



NATIONAL RURAL
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Position Paper

Public dental services in Australia: whose responsibility?

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This Position Paper represents the agreed views of the National Rural Health Alliance, but not necessarily the full or particular views of all of its Member Bodies.

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Public dental services in Australia: whose responsibility?

Introduction

Tooth and gum diseases are among the most common causes of morbidity in Australia. They have serious negative effects on quality of life.¹ Oral diseases are the most common of the chronic diseases and important public health problems because of their prevalence, their impact on individuals and society, and the expense of their treatment.²

Despite all of this, the Australian government in particular still separates oral health from general health and provides very limited resources for it.³ There remains contention about which level of government carries responsibility for oral and dental health. There may even be a general inference that, while medical services should be provided at least in part by government, dental services are a matter for personal attention. The situation is compounded by the considerable success of the Commonwealth's involvement for a few short years through the Commonwealth Dental Health Program—a clear pointer to how the current serious situation could be ameliorated.

Data from a new national Oral Health Survey will not be available for another three years, but available evidence indicates that those with worse teeth and gums are public patients, many of whom live in rural and remote areas. The Alliance is therefore keen to promote a practical fix to the problem.

There are many studies showing the link between dental and chronic diseases; for example, between periodontal disease and cardiovascular illness. Stroke is more likely to occur with elevated levels of certain periodontal pathogens.⁴ Periodontal disease and tooth loss are linked to coronary heart disease (CHD)⁵ and there is specific evidence of an association between periodontitis and heart attack, even after adjusting for well-known risk factors.⁶ There is some evidence that effective dental treatment of individuals with CHD may provide protection against future deterioration in heart health.⁷

Dental ill-health is not only costly in terms of personal discomfort and disadvantage; it is also expensive in economic terms. Dental decay is the most expensive diet-related disease in the country, costing more than CHD, hypertension and diabetes,⁸ and it can lead to hospitalisation: in 2002–03, 223 patients were hospitalised for dental conditions.⁹

Both prevention and cure of dental and periodontal disease are therefore important for overall health. Dental services are, however, almost entirely removed from medical services in Australia. Funding is provided separately, and there is a strong history of the Commonwealth Government deeming dental health to be a State

issue, despite the Commonwealth having the same constitutional powers (in s. 51, xxiiiA) to fund dental services as it has for medical services.

While all states and territories provide some public dental health services to individuals who are economically disadvantaged, there is great variation in this respect between the jurisdictions. The appendices in the second section of this paper detail the services available in each state and territory and a comparison of the oral health status of the residents of each.

Current oral health in Australia

The dental health of Australian children is good overall, currently ranking 2nd among OECD countries.¹⁰ Dramatic improvements occurred between the 1970s and the 1990s, but a recent trend reversal has been documented, with overall caries experience rising between 1996 and 1999 among six-year-old children, and a 21.7% increase in decay among five year olds.¹¹ This observation may particularly reflect the negative experiences of certain groups of children. The 1997 Save Our Kids' Smiles program in NSW showed that rural children were significantly more likely to have dental caries than those from metropolitan areas.¹² Indigenous Australian children are also known to have significantly worse dental health than non-Indigenous groups.¹³

Dental health deteriorates after childhood in all populations. The 18–24 age group has poorer oral health than might be expected, given the low level of caries in children. This population has, on average, seven teeth with caries compared with two at age 12.¹⁴ This trend continues over time and adult oral health in Australia languishes behind that of many other developed nations.

Dental caries is the most prevalent health problem among Australians, and periodontal disease is the fifth most prevalent. Ninety per cent of tooth loss is attributable to these two factors.¹⁵

A monitoring survey of dental health among adult public patients, published in 2004 by the Australian Institute of Health and Welfare (AIHW), showed an overall drop in oral health status since 1995. Trends varied somewhat between patients from metropolitan areas and those from rural and remote locations (see next section).

The AIHW survey showed that although rates of edentulism (complete tooth loss) did not rise significantly between 1995–96 and 2001–02 in adult public dental patients, the overall number of decayed teeth was higher in 2001–02 (2.65 compared with 1.97 per person) in all age groups for both general and emergency care.¹⁶ The increase in decayed teeth in metropolitan areas principally concerned those in the 18–24, 25–44 and 45–64 age groups, while in remote and rural areas the increases reflected deteriorations in the 25–44 and 65+ age groups. This may be linked to increased retention of teeth in older adults. Comparisons with private patients show lower levels of decay in the population receiving private treatment: 2.3 decayed teeth among those aged 18–24 and 2.0 decayed teeth among 25–44

year olds in 1998–99¹⁷ compared to over 4 decayed teeth in each age group in the survey of public patients.

Numbers of missing teeth were higher in 2001–02 than 1995–96, particularly among rural and remote patients and numbers of filled teeth fell among this population. Increased combined numbers of decayed, missing and filled teeth (DMFT) were identified overall. The rise in metropolitan measures was due to an increase among the 25–44 age group, whereas in rural and remote areas the change was mainly due to an increase in the 45–64 and 65+ age groups.

Rates of periodontal pockets were measured and the nationwide rate of periodontal disease showed an improvement. However this was not the case for rural and remote patients. In these populations, overall rates of periodontal disease increased, especially in the over-65s.

Trends specific to the different states and territories of Australia are at Appendix 1.

Specific problems facing people in rural and remote areas

In Australia, the availability of dentists is considerably lower outside major urban locations.¹⁸ At the same time, those living in rural and remote areas and Indigenous communities often have higher rates of dental disease than metropolitan populations and a significantly higher level of edentulism has been reported in the Indigenous population (16.3% compared with 10% in the non-Indigenous population).¹⁹ A lack of dental health awareness has been identified among adult Indigenous Australians.²⁰ This is a rural and remote issue to some extent as the proportion of the population who are Indigenous rises from 1–2 per cent in the major cities to 30 per cent in remote areas.

Indigenous Australian children have more than twice as many caries as non-Indigenous children, in both deciduous and permanent teeth. This problem appears to be increasing.²¹ Preliminary results from ongoing research by the Centre for Rural and Remote Oral Health (CRROH) have shown that pre-school children (aged 2–5 years) in remote communities often experience dental problems. Higher levels of decay were found in Indigenous children compared to non-Indigenous children. Over 30% of all children did not own a toothbrush and almost 30% of all the children surveyed had experienced toothache.²²

Unpublished research by the same group has shown that, although the oral health of Aboriginal children is poorer than that of non-Aboriginal children, the hospitalisation rates for non-Aboriginal children are significantly higher. It is 31 times more likely that a non-Aboriginal high school child will be admitted to hospital for removal of embedded and impacted teeth than will an Aboriginal high school child in WA.²³ Public dental health programs should make greater use of Aboriginal Health Workers to encourage prevention and referral for treatment.

In WA, examination of waiting lists for oral surgery indicated significantly fewer entries for patients from rural or remote communities, suggesting that access to dental surgical care was more difficult for individuals living far from urban

centres. Most entries on the waiting lists were from highly accessible locations, while the lowest numbers came from remote and very remote areas. Significantly lower numbers of Indigenous Australians were present on the waiting lists. The researchers concluded:

Demand for specialist services are not driven through the expected factors of disease burden as indicated by socio-economic status, but by access to general dental services.²⁴

Similar results were found for patients awaiting orthodontic treatment.

The shortage of public dental professionals is particularly pronounced in rural areas. Approximately 28% of public jobs remain unfilled in rural NSW.²⁵ This figure may well be even higher in other more remote areas.

Some jurisdictions have schemes in place to improve access to dental care for rural and remote citizens, or to encourage rural populations to seek dental treatment.

In WA they include the Health Department's maintenance of dental clinics in larger rural centres where there is no general practice. A number of itinerant services visit smaller communities to provide treatment. There is also a subsidy scheme in place for country residents to access care through private dentists where there are no public services available.

Queensland offers an incentive for dentists to practise in rural and remote areas. Extra payment is made on a sliding scale ranging from \$3 000 to \$20 000 per year. Even some of the coastal and near-coastal areas have had greater difficulty attracting dentists, as the rural and remote allowances are lower there.²⁶ Scholarship holders have been placed in these locations when available. The Crocodile Smiles program targets Indigenous Australian communities in North Queensland. Specific mobile clinics visit Indigenous communities to provide access for adult patients but measures to encourage the populations there to seek dental care have not been detailed.

In SA, a population health funding model is in place whereby eligible patients with country postcodes are allotted higher weighted funding. When eligible populations do not have access to a public dentist, as is often the case in rural and remote areas, they are subsidised to visit a private practice. However, private practices in rural areas often struggle to maintain staff numbers adequate to treat their own patients, let alone additional public patients.

A dental program targeting Indigenous Australians in SA operates both as part of the mainstream dental service and also in partnership with specific communities, providing funding, evaluation, equipment and staffing. For instance, a private dentist is paid to travel to Yallata to treat patients in the Indigenous community there, and dental students travel to the Pika Wiya Aboriginal Health Service at Port Augusta to treat adult and child patients in the community once a month.

Similar arrangements are in place elsewhere in SA, whereby private dentists travel to areas such as Coober Pedy and Roxby Downs to provide care to both private and public patients. A capitation arrangement is in place for school-age patients

and additional funding is provided for the treatment of Indigenous adults. Additional funding of \$480 000 has recently been allocated to country areas of SA.

The shortage of dentists in rural and remote SA as elsewhere, particularly in the public sector, has persuaded the state to place an additional 30% loading to salaries paid for metropolitan dentists to travel to rural areas for a few days at a time to treat patients. From July 2005, higher fees will be paid to private dentists in country locations to provide care to public patients.

In Victoria, there are 33 Community Dental Program clinics in rural areas that provide public care to concession cardholders and their dependents. Travelling dental teams work in clinics where there are staff shortages and there is a travel scheme for those who require care in Melbourne.²⁷

In the NT, dental therapists and dentists travel to rural and remote communities regularly, providing services from clinics based in health centres and mobile dental vans. No specific schemes are in place to target adult groups who might not otherwise seek dental treatment.

For NSW dentists in the public sector, there are financial incentives to encourage them to practise in country areas.²⁸ There are no incentives for private dentists in NSW and no measures are in place in NSW or Tasmania to target rural communities.

Other special need groups

Certain other groups have been identified who have especially poor access to dental services. These include pre-school children, individuals aged 18–25 and the elderly.²⁹ Some states and territories have schemes in place to help ensure such groups gain access to care.

In SA, there are schemes targeting older adults, homeless people and the disabled. The Age Care Project is undergoing a 12-month pilot. This scheme operates in metropolitan Adelaide and aims to introduce oral health into health assessments at home, by which doctors or registered nurses assess adults aged 75 and over (and Indigenous Australians aged 55 and over) in their own homes to identify general health needs. Individuals with dental health problems are then referred to public dentists, if the patient is eligible, and given priority status.

In addition, a program targeting supported individuals in residential facilities (homeless hostels etc) is in place in country and metropolitan areas. Special needs treatment programs target patients with disabilities, those who are HIV positive and others with acute medical conditions. Such programs are available in Adelaide and throughout the state as part of Community Dental Services.

The state also operates a domiciliary service for eligible public dental patients who are housebound, but this only applies to the metropolitan area.

WA offers additional services for housebound patients, those in long-term care homes and other ‘special groups’, while, in Queensland, there are some programs to improve access to services, in particular targeting children aged 0–3 years.³⁰

Victoria operates a domiciliary scheme to help housebound patients access public dental care, but this is only available in Melbourne.

In the NT, the public dental service works in collaboration with the Cardiac and Rheumatic Heart Disease Units to provide services to chronically ill clients.

In the ACT, a special needs pathway is in place, in addition to a memorandum of understanding with key community groups to assist disadvantaged people access dental services. The community groups include drug support groups, Corrective Services, the Aboriginal Health Service, refugee support groups and Disability ACT. There are no specific schemes in place in Tasmania or NSW to target groups who do not usually seek dental care.

Policy success: the Commonwealth Dental Health Program 1994–97

The Commonwealth Dental Health Program (CDHP) was introduced in January 1994 to improve access and reduce waiting times for public dental services by increasing public dental resources and subsidising patients with concession cards to see private dentists for restorative dental treatment (denture services were not covered). The Commonwealth Government provided funding to state and territory governments to pay for private dentists to deliver both emergency and general care, with the aim of moving care away from emergency to general care.

Approximately \$100 million was to be provided annually to fund the program. Direct expenditure by the Commonwealth Government was \$152 million in 1995–96, the year before the CDHP was terminated.

The Coalition Government discontinued funding for the CDHP, and responsibility for funding the bulk of public dental services reverted to the state and territory governments.

According to the AIHW’s Dental Statistics and Research Unit, the benefits of the CDHP were manifold.³¹ In the 24 months following the introduction of the CDHP, eligible concession cardholders who received public-funded dental care reported:

- a reduction in perceived need for extractions (from 12.7% in 1994 to 9.3% in 1996) and fillings (down from 25.8% to 17.1%)
- reduced frequency of toothache (from 23.3% to 19.8%)
- greater frequency of dental care visits (the percentage who saw a dental professional during the previous 12 months increased from 58.6% to 67.4%)

- shorter waiting times (those waiting less than one month for a check-up increased from 47.5% to 61.5% while numbers of patients waiting 12 months or more fell from 21.1% to 11.3%)
- fewer extractions (down from 43.8% to 36.5% among those last visiting for a problem) and more fillings (from 21.7% to 53.5% among those last visiting for a check-up)
- greater levels of satisfaction with dental care received, both among patients visiting public services and those subsidised to visit private practices (on a scale of 1–5, satisfaction scores increased from 3.69 in 1994 to 3.93 in 1996).

Overall, an additional 200 000 patients received public dental care each year in the two years following introduction of the Program.

Despite the improvements in dental care and dental health described above, only a small shift away from emergency care towards general dental care was observed. Concession cardholders remained more likely to visit a dentist to resolve a problem rather than for a check-up; more likely both to perceive the need for and have a tooth extracted; and more likely to experience toothache.³²

Following the termination of the CDHP, waiting lists grew by 20–30% nationwide, with some patients now waiting up to 5 years for treatment. At the time of the program’s termination, 380 000 public patients were waiting an average of 6 months for treatment. This increased to 500 000 patients waiting an average of over 8 months in May 2000.³³

The program had a range of effects in the different states and territories, as described below. Overall, its introduction was a benefit and its termination a blow. The Australian Dental Association supported the CDHP but it also indicated that there were some shortcomings that should be addressed in any similar program developed in the future.

In NSW, the introduction of the CDHP “significantly improved access to oral health services to eligible adults”. The subsequent loss of Commonwealth funding allocated under the CDHP, for most Area Health Services, caused a “significant reduction in the ability to provide adult services and a rapid expansion of lists and time delay for access to oral health care”.³⁴

Likewise, the impact of the Commonwealth Dental Health Program was considerable in Victoria. Waiting times prior to the program were over 4 years in some public oral health clinics and the state-wide average dropped to under 12 months during the program. *More people were treated, more fillings placed and less teeth extracted.*³⁵

Queensland was unique in that the State Health Department replaced the funding shortfall that arose following termination of the CDHP. In that jurisdiction, the CDHP had a positive impact on dental waiting lists, although there is limited evidence of its influence on oral health. The impact of termination was obviously reduced through full state supplementation of the funds lost.

The introduction of the CDHP in SA had a positive effect on waiting lists. The loss of the CDHP removed \$10 million a year from South Australian services, with the result that the average waiting time peaked at 4 years in 2002. To address the shortfall, the state government provided additional funds. A further one-off payment of \$3 million was made in 2004–05 with the announcement of a further \$3 million for 2005–06.

In WA, the CDHP reduced waiting lists from approximately 6.5 months in 1992 to 3 months by 1996. With the cessation of the CDHP, the waiting time grew to an average of 17.3 months by January 2004. However, state government initiatives in 2004 and 2005 have reduced the average waiting time.

In Tasmania, the program enabled an adult service to be developed. Prior to its inception the only public treatment available to adults was relief of pain through hospitals. The termination of the CHDP reportedly “decimated the service”. At one stage, only six public dentists were operating for the whole of the state, with a potential client population of 180 000.

In the ACT, significantly reduced waiting times for restorative treatment were recorded following the introduction of the CDHP. The funding of approximately \$1 million per year (1996 prices) represented a significant proportion of all funds available for adult restorative dental care (approximately \$1.7 million in the 1995–96 financial year). The effect of the withdrawal of Commonwealth funds on waiting times for an appointment for non-urgent restorative work increased waiting lists significantly in the ACT. In June 1996, the waiting time was under 10 weeks, in April 2001 it was 104 weeks.

A number of strategies have been introduced in the ACT since July 1997 to lessen the impact of the withdrawal of the Commonwealth funds. These include the introduction of client contributions for all adult dental services, including dentures; the relocation of two adult clinics; the introduction of two referral schemes to enable clients to be seen in the private sector. In addition, in the 1997–98 budget, the ACT Government increased funding to the Dental Health Program by \$500 000 to increase the number of surgeries and to support oral health promotion activities.

Conclusion

Dental health in Australia is poor among adults and deteriorating among children. The most recent National Oral Health Survey was carried out in Australia in 1987–88 and the results of a second survey will not be available for a further three years. Evidence currently available indicates that those with worse teeth and gums tend to be public patients who are often resident in rural areas.

The CDHP drastically reduced waiting times for public dental patients. Most public dental services have been significantly reduced since its termination, which is contributing to the poor levels of oral health today. The poor oral health of public patients has significant costs, both human and economic, yet the main

dental problems facing these Australians are quite amenable to prevention and early intervention

It is vital that the scale of the problem of dental and gum diseases be recognised. Whether the Australian Government reinstates a funding package similar to the CDHP, or the states and territories follow the example of Queensland and make up the shortfall themselves, action must be taken to reverse the trend in deteriorating oral health and ensure equality of care across the country.

Recommendations

1. **A long-term Commonwealth Government-funded dental health scheme should be re-established as a matter of urgency.** The budget for this scheme should be sufficient to clear the backlog for emergency treatment, and to allow patients who cannot afford private dental care to receive the appropriate dental treatment they need, whether this be provided through the public system or by subsidising private dentists.
2. **Joint state/Commonwealth dental schemes should also be established to address non-emergency dental treatment.** Budgetary commitments for this should be sufficient to reduce waiting times and allow preventative dental care to be available to all eligible persons within a reasonable time frame. Direction of funds specifically towards general care will have a greater impact on long-term health outcomes.
3. **A public health promotion campaign should be developed to encourage and enable people to take measures to prevent tooth and gum diseases,** rather than waiting until emergency treatment is needed. Increased awareness of the importance of diet, food standards, personal hygiene, water standards and preventative dental care will reduce the need for emergency treatment, with economic and health savings in the longer term.
4. **Services should be better targeted on a genuine needs basis,** rather than where there is or has been high take-up in the past. Statistics on the evidence of need have been skewed because, where there is under-service, there can be a lack of explicit evidence of need. Even when the health effects are serious, active demand for a service disappears where there is no prospect of supply.
5. **Greater funding for specific programs targeting Indigenous Australians** is needed, as evidenced by the stark differences between the dental health of Indigenous and non-Indigenous children.
6. There needs to be **a national effort to recruit and retain greater numbers of dentists and dental therapists to rural and remote areas.** The current scarcity of the dental workforce in those areas contributes to the inadequacy of public dental services. Research shows that the dental workforce issues are similar to those experienced by other health care practitioners³⁶, and solutions similar to those for doctors and nurses need to be implemented.

Appendix 1 Trends in dental health between 1995–96 and 2001–02³⁷

New South Wales

A lower percentage of edentulous patients (with complete tooth loss) was observed overall and within most age groups in NSW compared to the national data. There was a negligible change in edentulism over time, while the national data showed a small increase in complete tooth loss among patients presenting for public dental services.

The trends for decayed teeth in NSW were consistent with the national picture, showing significant increases over time overall and for each age group.

Victoria

Rates of complete tooth loss were no different in Victoria to the national average. The only significant increase in the number of decayed teeth was observed among 25–44 year olds, while the national data showed significant increases in all age groups.

Queensland

In general, Queensland had higher percentages of edentulous patients compared to the nation as a whole.

There was an overall increase in the number of decayed teeth, reflecting a rise in levels of decay among individuals aged 25–44 and 65+, while the national trends showed increased numbers of decayed teeth in all age groups. There was no change over time in the overall number of missing teeth in Queensland, in contrast to the national data, which showed a significant increase. There was a significant decrease in the number of missing teeth among those aged 25–44 while, nationwide, a significant increase was observed.

Western Australia

The percentage of edentulous patients in WA was lower overall and in most age groups than the national average.

Also in contrast to the national data, there was a significant overall decrease in the number of decayed teeth (due to a fall among individuals aged 65+). The number of missing teeth showed no significant overall change over time, while the national data showed a significant increase in this measure. Numbers of filled teeth showed a significant overall increase (due to a rise among the 65+ age group) while the national data showed a significant overall decrease. There was no significant change over time in overall rates of decayed, missing and filled teeth (DMFT) while the national data showed a significant overall increase in DMFT.

South Australia

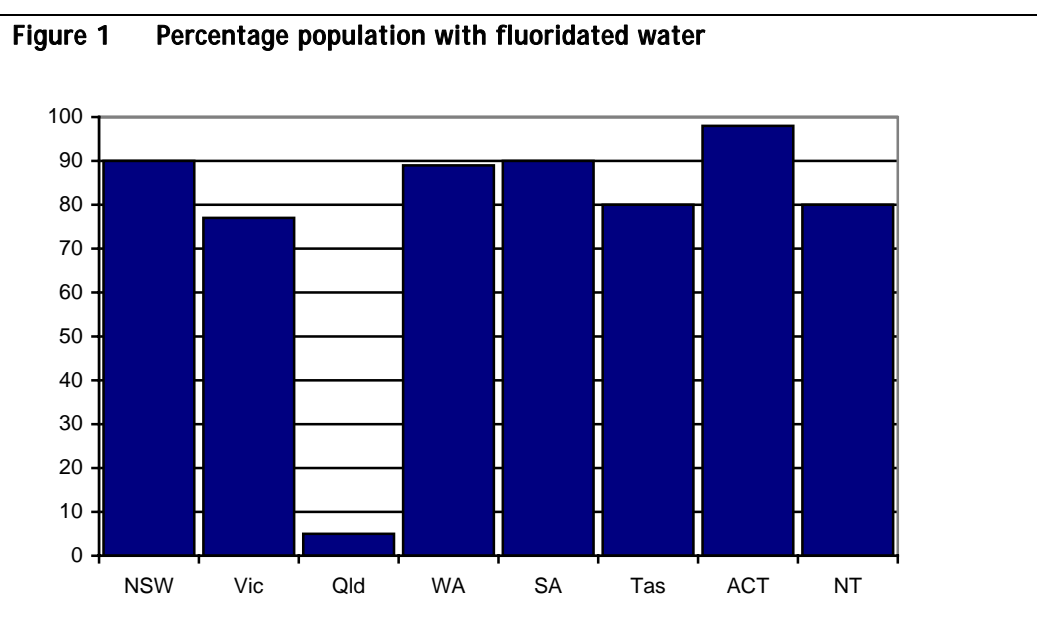
The percentage of edentulous patients in SA was higher than the national estimates in 1995–96 but similar to the national estimates in 2001–02. SA dental patients had comparable levels of caries experience as the national average and other measures were also similar.

Northern Territory

The overall proportion of edentulous patients was lower in the NT compared to the national average. In contrast to the national data, the NT trends showed a significant overall decrease over time in the number of decayed teeth. There was no significant change in the overall numbers of missing teeth but decreased numbers of missing teeth were observed over time among the 25–44 and 45–64 age groups, while the national trends showed a significant increase over time in this measure. Again in contrast to the national data, a significant overall increase was observed in the number of filled teeth over time, particularly in the 25–44 and 45–64 age groups. There were no significant changes in DMFT over time in the NT, while the national data showed an increase in DMFT.

Fluoridation

Both children and adults who live in areas where water is fluoridated have been shown to have reduced experience of caries compared to individuals living in non-fluoridated areas.³⁸ Dental problems are among the most frequent reasons as to why children aged 1 to 4 years are admitted to hospital. Looking at their places of residence, the rates of hospital admissions from those areas that do not have water fluoridation are 10 times higher than in those areas with water fluoridation.³⁹ Figure 1 summarises access to fluoridated water across Australia.



In NSW, around 90% of the population has fluoridated water. Fluoride is present in almost 100% of the water supplies in Sydney. This level falls to 84% in the

Hunter area and 68% in other regional areas.⁴⁰ In WA, close to 90% of public water supplies are fluoridated, while 77% of the population of Victoria has access to fluoridated water. In Tasmania, 80% of the reticulated water is fluoridated. Some rural areas or areas with population less than 500 have non-fluoridated reticulated water or tank water. In SA, 90% of the population has fluoridated water (80% added fluoride, 10% naturally present fluoride) and approximately 80% of the population of the Northern Territory has access to fluoridated water. Fluoride is added to the water in Darwin and Katherine, and occurs naturally in Alice Springs and some other smaller centres. The ACT has almost total fluoridation coverage. Only a small rural area, covering 1–2% of the population, is not fluoridated.

Queensland is the only state or territory not to fluoridate its water, with the exceptions of Townsville, Dalby, Mareeba and Moranbah. Thus less than 5% of the population has access to fluoridated water.

Appendix 2 Free/subsidised dental care in the states and territories

Most dental treatment is provided by the private sector in Australia and is financed through direct out-of-pocket expenses. Certain groups are financed by the Commonwealth Government, but funding for public dental services is predominantly provided by the state and territory governments.

All jurisdictions provide free or subsidised care to primary school children but only NSW, NT, Tasmania and SA provide free care from birth to 18 (there is an annual subscription for some secondary school students in SA). Concession cardholders and their dependents are generally covered for free or subsidised care, but the personal contribution varies. Some states provide additional services for vulnerable (eg housebound) patients but, again, provision depends on location and rural/remote communities may not be covered. Emergency dental care provision also varies. Some states operate membership schemes that allow emergency care for a small fee.

The eligibility criteria and public dental services provided are outlined for each state and territory below.

New South Wales

Free dental care is provided to children from birth to age 18 (if the child is still in full-time education), or to age 14 if the child has left school. Adult patients are eligible for free care if they have a Centrelink card or are the dependent of a Centrelink cardholder. Emergency care is available to eligible adult and child patients and the same conditions apply. A Priority Oral Health Program is in place, which aims to provide public services on the basis of need rather than on a 'first come, first served' basis. It offers options for eligible patients to make appointments by telephone or by attending a clinic in person.

The Oral Health Fee For Service Scheme (OHFFSS) provides vouchers that can be used at private clinics by public dental patients. It has been in place since July 2001 and has recently been extended. Individuals requiring treatment for acute conditions and denture services may seek assistance under this scheme. The upper limit for payment under OHFFSS is \$170 per course of acute care and \$780 for denture services. However, actual levels of funding per client are low, and many concerns have been voiced about this scheme.⁴¹

In 2001–02, approximately 227 200 individuals (95 400 males, 131 900 females) saw a public dentist. This represents 4.5% of the population⁴² (see Figure 1). Reported numbers of dental visits in recent years can be seen in the Table 1 below.

Table 1 Public dental visits in NSW

	1999–00	2000–01	2001–02	2002–03	2003–04
Children	493 473	454 083	516 468	549 230	550 900
Adults	606 096	536 296	752 583	885 941	844 665
Specialist appointments	50 914	57 235	80 128	86 612	76 509

Victoria

All preschool and primary school age children are eligible for subsidised or free dental care in Victoria. Primary school children are treated in the School Dental Service (SDS). Adolescent dependants of Centrelink cardholders are eligible for free care—from the SDS while in Years 7 and 8 and from the Youth Dental Program from Year 9 up to the age of 18 years. The children of non-concession cardholding families must pay \$27 per child for each course of care.

Adult patients who have Health Care Cards or Pensioner Cards are eligible for subsidised dental care. Payment of \$21 per visit (up to a maximum of \$84 for a course of care) is required. Emergency care is charged at the same rate and is only available to Centrelink cardholders and their children. The maximum cost of dentures to cardholders is \$105.

Approximately 12% of Victorian cardholder residents see a public dentist each year, and about 4% of Victorian adult residents overall see a public dentist each year.

Queensland

All children receive free dental care from age 4, ie. pre-school, to Year 10 with universal eligibility. Adult patients who have Centrelink Health Cards, Pensioner concession cards, and Seniors cards, receive free general care. Patients eligible for general care may also receive emergency care.

In total, 54% of the entire population of Queensland is eligible to receive public dental services. In 2003–04, 21% of the eligible population (11% of the whole population) were seen by Queensland public Oral Health Services. A greater percentage of the eligible population was seen in areas outside Southeast Queensland (29%) than in Southeast Queensland (23%). The estimated numbers of public patients receiving dental treatment in 2004–05 are:

- adult, emergency/immediate 275 000
- adult, general 299 000
- school children 651 000

Western Australia

The School Dental Service provides free general dental care to pre-primary, primary and secondary school children (up to Year 11 for those in metropolitan areas and Year 12 for those living in country areas).

Adult patients must hold a Centrelink card or be the dependent of a cardholder to be eligible for subsidised treatment. Emergency care is available to eligible patients. Approximately 20% of the adult population sees a public dentist, with around 180 000 children and 81 000 adults treated under the public dental system each year.

South Australia

Dental care is free or subsidised from birth in SA up to age 18. All primary school children are treated free of charge, but a small annual fee (\$35.00) is required from the children of non-Centrelink cardholders in secondary school for general treatment. The service remains free to Centrelink or school cardholders. Orthodontic referrals are made to a private dentist, but patients with a concession card may be treated at the Adelaide Dental Hospital with a co-payment.

Adult patients who hold a Centrelink card are eligible for subsidised treatment. This also applies to emergency care. Funding is available in SA to enable public patients to access private care if necessary.

The total number of adults eligible for public treatment in SA in 2003–04 was 411 569 (27.4% of the entire population). In country areas, there were 109 007 eligible patients and 19.5% of these received public treatment.⁴³ In metropolitan areas, there were 302 562 eligible patients and 15.6% of these received public treatment.⁴⁴ Overall, therefore, 4.6% of the whole population saw a public dentist.

Approximately 184 000 children were under the care of the School Dental Service in 2003–04. In the same year, 95 758 adult patients received publicly funded treatment, either in public clinics or as subsidised private care. Overall figures for dental services visits in 2003–04 were:

- children, general 221 713
- adults, general 179 249
- specialist appointments 49 952

Tasmania

Tasmanians are eligible to receive free dental care from birth up to age 18.

Adult Centrelink cardholders pay a minimum of \$25 per course of care. Emergency care is also covered, and is charged at the same rate.

Approximately 15% of the eligible adult population of 180 000 sees a public dentist. This represents around 5.4% of the overall population. Overall, approximately 13 000 adults and 58 000 children are treated by public dental services each year.

Australian Capital Territory

Pre-school, primary and secondary school children (up to 18 if dependents of a concession cardholder) receive subsidised dental care in ACT. To access care, children must be members of the Membership Scheme. Primary school children pay \$40 per annum, as do pre-school children requiring treatment (up to a

maximum of \$100 per family). This is reduced to \$20 per child (maximum \$50) for low-income families.

Adult patients with a Centrelink card are eligible for subsidised care. Each course of treatment costs \$25 minimum (\$250 maximum) and emergency treatment is charged at the same rate. There is no maximum for patients who require dentures.

The percentage of patients who see a public dentist is unknown but, over the past 12 months, around 5800 adults and 18 600 children have received dental services from the public Dental Health Program.

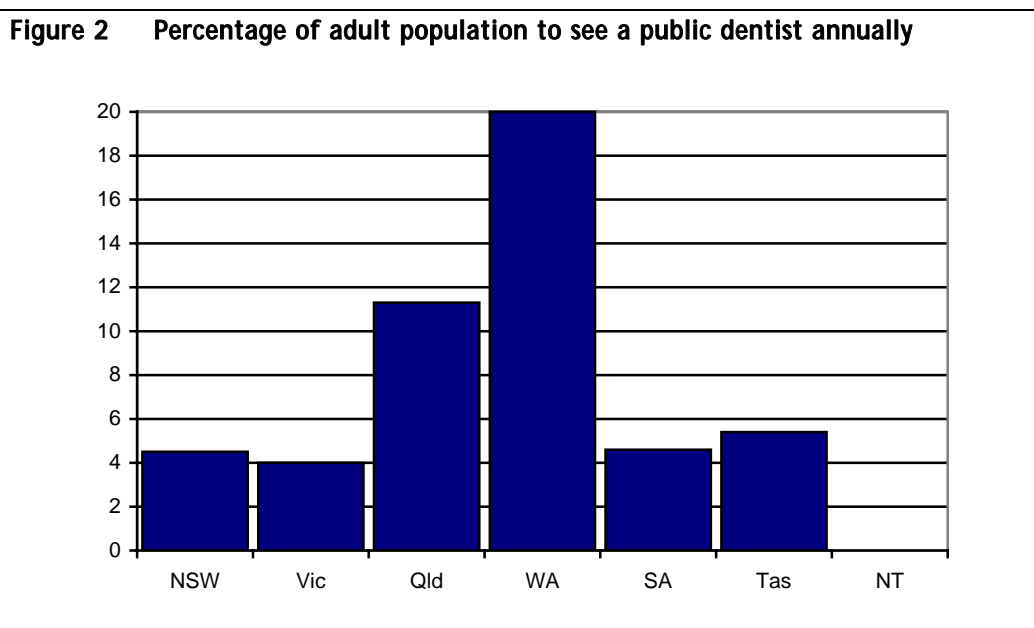
Northern Territory

Free dental care is provided in the NT from birth and throughout primary and secondary school.

Adult patients with a Centrelink card are eligible for free or subsidised care. Additional eligible clients include residents of communities more than 100 km from permanently staffed dental facilities, people who are institutionalised, refugees from 6 months after arrival and holders of a ‘torture and trauma victim’ certificate.

Orthodontic services are not available to adults but are available to school children who are dependents of Centrelink cardholders.

The proportion of patients who see a public dentist in the NT is unknown but, in 2004–05, approximately 17 438 visits were made by youth and adult patients to a public dental service in NT. In the same year, 37 595 visits were made by children aged 0–13 years.



Appendix 3 Waiting times

While waiting times for emergency dental care are short throughout the country, waiting times for general dental care are extensive (estimated to be between 10 and 54 months in 2000).⁴⁵

Waiting times vary significantly between the states and territories. Figures published by the National Advisory Committee on Oral Health in 2004 showed the largest waiting lists were in Victoria and smallest in ACT, in both 1997 and 2002.⁴⁶ Patients had to wait longest (up to 58 months) in NSW, 15–30 months in ACT but only 8 months in WA in June 1997, while the longest waiting time in 2002 was 49 months in SA (figures were not available for NSW). WA again had the shortest waiting time, which had risen to 13 months.

New South Wales

Since the introduction of Oral Health Reforms and the Priority Oral Health Program in NSW, waiting list data relating to eligible cardholders has been collected on an area basis only and very few overall figures regarding numbers of patients awaiting treatment or length of waiting time are available. From time to time, the data are collated centrally, and the most recent information shows that there were 162 303 patients on waiting lists in August 2004. Of these, 84 866 were waiting for assessment and 77 437 were waiting for dental treatment.⁴⁷ The waiting list has grown significantly since December 2000, when 120 252 patients were awaiting treatment, and December 2003, when the number was 122 622.

No more current waiting times are available other than those mentioned above.

Victoria

In Victoria, concession cardholders with urgent dental needs are assessed within 24 hours. Waiting times for restorative treatment depend on the centre and vary widely. At the Royal Dental Hospital of Melbourne, for instance, patients in need of denture care must wait 38 months, and the waiting list for general care is 24 months. Patients at Darebin Community Health (Northcote) must wait 12 and 6 months for these services, while Bairnsdale Regional Health Service patients must wait 41 and 44 months, respectively.⁴⁸

The state-wide average waiting time for non-urgent general care was 31 months in October 2004 and 35 months for non-urgent denture care.⁴⁹ Doura Galla Health Service patients who need dentures must still wait 50 months for an appointment, however. Urgent dentures are provided within 3 months and, reportedly, over half of those receiving dental care through the Community Dental Program receive care quickly.

Queensland

In Queensland, emergency services are provided within 24 hours. Waiting times for general services range from 0 weeks to 4–5 years in many clinics around Queensland (including Brisbane, SE Queensland, Northern Queensland and

Central Queensland). Only Western Queensland has clinics without these waiting times; here they range from 0 to 1.2 years. The disparity between Western Queensland and elsewhere in the state occurs because there are fewer eligible patients in this area.

The average wait for general services is approximately 1 year longer in South-East and Central Queensland than in Northern and Western Queensland.

Western Australia

In WA the current average waiting time for general dental care is 10.9 months. Specialist care is discipline dependent, ranging from 10 weeks for oral pathology/medicine to 3 years for orthodontics.⁵⁰

South Australia

In SA, as a whole, waiting periods as of May 2005 were:

- general care 28.1 months
- specialist care 25.6 months
- (orthodontic specialist care 30.6 months)
- dentures (non-priority) 33.4 months

Little variation between country and metropolitan areas is observed in SA (28.6 versus 28.1 months, respectively, for general care). For denture services, 70% are regarded as priority and are provided immediately. Of the non-urgent cases provided under the Pensioner Denture Scheme, in country areas, the wait for dentures is 23.4 months compared to 39 months in metropolitan areas.

Tasmania

In Tasmania, there are no public adult services in rural areas and all adult patients are therefore seen in urban clinics based in four major sites across the state. General adult care waiting time can be up to five years. Children are seen in rural and urban clinics and there is no waiting list.

Australian Capital Territory

In the ACT, at 30 June 2005, waiting times were:

- adult restorative treatment 9.6 months
- adult denture service 4.8 months
- child and youth services no waiting list

Northern Territory

In NT, urgent cases are usually seen on the same day and always within 2–3 days. The waiting time for general treatment in Darwin and Alice Springs is between 21 and 24 months. There is no waiting time for Gove and a 1-month wait in Katherine.

There is no waiting time for serious functional orthodontic treatment but waiting time for non-urgent orthodontic treatment can be up to 12 months. The waiting time for dentures varies, the longest being 21 months in Alice Springs.

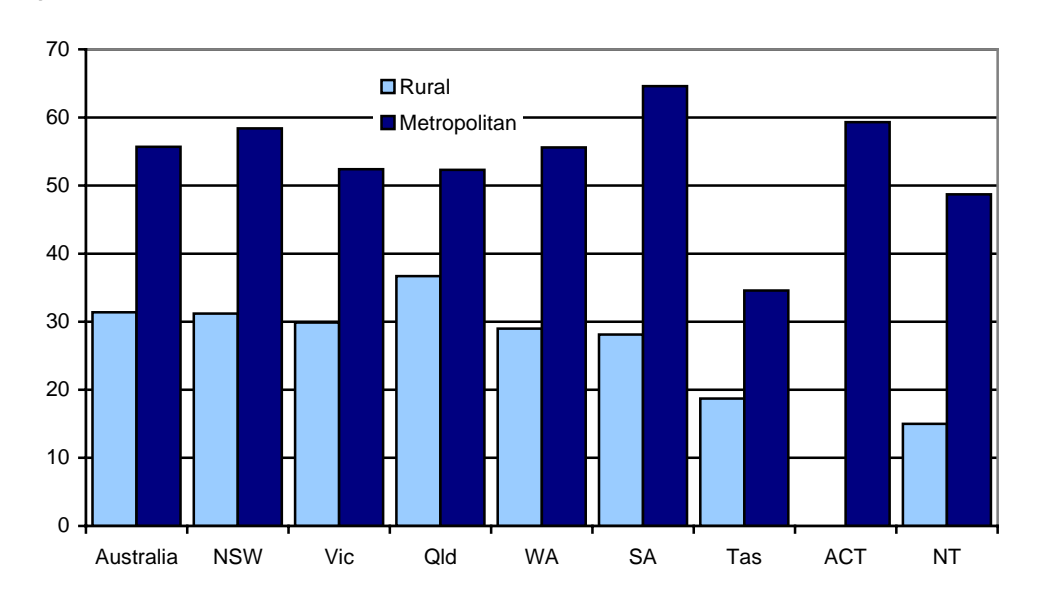
Appendix 4 Dental workforce

Overall numbers of dentists per head of population appear to be increasing (to 46.9 per 100 000 population in 2000 from 43 in 1994). However, compared to other developed countries, Australia still lags behind in terms of dental workforce numbers.⁵¹ It is difficult to project whether the rise will be sustained into the longer term although there is no doubt that the number of dentists is low by historic levels. Numbers of dental graduates have fallen by one-third since the 1970s.⁵² At the same time, the cost of studying dentistry is rising.⁵³ Currently, around 250 dentists qualify each year, but Spencer et al project that, in order to meet rising demand, an additional 120 dental graduates per year are needed across the country.⁵⁴ Only 70 more Bachelor Degrees in Oral Health (for dentists, dental therapists and oral hygienists) have been funded by the Commonwealth Government from 2005.

Most dentists work in private practice. In 2000, 82.6 of dentists worked privately, with 16.2% in the public sector and 1.2% in other areas.⁵⁵

Significantly fewer dentists operate in rural compared to metropolitan areas (see Figure 3). Taking Australia as a whole, a comparison by the AIHW between rates of dentists practising in rural and metropolitan areas showed there are 55.7 dentists per 100 000 population in metropolitan areas and only 31.4 in rural areas in 2000.⁵⁶ In addition, rural dentists see more patients than their counterparts in the city.⁵⁷

Figure 3 Dentists per 100 000 population in 2000



New South Wales

In NSW, there was a total of 3126 dentists in 2000. There are only approximately 240 dentists working in the public sector despite over 2.5 million patients being

eligible for public dental care. There is great variation in the state, with approximately 80 dentists per 100 000 in the Eastern Suburbs of Sydney compared to around 17 dentists per 100 000 patients in the Wentworth area.⁵⁸ The AIHW comparison showed 58.4 versus 31.2 dentists operating in Sydney compared to the rest of the state in 2000.

Victoria

Figures are lower in Victoria, where there was a total of 2200 dentists in 2000. Again, significantly higher numbers per head of population worked in metropolitan Melbourne, with 52.4 dentists per 100 000 population, compared to 29.9 in other parts of the state.

In the public oral health sector, for the December 2004 quarter, there were 71.8 full-time equivalent (FTE) clinicians working in rural clinics and 142.9 FTE clinicians working in metropolitan Melbourne clinics.

Queensland

In Queensland, there are 172.26 FTE public dentists in Brisbane and SE Queensland and 126.65 FTE dentists in the rest of the state (Northern, Central and Western areas). In 2000, Queensland had the highest number of dentists operating outside of the capital city of all the states and territories, at 36.7 per 100 000 population.

Western Australia

In WA, approximately 870 dentists currently work in metropolitan areas compared to approximately 120 dentists in rural areas. The AIHW comparison showed an increase of 35% overall between 1994 and 2000.⁵⁹ In Perth, there were 55.6 dentists per 100 000 population in 2000, compared to 29 in the rest of the state.

South Australia

AIHW comparisons showed the greatest number of dentists per 100 000 population, 64.6, in Adelaide. This dropped to 28.1 for the rest of the state.

Tasmania

Tasmania was the only state in which dentist numbers fell between 1994 and 2000. The percentage of dentists operating outside of metropolitan areas also fell over this period, by 8.7%. Currently, all 17 public dentists are based in urban centres and there are approximately 25 dentists per 100 000 population.

Australia Capital Territory

In 2000, in ACT, there were 59.3 dentists per 100 000 population. Current figures are not held by the Health Department.

Northern Territory

NT showed the greatest drop in dentists treating patients outside of the capital city between 1994 and 2000, of all the states and territories. In 2000, there were 27%

fewer dentists practising outside of Darwin compared to 1994 (15 compared to 20.5).

Currently, in NT, all public sector dentists are based in the five larger centres, including Gove. There are 16 dentist positions in the public dental service. Approximately 50% of these dentists travel to rural and remote communities. Four of these positions are 100% dedicated rural positions while the other four positions include urban and rural components.

Australian rural dental workforce issues

The high costs associated with studying dentistry may mean that graduates are more likely to remain in metropolitan areas rather than moving to rural or regional locations. Such individuals may be more likely to opt to work in the private rather than public sector, in order to pay off the debts they have incurred.⁶⁰

The supply of dentists in regional/rural/remote areas is substantially lower than for major city areas. Even where there are dentists, access to services is also determined by transport considerations (car ownership, road conditions) and, to a significant extent, by socio-economic issues. There needs to be further study of the reasons why people in rural and remote areas are unable to access dental care so that it becomes clearer to all that it is not only the workforce shortages that explain this important public health issue (see Teusner⁶¹).

Role of oral hygienists/dental therapists

Dental therapist and oral hygienist numbers are rising across Australia and it has been suggested that, in the absence of a dentist, they may be permitted to provide greater levels of care in the future. They often work with communities, promoting oral health and general well-being, and are the backbone of the school dental services, but their work is currently limited.

NSW has the lowest number of dental therapists and oral hygienists per capita of all states and territories in Australia.⁶² In this area, dental therapists may not work outside the public sector (although they may practise as oral hygienists in the private sector).

In Victoria and WA, dental therapists and hygienists may provide care only within a team headed by a dentist. The dentist does not have to be present in the clinic, but must be available for discussion and referral if required. In Victoria, dental therapists can treat patients up to 25 years old, but those from 18 to 24 years need to have been referred by a dentist.

In SA, dental therapists may provide fillings, extractions etc to patients up to the age of 18, and are mainly used in the School Dental Service. Dental Therapists now graduate with a Bachelor of Oral Health and skills in both dental therapy and hygiene. In the private sector, the same individuals predominantly provide oral hygienist services to adults. Therapists and hygienists require supervision, but in the public system a dentist need only be 'accessible' whereas in the private system

s/he must be physically present. A debate regarding the necessity of this supervision is ongoing as part of a regulatory review. There is professional resistance to an increased role for dental therapists and oral hygienists.

In Tasmania, dental therapists are restricted to treating children under 18 and oral hygienists are restricted to their practice. Likewise, in Queensland, oral hygienists mostly perform oral hygienist work in the adult services but dental therapists are extensively used in rural schools.

In the NT, school-based dental clinics are also staffed by dental therapists who provide assessment and treatment with support from a dentist when needed. The dental therapist's role may expand to include treatment of 13–18 year olds in rural and remote communities.

Appendix 5 Funding

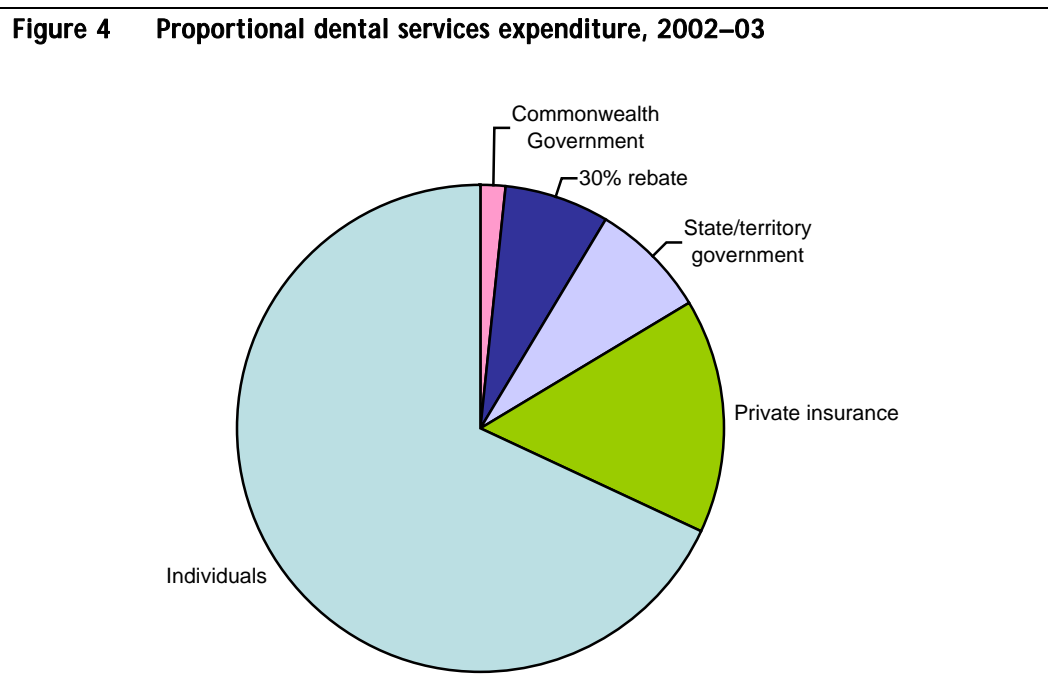
Total spending on dental services in Australia rose from \$1.71 billion in 1992–93 to \$4.37 billion in 2002–03 (4.9% to 6.06% of total health expenditure).⁶³

The Commonwealth Government's proportional share of dental expenditure fell from 2.22% in 1992–93 to 1.78% in 2002–03. Indirect Commonwealth expenditure, through the 30% private health insurance rebate, was \$298 million in 2002–03, representing 6.81% of total dental expenditure. The number of dental benefits has increased since the introduction of this rebate in 1999 from 14.4 million to 22.7 million in 2004. Costs of private health insurance are growing as a result, however, and benefits are reportedly not keeping up with dental care costs.⁶⁴

State/territory and local governments spent \$342 million on dental services in 2002–03, representing 7.82% of total expenditure (\$32 million less than in 1999–2000, when this funding represented 12.94% of total dental expenditure). This expenditure includes payments for public and school dental services.

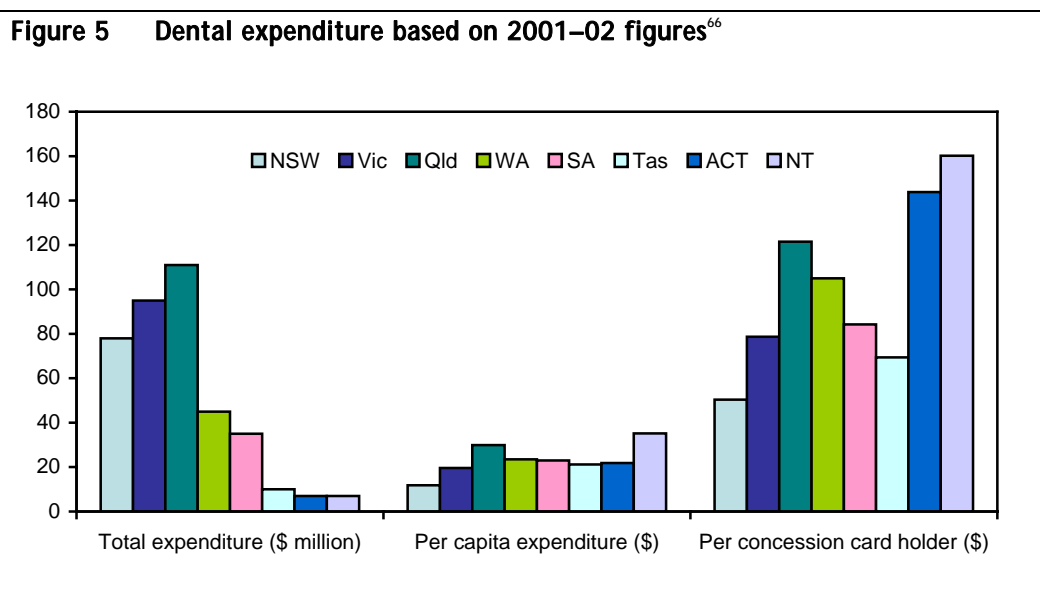
Over 15.5% of total dental spending was attributed to private health insurance funds in 2002–03, which is half the proportion of funds spent a decade earlier.

Direct out-of-pocket expenses account for the remaining expenditure on dental services. This rose from \$984 million and 57.6% in 1992–93 to \$2.96 billion and 67.3% of total expenditure in 2002–03.



The Commonwealth Government contributes a relatively small amount to the provision of dental care (see Figure 4). However, it continues to fund dental care

for specific populations, such as the Department of Veterans' Affairs, Department of Defence, in-patient dental care and outpatient radiological dental services (through Medicare).⁶⁵ It also provides some indirect funding for dental services through the Aboriginal Health Council. Planned changes to Medicare include the provision of limited subsidised dental care for the first time for referred patients with chronic health conditions that are exacerbated by poor oral health, however, the bureaucratic processes are considered by the ADA to be complex and limiting. All states and territories fund the vast majority of public dental services, but spending varies significantly. According to the AIHW, in 2001–02 Queensland had the greatest expenditure (\$111 000 000) and NT and ACT the least (\$7 000 000). Per capita dental expenditure was greatest in NT (\$35.23) and least in NSW (\$11.76). Per concession cardholder spend was also greatest in NT (\$160.16) and least in NSW (\$50.40, see Figure 5, below).



- In NSW, in 2001–02, approximately \$85 710 000 was provided by the state government to cover public dental services.⁶⁷ Currently, the figure is about \$106 million.⁶⁸
- In Victoria, in 2001–02, expenditure for public dental services was \$63.81 million in total.⁶⁹
- In Queensland, the estimated budget for 2004–05 was \$40.5 million for the School Oral Health Service and \$87.4 million for the Adult Oral Health Service. This has increased from \$111 million in 2001–02.
- The expenditure in WA for 2004–05 will be approximately \$44.5 million. The WA Government also contracts some dental services through the University of WA, however, granting as much as \$7.8 million over and above that provided to the Department of Health. The total sector spend will therefore be around \$52 million.
- In 2003–04, funding for public dental services in SA totalled \$46.3 million. In 2001–02, funding was lower, at \$37.1 million.

- In Tasmania, approximately \$15 million is provided each year. In 2001–02, according to the National Oral Health Plan 2004–2013, this figure was lower, at \$9.75 million.
- In ACT, approximately 90% of overall funding of current public dental services (\$7 449 000) is provided by the ACT Government and 10% (\$700 000) is from patient co-payment. In 2001–02, government funding totalled \$5.64.
- In NT, the budget allocation for public dental services in 2004–05 was \$7.11 million. This has increased from \$5 980 000 in 2001–02.

Notes

- 1 Spencer 1999, NSW Public Health Bulletin.
- 2 Sheiham 2005, Bulletin of the World Health Organization 83 (9).
- 3 See Figure 4.
- 4 Pussinen et al, Stroke. 2004;35:2020–3.
- 5 Elter et al, J Periodontol Res. 2004;75:782–90.
- 6 Cueto et al, J Periodontal Res. 2005;40:36–42.
- 7 Montebugnoli et al, J Clin Periodontol. 2005;32:188–92.
- 8 NSW Public Health Bulletin 1999.
- 9 Steering Committee for the Review of Government Service Provision 2005, cited in ADA submission to HoR Standing Committee on Health and Ageing 2005 ‘Inquiry into Health Funding’.
- 10 National Advisory Committee on Oral Health 2004. Healthy Mouths Healthy Lives: Australia’s National Oral Health Plan 2004–2013.
- 11 Armfield et al. 2003. AIHW DSRU.
- 12 AHS Health Status Profiles. NSW Health Dept.
- 13 This and other ongoing research projects are detailed at: <http://www.crroh.uwa.edu.au>.
- 14 Brennan et al. 1997. AIHW DSRU.
- 15 AHMAC 2001, cited in ADA submission to HoR Standing Committee on Health and Ageing 2005 ‘Inquiry into Health Funding’.
- 16 Brennan, Spencer 2004. AIHW DSRU.
- 17 Brennan, Spencer 2002. AIHW DSRU.
- 18 Szuster, Spencer 1997. AIHW DSRU.
- 19 AHMAC 2001, cited in ADA submission to HoR Standing Committee on Health and Ageing 2005 ‘Inquiry into Health Funding’.
- 20 Kruger et al. Knowledge and perceptions of oral health in a rural Community. A report to the Health Department of Western Australia. November 2003.
- 21 AIHW DRSU 2003, cited in ADA submission to HoR Standing Committee on Health and Ageing 2005 ‘Inquiry into Health Funding’.
- 22 This and other research projects are detailed at: <http://www.crroh.uwa.edu.au>.
- 23 Estie Kruger, CRROH, personal communication.
- 24 Kruger et al. Australian Dental Journal 2005.
- 25 Legislative Council Standing Committee on Social Issues’ Inquiry into Dental Services in NSW, transcript 29 June 2005.

- 26 The locations in which dentists are paid additional incentives to practise are divided into three zones and the payment varies between these areas: Zone 1—\$3000; Zone 2—\$5000; Zone 3—\$20 000.
- 27 See *Transport and accommodation assistance for health patients from rural and remote areas*, NRHA, October 2005.
- 28 Legislative Council Standing Committee on Social Issues' Inquiry into Dental Services in NSW, transcript 29 June 2005.
- 29 WA evidence to 1998 Senate Inquiry into the Provision of Public Dental Services in Australia.
- 30 These programs operate in the Hervey Bay and Redcliffe/Caboolture areas.
- 31 AIHW DSRU. Commonwealth Dental Health Program—Evaluation Report 1994–1996. Available at <http://www.aihw.gov.au/publications/health/cdhper94-6/cdhper94-6-c00.html>.
- 32 See reference above.
- 33 House of Representatives transcript, 20/06/05, 3.29 pm.
- 34 Email from John Skinner, Centre for Oral Health Strategy NSW, 13 July 2005.
- 35 Email from Dr John Rogers, Principal Dental Advisor, Dental Health Unit, Department of Human Services.
- 36 Kruger, Tennant. Oral Health Workforce in Rural and Remote Western Australia: practice perceptions. A report to the Health Department of Western Australia. November 2003.
- 37 The most recent National Oral Health Survey was carried out in Australia in 1987–88 and the results of a second survey will not be available for a further 3 years. The figures in this section are from the survey of dental health among adult public patients published in 2004 by the Australian Institute of Health and Welfare (AIHW).
- 38 Slade et al. 1996; Grembowski et al. 1992; Hopcraft & Morgan 2003.
- 39 Legislative Council Standing Committee on Social Issues' Inquiry into Dental Services in NSW, transcript 29 June 2005.
- 40 These are 2003 figures. In 2002, the Hunter area had only 34% fluoridation and regional areas 55%.
- 41 According to the submission by NCOSS to the Legislative Council Standing Committee on Social Issues' Inquiry into Dental Services in NSW, "the levels of funding received within Area Health Services for this scheme means that in reality there is only \$40 available per eligible client". Additional concerns include the low cost of reimbursement for dentures.
- 42 NSW Health Survey 1997, 1998 and 2002 (HOIST). Centre for Epidemiology and Research, NSW Department of Health.

- 43 17 171 general (restorative and denture) services provided through public dental clinics and publicly funded general restorative services through private dentists, and 4089 publicly funded denture services provided through private dental practitioners.
- 44 38 551 and 8649 services, respectively. Note: Metro does not include Adelaide Dental Hospital data (mainly students for general care and specialist care for the State).
- 45 AHMAC 2001.
- 46 National Advisory Committee on Oral Health 2004. Cited in ADA submission to HoR Standing Committee on Health and Ageing 2005 'Inquiry into Health Funding'.
- 47 <http://www.smh.com.au/news/Health/Dental-crisis-exposes-great-divide/2005/02/14/1108229934499.html?oneclick=true>.
- 48 See <http://www.health.vic.gov.au/yourhospitals/dental/> for waiting times for other agencies in Victoria.
- 49 Waiting times by Department of Human Services regions, included in Victorian Auditor-General's report, tabled in Parliament in May 2005.
- 50 Other waiting times include: Endodontics, 38 weeks; Oral Surgery metropolitan/country, 33/28 weeks; Paedodontics, 19 weeks; Periodontics, 40 weeks; Prosthodontics, 2 years.
- 51 Teusner, Spencer 2003. AIHW DSRU.
- 52 National Advisory Committee on Oral Health 2004. Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004–2013.
- 53 ADA submission to HoR Standing Committee on Health and Ageing 2005 'Inquiry into Health Funding'.
- 54 Spencer et al. The dental labour force in Australia: the position and policy directions. AIHW Population Oral Health series No. 2.
- 55 Teusner, Spencer 2003. AIHW DSRU.
- 56 Teusner, Spencer 2003. AIHW DSRU.
- 57 Barnard, White. Australian Dental Association News Bulletin 1999; 266:13–21.
- 58 Legislative Council Standing Committee on Social Issues' Inquiry into Dental Services in NSW, transcript 29 June 2005.
- 59 Teusner, Spencer 2003. AIHW DSRU.
- 60 ADA submission to HoR Standing Committee on Health and Ageing 2005 'Inquiry into Health Funding'.
- 61 Teusner 2005 Australian Dental Journal 50:2.
- 62 Legislative Council Standing Committee on Social Issues' Inquiry into Dental Services in NSW, transcript. 29 June 2005.
- 63 ADA submission to HoR Standing Committee on Health and Ageing 2005 'Inquiry into Health Funding'.

- 64 Private Health Insurance Administration Council 2005. Cited in ADA submission to HoR Standing Committee on Health and Ageing 2005 'Inquiry into Health Funding'.
- 65 ADA submission to HoR Standing Committee on Health and Ageing 2005 'Inquiry into Health Funding'.
- 66 AIHW 'Health Expenditure Australia'. Cited in ADA submission to HoR Standing Committee on Health and Ageing 2005 'Inquiry into Health Funding'.
- 67 Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004–2013. Available at: <http://www.health.sa.gov.au/Default.aspx?tabid=59>.
- 68 Legislative Council Standing Committee on Social Issues' Inquiry into Dental Services in NSW, transcript 29 June 2005.
- 69 Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004–2013. Available at: <http://www.health.sa.gov.au/Default.aspx?tabid=59>.