospital • Royal Perth Hospital Dental Clinic • Residents in rural locations	
South Australia	
South Australian adults with a Health Care Card or Pensioner Concession Card can attend public clinics to access general and some specialist dental services. A co-payment applies for general dental care, of up to $166. Costs for denture care are available online. ***Emergency dental care services** are also available, with a **co-payment** of $65.*	All children under 18 who live in or go to school in South Australia can attend a public dental clinic (also known as the School Dental Service). There are no out of pocket costs for kids who: • haven't started school • are covered by the Child Dental Benefits Schedule, a Pensioner Concession Card, a Health Care Card or a School Card Scheme. *If a child is not covered, dental care is **$50 a year**.*

<table>
<tr><td colspan="2">The Aboriginal Oral Health Program (AOHP) aims to improve the oral health of Aboriginal people by increasing oral health knowledge in the community and by improving access to dental services. Eligible Aboriginal adults can access free priority general and emergency dental care at South Australian clinics.</td></tr>
<tr><td colspan="2">Tasmania</td></tr>
<tr><td>Public dental services for adults are provided from six major dental centres: Burnie, Devonport, Launceston, Clarence, Glenorchy and Hobart.

To access public services Tasmanians must hold a current Pensioner Concession Card or Health Care Card.
Tasmania requires a co-payment contribution (prices from 1 July 2022):
General dental care, such as a check-up, scale and clean and fillings: $45
Priority dental care to treat an urgent single dental problem: $45
Some high-cost additional treatments: discussed at appointment</td><td>Tasmanian public dental services are available for babies, children and teens up to age 18 living in Tasmania

Most services do not require a patient contribution.</td></tr>
<tr><td colspan="2">Australian Capital Territory</td></tr>
<tr><td>Adult ACT residents who hold a Centrelink-issued Pension Concession or Health Care Card, a Veteran's Affairs card or an ACT Services Access card can access public dental services.

Interstate Centrelink concession card holders who are visiting the ACT for short periods of time AND who are assessed as needing an emergency appointment can access one off services. This does not include the surrounding areas of the ACT such as Yass, Murrumbateman, Queanbeyan, Cooma and Goulburn.

Co-payments may apply:
an emergency course of care is $47.35
denture repair is a minimum of $47.35.
There is a cap of $450 per course of care for restorative treatments. This does not include root canal therapy, splints or denture work</td><td>Child and youth dental services are available to:
all children under the age of 14 years who live in the ACT or attend an ACT school
young people under the age of 18 with a Centrelink-issued Pension Concession or Health Care Card
children who are under the care of the Canberra Health Services Cleft Palate Clinic.
Children under the age of 14 years who are visiting the ACT for short periods of time AND who are assessed as needing an emergency appointment can access one off services. This does not include the surrounding areas of the ACT such as Yass, Murrumbateman, Queanbeyan, Cooma and Goulburn.

Some fees apply:</td></tr>
</table>

	• Children under 5 years (who require treatment) – No fee • Children aged 5 to 14 – $72.60 per child per 'course of care' • Children under the age of 18 years who are listed on a Health Care Card or Pension concession card – No fees for general treatment • Co-payments apply for children for items such as space maintainers, splints and if eligible orthodontic services. *There may be a small co-payment for a course of care if a child is not covered by a Centrelink pension concession or health care card or eligible for Child Dental Benefits Scheme (CDBS).*
Northern Territory	
Free public dental services are available to those with a Centrelink Pensioner Concession Card or Health Care Card. In addition, those who live more than 100 km away from the nearest dental service in a remote area, and need emergency dental care but don't have access to private dental services, can receive care from the visiting dental team. ***Certain non-Australian residents*** *are not eligible for public dental services.*	Children and young people under 18 years old, and for those of school-age, still in school and not working full-time, can access free public dental services. Children who have been living in the Northern Territory for less than six months can only access emergency services, not general services. To receive free orthodontic services: • must be the holder or dependant of a Health Care Card or Pension Concession Card • meet strict clinical criteria based on clinical assessment of a public orthodontist or dentist • orthodontic treatment must be completed by the age of 18. *Children can attend* ***school-based dental clinics*** *from age 0 until they primary school. Once they start year 7 they attend* ***community dental clinics****.*

Appendix 3
National inquiries into dental care since 1998

The following list of Federal-level inquiries are reports was collated by the Parliamentary Library. It is presented in chronological order.

- Senate Community Affairs References Committee, *Report on Public Dental Services*, May 1998
- Senate Select Committee on Medicare – First report – *Medicare–healthcare or welfare?*, October 2003
- Senate Select Committee on Medicare – Second report – *Medicare Plus: the future for Medicare?*, February 2004
- Senate Standing Committee on Community Affairs, *Health Insurance Amendment (Medicare Dental Services) Bill 2007 [Provisions]*, September 2007
- Senate Standing Committee on Community Affairs, *A decent quality of life: Inquiry into the cost of living pressures on older Australians*, March 2008
- National Health and Hospital Reform Commission, *A Healthier future for all Australians*, June 2009
- National Advisory Council on Dental Health, *Final Report of National Advisory Council on Dental Health*, February 2012
- Senate Finance and Public Administration Legislation Committee, *Health Insurance (Dental Services) Bill 2012 [No. 2]*, May 2012
- Community Affairs Legislation Committee, *Dental Benefits Amendment Bill 2012 [Provisions]*, October 2012
- House Standing Committee on Health and Ageing, *Bridging the Dental Gap: Report on the inquiry into adult dental services*, June 2013
- Oral Health Monitoring Group [prepared under the auspices of the COAG Health Council], *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024*, 2015
- Australian National Audit Office (ANAO), *Administration of the Child Dental Benefits Schedule*, December 2015
- Independent *Reviews of the Dental Benefits Act 2008*[1] (as required under Section 68 of the Act):
  - 2009
  - 2012
  - 2016
  - 2019

1. The fifth review is underway and closed its consultation in August 2022. The final report is to be tabled in the Parliament by mid-2023 (it has not been tabled as at end May 2023).

- Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, December 2016 and October 2017
- Community Affairs References Committee, *Value and affordability of private health insurance and out-of-pocket medical costs*, December 2017
- Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect*, March 2021
- KBC Australia, *Increasing Dental and Oral health training in rural and remote Australia: Feasibility study*, September 2022

Appendix 4
Progress on key recommendations from inquiries since 1998

The information in this table was researched and collated by the Parliamentary Library.

Inquiry	Overview and key recommendations	Response and implementation
Senate Community Affairs References Committee, *Report on Public Dental Services*, May 1998	The Inquiry made 9 recommendations, on issues including: • the need to promote oral health • the creation of a vocational training program for new dental graduates to encourage work in rural and remote areas • the expansion of the role of dental auxiliaries such as therapists and hygienists • support for a national oral health training strategy, specifically including those working in aged care and Indigenous health • the development and evaluation of pilot programs to address priority groups including pre-school age children, young adult Health Card holders (18-25 years), aged adult Health Card holders (65+ years), the homebound, rural and remote, and Indigenous communities • the Commonwealth should lead the introduction of a national oral health policy,	The Government response (February 1999) made clear that dental care was a State responsibility: Notwithstanding the Committee's finding that some low income earners currently have difficulty accessing public dental services, the Government's position continues to be that the provision of public dental services is a State responsibility and that the States must resolve the structural, management and financial problems in their dental services. (p. 1) It was also noted that the introduction of the GST meant states would be 'better off' than before and could determine their own priorities in terms of the provision of healthcare. In response to the recommendations: The Government's overall response to the recommendations of the

	potentially through the National Public Health Partnership • this policy should include: • national oral health goals • national standards for the provision of, and access to, oral health care • national strategies and prioritise for oral health care reform, particularly preventative strategies • minimum service targets • monitoring of goals through national data collection • the allocation of resources for a national oral health survey • creation of a dedicated section for oral health within the Department of Health and Family Services.	report is that by and large, Commonwealth involvement in their implementation would be ineffective. The States must take up those recommendations they consider will improve access and service delivery. For its part the Commonwealth is prepared to assist the States to deliver better services by facilitating the inclusion of reliable oral health data in the National Public Health Information Development Plan, if this is what the States want. (p. 2) While the Committee recommended a national health strategy be developed, it does not appear that one was implemented until 2015 with the introduction of the National Oral Health Plan.
Senate Select Committee on Medicare – First report – *Medicare– healthcare or welfare?*, October 2003	Recommendation 10.1 (chapter 10, p. 132): The Committee recommends that the Commonwealth immediately recommit to a Commonwealth contribution towards public dental health services and negotiate targets with the states and territories, particularly for high need groups.	No response to the Committee report was found. However, Committee Government Senators noted that they disagreed with Recommendation 10.1 (p. 232).
Senate Select Committee on Medicare – Second report – *Medicare Plus: the future for Medicare?*, February 2004	Recommendation 5.1: The Committee again recommends the creation of a new Commonwealth Dental Health Program and the active consideration of measures to address workforce shortages in dentistry. (p. xvi and 96)	No response to the Committee report was found. As explained in this this Parliamentary Library publication exploring Commonwealth involvement in funding dental care (particularly the transition from the

		Howard to the Rudd Government): In July 2004, as part of a suite of reforms to Medicare known as MedicarePlus, the government announced the introduction of limited Medicare benefits for patients whose chronic conditions (for example, diabetes), were significantly exacerbated by dental problems. This was consistent with the application of Medicare benefits based on an identified clinical need… The dental component of the initiative known as the Allied Health and Dental Health Care Initiative (AHDCI) allowed a patient with an Enhanced Primary Care (EPC) plan on referral from a general practitioner, to access Medicare benefits for up to three dental treatments a year from a private dentist, with a maximum rebate of $220 per year. The supply of prostheses such as dentures, bridges, crowns or implants was not covered. (p. 9) With uptake of the program lower than expected, eligibility was later expanded and the price cap raised.

Senate Standing Committee on Community Affairs, *Health Insurance Amendment (Medicare Dental Services) Bill*	The purpose of the Bill was to increase access to dental treatment under Medicare for people with chronic conditions and complex care needs. The Bill was introduced following the 2007–08 Budget which announced the expansion of the Enhanced Primary Care dental items	The subsequent Act was registered in early October 2007. This enabled the Health Insurance (Dental Services) Determination 2007 which commenced 1 November 2007 and

2007 [Provisions], September 2007	to provide Medicare rebates and more services to eligible patients. The estimated cost of the expansion was $385.6 million over 4 years from 2007–08. (pp. 1–2) The Committee recommended (p. 10): • That a formal education program targeting dentists be established, including information about the working of the new Medicare rebates relating to dentistry. • That early monitoring and evaluation of the scheme be undertaken to ascertain who is accessing the rebates and for what conditions, and ascertain if the criterion that a 'patient's oral health must be impacting on, or likely to impact on, their general health' is well understood and consistently applied. Monitoring and evaluation should cover both the immediate recipients of Medicare dental services and the broader population level. • That the Senate pass the Bill. Australian Labor Party (ALP) Senators provided a minority report dissenting from elements of the majority report which favoured a broad-based Commonwealth scheme (pp. 11–16).	provided for the Chronic Disease Dental Scheme (CDDS). The change in Government saw the attempted cancellation of the CDDS, to be replaced by a Commonwealth Dental Health Program (CDHP); however, during 2008 the rescinding of the relevant instruments was disallowed by the Senate (See Health Insurance (Dental Services) Amendment and Repeal Determination 2008 made under subsection 3C(1) of the *Health Insurance Act 1973*, 18 June 2008 and this Parliamentary Library publication, p. 12). This Scheme eventually closed on 30 November 2012 (see Government and Greens media releases announcing agreement to close the scheme and this Parliamentary Library article for further background). The *Health Insurance Amendment (Medicare Dental Services) Act 2007* remains in force; it

		appears this is because the Act did not specifically establish the CDDS, but rather allowed for a ministerial determination to be made around 'eligible dental services'. That is, the Scheme could be closed by ceasing the Determination rather than amending primary legislation. According to the Health Insurance (Dental Services) Bill 2012 inquiry (discussed later in this table), no education campaign was conducted (p. 10). However, it was found that the number of services provided through the expanded CDDS rose substantially, with expenditure on the Scheme at the time of the inquiry to be more than $2.3 billion. (p. 2) There were also significant concerns about non-compliance with the Scheme.
Senate Standing Committee on Community Affairs, *A decent quality of life: Inquiry into the cost of living*	Recommendation 9 of the report (p. xvii) concerned dental care: The committee recommends that the Government consider the appropriateness of current dental care arrangements for older people. The consideration should involve	A Government response was released in September 2008: In keeping with its election commitment, the Government's new

pressures on older Australians, March 2008	engagement with the State and Territory governments and aim to introduce measures to increase access to adequate dental care and include a cost-benefits analysis of the impact of inadequate access to dental care on other aspects of the health care system.	Commonwealth Dental Health Program will provide $290 million over three years from 2008–09 to the States and Territories. The Commonwealth, State and Territory Governments are working together to improve the standard of oral health in Australia and this program will help reduce the number of people waiting for public dental treatment by providing up to one million additional services. The Commonwealth Dental Health Program will also provide priority services to people with chronic diseases affected by poor oral health. (p. 15)
National Health and Hospital Reform Commission, *A Healthier future for all Australians*, June 2009	The Commission recommended (p. 26): • the establishment of the Denticare Australia scheme which would meet the costs of either private or public dental health plans. The scheme would be funded by an increase in the Medicare Levy of 0.75% • the introduction of a 1 year internship scheme prior to full registration • the national expansion of the pre-school and school dental programs	There was no systematic response to the report provided by Government. Neither the ALP nor the Coalition expressed support for a Denticare Australia scheme as suggested by the Commission. A summary of stakeholder commentary on the proposals can be found in this Parliamentary Library overview paper.

	• additional funding for improved oral health promotions with interventions to be decided based upon relative cost-effectiveness assessment.	(Note: The 'Denticare' proposal put forward by the Greens differs from that of the Commission)
Report of the review of the *Dental Benefits Act 2008*, 2009	The Committee noted 2 areas (p. 4): • the Government could consider replacing the single preventative dental check item (Dental Benefits Schedule item 88000) with individual items for each procedure provided to patients during their annual preventative dental check; and • as the Medicare Teen Dental Plan is in its early stages of operation, the Government could consider evaluating the program once it has matured, as part of the second statutory review of the Act.	The Second Review of the Dental Benefits Act, conducted in 2012 (discussed below) indicates that a single Dental Benefits Schedule item 88000 was retained. Indeed the 2012 Committee rejected the 2009 Committee's view that the single Medicare item number should be disaggregated into individual procedure items. (p. 21). The need for an evaluation was again recommended in the 2012 review (discussed below).
Report on the Second Review of the *Dental Benefits Act 2008*, March 2012	The Committee noted 4 issues (p. 4): • the Government should consider an evaluation of the operation of the Medicare Teen Dental Plan as part of its review of dental needs and priorities through the National Advisory Council on Dental Health. • the Panel notes the improvements made in the program's communications materials to date, and urges the implementation of market research findings from mid-2010 concerning further	

	improvements to the appearance the voucher for the program. • further work to promote the program to specific groups, including Aboriginal and Torres Strait Islander teens, Cultural and Linguistically Diverse teens, homeless teens and teens living with a disability • the 30% utilisation rate of the vouchers, coupled with a decline in uptake from 32% in 2009-10 to 30% in 2010-11 was disappointing.	
National Advisory Council on Dental Health, *Final Report of National Advisory Council on Dental Health*, February 2012	• The Government established the National Advisory Council on Dental Health to provide independent advice on dental health issues, including options and priorities for consideration in the 2012–13 Budget. The Council's report included a goal and a number of aspirations (Chapter 5, pp. 55–64). The first goal was for 'An integrated national oral health system, as part of the broader health system, that provides equitable access for people in Australia to prevention, promotion and clinically appropriate, timely and affordable oral health care.' (p. 55) Although the Council was in agreement on the principle of universal access, no model was put forward (p. 56). • Aspirations included:	The Government welcomed the report. The report appears to have informed subsequent Commonwealth dental health policies, specifically the Child Dental Benefits Schedule and the National Partnership agreement with states and territories to alleviate pressure on adult public dental waiting lists.

	• The Council called for oral health to be integrated into general health (pp. 56–57) • The Council called for equity and access to services (pp. 57–58) • Better access for children, noting the differences across states and territories (p. 58) • Supporting oral health across the population through a national oral health campaign (coordinated with states and territories) (p. 59) • One level of government should be responsible for the delivery of dental services and the division between the Commonwealth and state and territories should be clarified (pp. 59–60) • 'The Council recognises that waiting times for services, especially for adults, are unacceptably long, with a public system highly skewed to emergency and urgent care, which undermines access to timely preventive care and to early intervention. But attention needs to be focused on the key cause, which is a lack of funding, not withstanding Commonwealth and states increasing funding over recent years. This has been a blind spot for all governments across Australia over decades. The Council believes that the public sector is underfunded and that long-	

	term investment will improve access.' (p. 61) • Enhance workforce capability, especially outside major cities (pp. 62–63) • Enhancing data collection, research and analysis (pp. 63–64) • Chapter 6 outlined options (and costings) for reform for both children and low-income adults (p. 65): • For children the Council proposed two options for a universal scheme: • An individual capped benefit entitlement (Option 1), which would cover basic preventive and treatment services. The benefit could be used in the public or the private sector. • Enhanced access to public dental services (Option 2), which would increase access for all children to basic dental services by enhancing existing public sector services. For low-income adults: • A means tested individual capped benefit entitlement (Option 3), which could build on the legislative framework for existing programs. Access to higher level services or caps could be provided in exceptional circumstances. • Enhanced access to public dental services (Option 4)	
Senate Finance and Public Administration Legislation	This Bill sought to 'redress past and future inequities that have arisen from the operation of subsection	The Bill did not pass.

Committee, *Health Insurance (Dental Services) Bill 2012 [No. 2]*, May 2012	10(2) of the Health Insurance (Dental Services) Determination 2007'. The Committee recommended that the Bill not be passed as 'the Bill may not be the best way to deal with the problems that have arisen, as the proposed actions would create further inequities.' (p. 28) Coalition Senators issued a dissenting report, recommending the Bill be passed.	
Community Affairs Legislation Committee, *Dental Benefits Amendment Bill 2012 [Provisions]*, October 2012	The Bill sought to establish the framework for the Child Dental Benefits Schedule (CDBS), which would subsidise dental care for children aged between 2 and 18 years. This was part of a $4 billion package introduced by the Rudd Government (and co-announced by the Australian Greens). (pp. 1–2) The CDBS would abolish the CDDS and replace the Medicare Teen Dental Plan (MTDP) that had been introduced in 2008. The Committee recommended the Bill be passed.	The Bill passed and commenced on 1 January 2014. The CDBS remains in place and open to those children who receive (or whose parent/guardian receives) an eligible government payment.
House Standing Committee on Health and Ageing, *Bridging the Dental Gap: Report on the inquiry into adult dental services*, June 2013	• The Committee inquired into adult public dental services to help inform development of a new National Partnership Agreement (NPA) on adult public dental that was expected to commence from 1 July 2014. The Committee considered (ToR): demand and wait lists for services; the type of dental services supported by Australian governments; availability and	No Government response could be found. In the 2014–15 Budget, the National Partnership Agreement (NPA) for adult public dental services was deferred from 2014–15 to 2015–16. This deferral was expected to result in savings of $390.0 million

	affordability of services for those with special dental health needs; service provision across different regions; the coordination across different levels of government and private health; and workforce issues. • The Committee made 13 recommendations (pp. xi–xiv), many of which related to the anticipated Adult Dental Services NPA, including: • the NPA should require state and territory government to improve linkages with private dental service providers and not-for-profits • allow dental hygienists, dental therapists and oral health therapists to practice independently and pilot a scheme to provide these professionals with Medicare provider numbers • improve the focus on preventative dental care • Australian governments develop a formula for the allocation of funding to state and territories under the NPA based on the size and distribution of priority population groups • include a 'maintenance of effort' clause in the NPA so that state and territory governments must maintain public dental clinical activity for adults • the NPA include a performance and reporting framework to monitor	over 4 years, to be invested in the Medical Research Future Fund (MRFF). (p. 137) In the 2015–16 Budget, a one year NPA on dental services was announced, replacing the deferred NPA committed to by the Labor Government at the time. Further similar agreements on adult public dental services have been negotiated since this time, including the current Public Dental Services for Adults Schedule (to be extended to June 2025 as announced in the 2023–24 Budget (p. 138).

	specific Key Performance Indicators (KPIs) • the NPA include a provision that requires all signatories to begin negotiations for a new agreement at least 12 months prior to the NPA's expiration • the Department of Health and Ageing, along with state and territories, consider the creation of a Commonwealth Chief Dental Officer or independent advisory body to improve coordination across Australian government, increase engagement with private providers and provide independent policy advice • the Australian Government commit to a dental policy framework that guarantees long-term sustainability and funding support for public dental services • the establishment of an implementation strategy for the National Oral Health Plan 2014–2023 • the Australian Government adopts a strategic policy which supports phased progress toward a universal access to dental services scheme.	
Oral Health Monitoring Group, *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024*, prepared under	The National Oral Health Plan did not include recommendations, rather it aimed to set the national direction and provide a framework for collaborative action. The Plan's national goals were to improve oral health status and reduce inequalities across the	In December 2020, the Australian Institute of Health and Welfare released the *National Oral Health Plan 2015–2024: performance monitoring report*. For the 26 indicators identified, the report found there

the auspices of the COAG Health Council, 2015	Australian population (p. 16). Four guiding principles were identified: • population health • proportionate universalism – 'everyone should receive some support through universal interventions, while groups that are particularly vulnerable should receive additional interventions and support' • accessible and appropriate services • integrated oral and general health (p. 17). Six foundation areas were identified, each with a goal and a series of strategies and indicators (overview is at p. 18): • oral health promotion • accessible oral health services • systems alignment and integration • safety and quality • workforce development • research and evaluation. The Plan also identified 4 priority populations: people who are socially disadvantaged or on low incomes; Aboriginal and Torres Strait Islander people; people living in regional and remote Australia' people with additional and/or specialised health care needs.	had been a favourable trend compared to the baseline for 7 indicators, an unfavourable trend for 9 indicators, and no change or no new data for the others (In brief report, p. 4).
Australian National Audit Office (ANAO), *Administration of the Child Dental Benefits Schedule*, December 2015	The ANAO made 4 recommendations, to which the Department of Health and Department of Human Services agreed. These included actions to identify and treat risks to administration, address low	In Attachment A (Appendix A) of the report, the Department of Human Services (DHS) response to recommendation 3 stated (p. 59) that it

	program uptake, improve performance measurement and reporting, and assist in assessing the achievement of program objectives.	would introduce a formal quality checking procedure for a sample of the records that require manual matching. This would include KPIs. This would be introduced by November 2015. The 2015–16 DHS Annual Report and 2016–17 report did not indicate whether this was introduced.
Report on the Third Review of the *Dental Benefits Act 2008*, March 2016	This Review came after the closure of the Medicare Teen Dental Program (31 December 2013) and the transition to the Child Dental Benefits Schedule (CDBS) (1 January 2014). The Review made 11 recommendations (pp. ix–xii) regarding improvements to the CDBS.	
Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services – Study Report*, November 2016	Chapter 6 examined public dental services (pp. 115-129). Overall, the PC found that introducing greater competition, contestability and user choice in public dental services could lead to better outcomes for patients and the wider community (p. 129).	
Community Affairs References Committee,	The Committee's report included a case study on the effect private health insurance has had on private dentistry (pp. 52–58).	The Government response: • noted recommendation

Value and affordability of private health insurance and out-of-pocket medical costs, December 2017	After hearing evidence that paediatric dentists had been excluded from private hospitals and day surgeries because the hospitals receive low rebates from private health insurers, the Committee recommended that private health insurers engage in negotiations with private hospitals and paediatric dentists to urgently resolve issues surrounding paediatric dentistry (Recommendation 11, p. x). The report also discussed 'preferred provider' schemes as part of the dental case study, which a number of submitters considered are anti-competitive. This provided context for recommendations to prohibit differential rebates for the same treatments provided under the same product in the same jurisdiction (Recommendation 12), and to request the Australian Competition and Consumer Commission reconsider whether private health insurers' use of claims processing data is anti-competitive and amend legislation to ensure claims data is not used for commercial gain (Recommendation 13).	11, commenting that these are commercial arrangements and therefore to be resolved between insurers, private hospitals and paediatric dentists (p. 6) • did not support recommendation 12, noting the ability to pay differential rebates is an essential part of the contracting process between insurers and health providers. It further noted that for general treatment services, such as dentistry, preferred provider schemes and insurer-owned clinics are popular with consumers because they give certainty about costs (pp. 6-7) • Noted recommendation 13, and observed that 'in many cases, consumers who use an insurer's own dental or optical

		centre will normally face no, or lower, out of pocket costs' and that 'the Government does not intend to remove arrangements that allow consumers the opportunity for reduced or no out-of-pocket costs by using an insurer-owned service provider' (p. 7).
Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services – Inquiry Report*, March 2018	Chapter 12 of the report looked at reforms to underpin more effective provision of public dental services (pp. 357-421) and included several recommendations: Recommendation 12.1: State and Territory Governments should report publicly against a set of benchmarks of clinically-acceptable waiting times for public dental services, split by risk-based priority levels. Reporting should commence as soon as possible. Governments should also make these benchmarks consistent across jurisdictions as soon as practicable. To facilitate user choice, provider-level reporting should be published monthly. To facilitate performance monitoring, aggregate measures should be included in public dental services' annual reporting processes (p. 373)	There does not appear to be a response to the report.

	Recommendation 12.2: The Australian, State and Territory Governments should establish outcome measures for public dental services that focus on patient outcomes and include both clinical outcomes and patient-reported measures. Governments should build on the work done by Dental Health Services Victoria on outcome measures, with a view to developing and implementing a nationally consistent outcomes framework. (p. 378) Recommendation 12.3 State and Territory Governments should implement comprehensive digital oral health records for public dental services as soon as practicable. Once implemented, these systems should be incorporated within the My Health Record system. (p. 383) Recommendation 13.1: State and Territory Governments should introduce a consumer-directed care scheme to public dental services. Under the new scheme, participating providers should be paid based on a blended payment model… (p. 397) Recommendation 13.2: The Australian Government should direct the Independent Hospital Pricing Authority, in consultation with State and Territory Governments and the dental profession, to immediately commence development of: • a costing standard for public dental services	

	• efficient prices for consumer-directed care payments. (p. 397) Recommendation 13.3: The Australian Government should replace the existing CDBS capped benefit with a capitation payment that is weighted to reflect the oral health care needs of eligible children. (p. 399) Recommendation 13.4: State and Territory Governments should provide access to consumer-directed care through a risk-based allocation model. Under the allocation model, governments should triage patients for both general and urgent care through an initial assessment. The initial assessment should identify and prioritise access for eligible users most at risk of developing, or worsening, oral disease… (p. 409) Recommendation 13.5: State and Territory Governments should establish effective commissioning processes for public dental services for those population groups who are not able to choose between alternative providers. (p. 415) Recommendation 13.6: The Australian, State and Territory Governments should transition to a consumer-directed care approach to providing public dental services by first establishing initial test sites before a staged rollout. (p. 418)	
Report on the fourth review of the *Dental*	This Review noted 4 issues (p. 8): • difficulties in obtaining initial parental consent –	The scheme is now available to those aged 0

Benefits Act 2008, July 2019	particularly in Indigenous, rural or remote communities • literacy level of Informed Financial Consent Forms and Patient notification letters • number of dentists and level of claiming under the CDBS compared to dentists registered • barriers to treatment for vulnerable populations as a result of the prohibition on payment for in hospital treatment. The report also made a number of recommendations relating to the above issues. This included changes to financial consent under Medicare bulk-billing rules and the lowering of the age for CDBS eligibility to 1 year of age.	to 17 (for at least one day in a calendar year).
Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect, vol 3A*, March 2021	Recommendation 60 (p. 301): Establish a Senior Dental Benefits Scheme: The Australian Government should establish a new Senior Dental Benefits Scheme, commencing no later than 1 January 2023, which will: a. fund dental services to people who: i. live in residential aged care, or ii. live in the community and receive the age pension or qualify for the Commonwealth Seniors Health Card. b. include benefits set at a level that minimises gap payments, and includes additional subsidies for	The Government response (2021) outlined (p. 42): This recommendation is subject to further consideration by 2023. The delivery of adult public dental services is currently a state and territory responsibility for which the Australian Government provides additional financial support through a National Partnership Agreement. The Australian Government also provides funding support for dental procedures conducted

	outreach services provided to people who are unable to travel, with weightings for travel in remote areas c. provide benefits for services limited to treatment required to maintain a functional dentition (as defined by the World Health Organization) with a minimum of 20 teeth, and to maintain and replace dentures.	for public hospital admitted patients and outpatients under the National Health Reform Agreement. Following the change of Government in 2022, this recommendation remains subject to further consideration.
KBC Australia, *Increasing Dental and Oral health training in rural and remote Australia: Feasibility study*, September 2022	An overview of recommended strategies is included on p. 59 (table 4-1). The report recommends a holistic approach to encourage more dental and oral health professionals, especially those willing to work within Modified Monash category 3–7 areas. The recommended strategies are underpinned by guiding principles (pp. 59–60), which include that programs should complement, rather than duplicate, programs across Australia and jurisdictions. Additionally, there should be monitoring of programs and a focus on Aboriginal and Torres Strait Islander health and students.	The Government is yet to respond to the report.