cohealth
care for all

Submission to:

Inquiry into the Provision of and Access to Dental Services in Australia

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

June 2023

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Contents

Summary....3
About cohealth....5
Terms of reference....6
a) The experience of children and adults in accessing and affording dental and related services....6
b) The adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas....8
c) The interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services....13
d) The provision of dental services under Medicare, including the Child Dental Benefits Schedule....15
e) The social and economic impact of improved dental healthcare....16
f) The impact of the COVID-19 pandemic and cost-of-living crisis on access to dental and related services....17
g) Pathways to improve oral health outcomes in Australia, including a path to universal access to dental services....18
i) Workforce and training matters relevant to the provision of dental services....19

Summary

As a provider of integrated primary health, mental health and social support services to individuals and communities that experience disadvantage in Melbourne, cohealth welcomes the opportunity to contribute to the Senate Select Committee into the Provision of and Access to Dental Services in Australia inquiry into the Provision of and Access to Dental Services in Australia.

Good oral health is essential for physical and mental health and wellbeing. It is an integral part of good general health and means being able to eat, speak and socialise without discomfort or embarrassment. Poor oral health, however, has serious impacts, including pain and discomfort, difficulty eating, impacts on general health, along with concerns about appearance and self-esteem. All of these influence eating, sleeping, work, socialising and mental health.

Despite the importance of oral health care, it is too often missing in healthcare conversations and policy making. Oral health is not included in Medicare as much other primary health care is, meaning that care is largely funded by individuals and private health insurance. People without the financial resources to meet these costs either go without dental care or languish on lengthy public dental waiting lists. Even prior to the current cost of living crisis more than 2 million people cited cost as a reason for delaying or not seeking care, despite needing it.[1]

In our work with diverse communities, cohealth has also observed that in addition to cost, other barriers exist that make oral health care even less accessible for the groups with the greatest need. These are discussed in later in this submission.

Barriers to access to dental care have long been an issue compounding health inequities. The Grattan Institute's 2019 report *Filling the gap: A universal dental scheme for Australia* outlined the serious inequalities of Australia's current dental system and proposed a path to improving this. cohealth encourages the committee to review this report as part of its deliberations. cohealth has long supported efforts to improve access to oral health services, particularly for those who face the greatest barriers to access. As such we are proud to be a member of the Victorian Oral Health Alliance (VOHA), and endorse the VOHA submission to this inquiry.

Recommendations:

1. **Federal and state governments increase investment in public dental care to ensure that people can receive care when they need it**
2. **Increase investment in oral health promotion and early intervention to improve people's oral health and reduce the need for more complex care**
3. **Review funding models and develop more sophisticated approaches to ensure public dental services, including prevention, emergency care and ongoing treatment, are accessible to those who most need it**

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[1] Duckett, S., Cowgill, M., and Swerissen, H. (2019). *Filling the gap: A universal dental scheme for Australia. Grattan Institute.* https://grattan.edu.au/report/filling-the-gap/

4. **Develop and fund community engagement initiatives that work with the communities facing the greatest barriers to oral health care to improve access to care.**
5. **Ensure public oral health funding models and enterprise bargaining agreements deliver competitive employment conditions for oral health practitioners**

About cohealth

cohealth is one of Australia's largest community health organisations, delivering care from over 30 locations across the inner, north, and west of Melbourne as well as statewide services across Victoria. We provide integrated general practice, medical specialist, dental, allied health, mental health, alcohol and other drug, counselling, family violence, and social support services to 50,000 people each year.

People using cohealth services typically experience social disadvantage and are consequently marginalised from mainstream health services or require a higher level of care and support – such as people who are experiencing homelessness, mental illness, use alcohol and other drugs, Aboriginal and Torres Strait Islanders, refugees and asylum seekers, recently released prisoners, LGBTIQA+ communities and people with chronic and complex health conditions.

cohealth has provided public dental care and treatment for over 35 years. Our Oral Health Program provides a range of preventive, restorative and health promoting activities at sites in Kensington, Niddrie and Footscray, and through outreach programs, including the Smile Squad.[2] As a fully accredited oral health provider we offer high quality, low cost or free emergency and general dental care.

Eligible clients are adults with a Health Care Card or Pensioner Concession Card, all children aged 0-12 years, and young people 13-17 years if they or their parents hold a current Health Care Card or Pensioner Concession Card, or if a child is eligible for the Child Dental Benefit Schedule. In line with guidelines from Dental Health Services Victoria we prioritise Aboriginal and Torres Strait Islander peoples, children and young people (under 18 years), people who are homeless or at risk of being homeless, refugees and asylum seekers, people with mental health issues, people registered with disability services, pregnant women and people over 80 years of age.

Our diverse workforce includes registered dentists, dental and oral health therapists, dental prosthetists, oral health educators and dental assistants working together to improve the oral health of our clients. Working as part of an integrated community health service, clients are also able to be easily referred between a range of other health, allied health and community programs and supports.

In 2021-22 cohealth provided oral health services to nearly 9,000 individuals, 43 per cent of who were priority clients. Clients received nearly 45,000 services, including preventative treatments, fillings, root canals, dentures, periodontic treatments and oral surgeries. 2,465 clients were provided vouchers to receive care from private dentists. 54 per cent of clients were born outside Australia, and over 1,000 required interpreters.

cohealth would welcome the opportunity to discuss this submission and our perspectives on the provision and access to dental services in Australia. Please contact Jane Stanley, Advocacy and Policy Advisor on jane.stanley@cohealth.org.au

[2] https://www.health.vic.gov.au/smile-squad

Terms of reference

a) The experience of children and adults in accessing and affording dental and related services

Dental and related services are unaffordable and out of reach for many Australians. Despite the importance of oral health to our physical and mental health and social connection, dental and oral health services are not included in Medicare, and are treated separately to the rest of the Australian health system. As a result, patients are responsible for the vast majority of the cost of dental care.

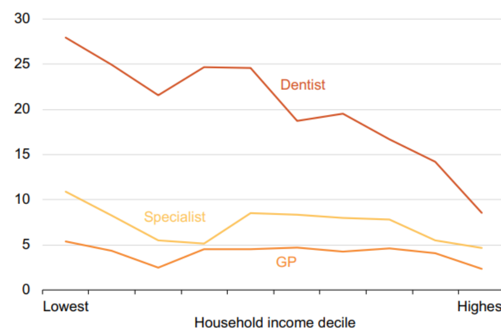
Those able to afford private health insurance receive some assistance with the cost of care, although they still face out of pocket costs and the costs of premiums. Everyone else bears the full cost of oral health care themselves, with 58 per cent of the cost of dental care born by individuals, significantly more than the 11 per cent of the cost of other primary care.[3] Some people are eligible for public dental services, however lengthy wait lists mean it can be years before they receive treatment for often painful dental problems.

As a result of the cost, many people delay or skip oral health care, even when there is a pressing need. In 2016-17 more than 2 million people, or 18.4 per cent of all Australian adults, who needed dental care delayed or avoided dental care because of the cost.[4]

In contrast, only 4.1 per cent of people who needed a GP, 662,500 people, delayed or skipped going to the GP because of the cost.[5]

Not surprisingly, people on low incomes are much more likely to avoid dental care because of the cost. An alarming 27.9 per cent of low-income adults who needed to go to the dentist in the previous 12 months report they skipped or delayed dental care because of cost. This is more than three times higher than for high-income adults.

Figure 1.4: Poorer people skip care due to the cost more often, but people at all income levels skip dental care more than other care
People who missed or delayed care due to cost at least once in the past 12 months, as a percentage of people who needed care, by equivalised gross household income decile



Source: *Filling the gap: A universal dental scheme for Australia. Grattan Institute*

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[3] Duckett, S., Cowgill, M., and Swerissen, H. (2019). *Filling the gap: A universal dental scheme for Australia. Grattan Institute*. https://grattan.edu.au/report/filling-the-gap/
[4] Duckett, S., Cowgill, M., and Swerissen, H. (2019). *Filling the gap: A universal dental scheme for Australia. Grattan Institute*. https://grattan.edu.au/report/filling-the-gap/
[5] Duckett, S., Cowgill, M., and Swerissen, H. (2019). *Filling the gap: A universal dental scheme for Australia. Grattan Institute*. https://grattan.edu.au/report/filling-the-gap/

Federal and state governments have implemented policies over the years to try to provide some relief by providing emergency care and preventative care to specific groups eg public dental services; the Child Dental Benefits Scheme; and school dental programs. However, these have very limited funding, eligibility criteria apply, and community awareness of them can be limited, meaning only a minority of Australians benefit.

Being unable to access oral health care has significant impacts, very often reducing people's quality of life:

- Less preventative care means that people have poorer oral health, and when they do receive dental care, problems are more severe
- Untreated tooth decay
- Gum disease
- Pain
- Difficulty eating, or avoiding certain foods
- Loss of teeth
- Embarrassment smiling or opening mouth
- Work impacts, such as taking time off, or difficulties gaining employment
- Costs of GP care, medications and hospital admissions as alternatives to dental care
- Social isolation
- Mental health impacts such as anxiety, depression, poor self-esteem and social stigma
- Impact on other health conditions, such as diabetes and cardiovascular disease

People from the communities cohealth works with confirm how difficult it is to obtain oral health care. This is particularly so for communities who face various barriers to accessing care, and are therefore vulnerable to poorer health. They tell us that oral healthcare is the most difficult service to access.

> *'In the past I've had to wait a long time to get a dentist appointment; it's been more than four years since I've seen one. I've had pain sometimes and bleeding gums. I felt excited today. I want more of this service for everyone.*
>
> *Today I had a clean and they found some decay. They helped me make a follow-up appointment to get a filling. It's very important to have healthy teeth and healthy gums.'* Public housing resident

Cost is the most widely recognised barrier to oral health care, but lack of knowledge about available services, and perceptions about their availability and safety also prevent access to care.

In 2022, cohealth's Local Partnership bi-cultural workers surveyed culturally diverse residents living in the suburb of Maribyrnong, finding that dental care was the most difficult service to access. The top three barriers making health services difficult to access were identified as language, perceived cost and flexibility of appointment.

cohealth conducted a similar health and wellbeing needs survey with residents living in public housing, boarding and rooming houses in five municipalities across north and west

Melbourne in 2022. Residents living in these settings make up some of Victoria's most vulnerable communities. This survey also found that dental care was the service most needed but the most difficult to access among residents in all accommodation settings. Residents also identified that accessing healthcare was the area where they needed most support.

Understanding eligibility criteria for access low or no cost healthcare is a key challenge. Of the 494 culturally diverse residents surveyed in Maribyrnong over 50 per cent of respondents were eligible for public dental services however 21 per cent of respondents were not aware of their eligibility. Many vulnerable community members are going without the care they need because they believe that care will be too expensive and waiting times too long.

> *'When we talked to the community about what was preventing them from going to the dentist they said there was a five year waiting list before you would get in so they didn't even bother'* North Melbourne Community Connector

Many residents have come to accept poor oral health as the norm and do not expect to have accessible healthcare.

> *'They knew the waiting list for dental treatment was incredibly long, so even if they had level-10 pain, they would just take a Panadol because they thought there's no way they could get it fixed...whether it was a slight problem or a very big problem, they were convinced that care was so out of reach, or that no clinic had time for them.'* Fitzroy Community Engagement Coordinator

It is important to note that these structural barriers to accessing oral health care, particularly cost, are the main drivers of poor oral health. As an Australian study found 'the commonly held view that the poor oral health of poor people is explained by personal neglect was not supported in this study'.[6]

It is clearly very difficult for people on lower incomes to access the dental care they need. The public dental health system aims to provide oral health care for lower income adults and children, however, as described below, it is not funded sufficiently to meet the need.

b) The adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas

Public dental services are, in theory, available to people living on very low incomes and who face barriers to affording private dental care. In Victoria, public dental services are available to:

- Children aged 0–12 years
- Young people aged 13–17 years who hold a Health Care Card or Pensioner Concession Card, or who are dependants of concession card holders

[6] Sanders et al, 2006, quoted in Duckett, S., Cowgill, M., and Swerissen, H. (2019). *Filling the gap: A universal dental scheme for Australia. Grattan Institute.* https://grattan.edu.au/report/filling-the-gap/

- People aged 18 years and over, who are Health Care Card or Pensioner Concession Card holders or dependants of concession card holders
- Children and young people in out-of-home care provided by the Department of Families, Fairness and Housing, up to 18 years of age (including kinship and foster care)
- People in youth justice custodial care
- Aboriginal and Torres Strait Islander people
- Refugees and asylum seekers.

In addition, the following groups receive priority access to public dental services:

- Aboriginal and Torres Strait Islander people
- Children and young people (where they or their parents hold a Health Care Card)
- People who are homeless or at risk of homelessness (with a Health Care Card)
- Pregnant women (with a Health Care Card)
- 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. (with a Health Care Card)

Priority access clients are offered 'next available appointment', and can access general care every 12 months. People who require emergency care, whether priority access clients or those in other public dental eligibility categories, are seen within the prescribed timelines for their designated emergency category. All non-priority access clients who are eligible for service and seeking routine dental or denture care are placed on the waiting list.[7]

i) Shortfall of public dental care

Public dental services are completely inadequate to meet demand across the country. In Victoria more than 1.5 million adults are eligible to access public dental care, however only 124,000 were able to receive care in the 6 months from June – December 2022.[8]

As a result, people can wait an extraordinary length of time for public oral health care. As of March 2023 the average waiting time for general dental care in Victoria was 15 months – well over a year.[9] In some parts of the state people can wait up to two years. During COVID-19 waiting times were even longer, with the average wait time at 31 March 2022 being 30 months. Once-off injections of funds from time to time have brought wait times down, such as one focussed on delayed care as a result of pandemic restrictions. However, with no ongoing increased investment in public detail average wait times will again increase. Having to wait for over a year for dental care is shamefully long.

In the Victorian health system there appears to be no urgency, or incentive, to address these wait times – indeed, the Victorian budget papers state a target wait time for public

[7] https://www.health.vic.gov.au/dental-health/access-to-victorias-public-dental-care-services
[8] https://adavb.org/advocacy/campaigns/public-dental-waiting-times
[9] Waiting time for dental services | Victorian Agency for Health Information (vahi.vic.gov.au)

dental care of 23 months.[10] While there is, rightfully, community and media outcry about lengthy wait times for hospital care and GP appointments, poor oral health and limited access to public care receives scant attention. It is a hidden health issue with significant impacts on people's daily lives.

Public dental service provision is supplemented by the use of vouchers that public providers can give patients to enable them to see a private oral health practitioner. While this practice can assist with increasing care, cohealth holds concerns about this practice being used in an ongoing manner:

- It fails to strengthen the public dental system
- It is a more expensive use of public funds as private providers charge more
- Private providers can – and do – refuse to see some clients. This is particularly so for those with more complex presentations or circumstances, or those who private providers may deem as 'challenging'. Under-resourced public providers meet their needs, incurring the additional associated costs
- Vouchers may not cover the full cost of care at private providers, so people still return to the public system to complete their course of care
- Disruption in continuity of care

With such limited access to, and high demand for, public oral health care, public providers have limited capacity to undertake the health promotion, education and early intervention work that would prevent oral health issues, or treat them before they need complex, expensive care. Victorian public providers are acutely aware of the benefits to clients and the health system of providing this, and support Dental Health Service Victoria's focus on greater emphasis on this area. However, while the system is so under-funded, demand for emergency care so great, and the oral health workforce limited, it is difficult to allocate resources to this vital component of oral health care.

Providing prevention and health promotion work through group programs can be an efficient and effective way to deliver oral health education. However, funding requirements can create a barrier to its delivery. In a trial of group work with new mothers from refugee and asylum seeker backgrounds the cohealth Oral Health Team has found that not all are comfortable providing their details to be registered on the Victorian client database (Titanium). However, in order to receive funding, all work needs to be recorded against individual people with DWAU[11] item codes claimed for each person attending. Requesting this level of detail is not conducive to conducting open, welcoming education/prevention sessions, guided by community participants needs/interests. As a result, no DWAU could be claimed for the work with this group, and revenue was reduced.

Recommendations:

1. **Federal and state governments increase investment in public dental care to ensure that people can receive care when they need it**
2. **Increase investment in oral health promotion and early intervention to improve people's oral health and reduce the need for more complex care**

[10] https://s3.ap-southeast-2.amazonaws.com/budgetfiles202223.budget.vic.gov.au/2022-23+State+Budget+-+Service+Delivery.pdf
[11] DWAU – Dental Waited Activity Units, the basis of public oral health funding

ii) Engaging communities to improve access

Identifying particular groups that are eligible for public dental services, and priority access within these, aims to ensure that care is provided for those facing the greatest barriers to accessing oral health services. However, with differences in individual state and territory oral health care funding, service models and eligibility requirements,[12] accessibility can depend more on postcode than oral health need.

As noted above, many people in the communities that cohealth works in are not aware that they are eligible for public dental services. Increased investment is needed in promoting public dental services, particularly in diverse languages and through the channels most appropriate to diverse communities. Taking information and services into communities, through outreach and out posting, in community languages, and delivering it through trusted community members has been demonstrated to increase knowledge of and engagement with public oral health services.

cohealth recognises that public dental providers are placed in a difficult position regarding promoting their services. With demand far exceeding service availability, there can be concern that promotion may lead to demand that cannot be met. At the same time, this means that people with lower health literacy, who are unable to navigate a complex system, or who do not have someone to support and advocate for them, are less likely to access services. Funding bodies need to adequately resource providers to improve access for all eligible people.

One unexpected finding during cohealth's work taking oral health services into communities was the number of people who had heard media reports about the lengthy wait times for public dental care, and while eligible for priority care, had assumed the wait time would be too long, and had not approached providers. While reporting lengthy wait times is essential to hold funders accountable and advocate for increased funding, an unintended consequence is that it deters some people from seeking care. cohealth encourages more nuanced reporting of wait times that recognises this risk.

Across Australia, guidelines on eligibility, priority groups and target wait times vary. cohealth urges nationally consistent policies to ensure public dental services are equitably provided and reach those with the greatest need.

iii) Improving accessibility for under-served groups

Health systems, including oral health, have traditionally developed in a way that suits providers, with little input from the communities they work with, particularly those that experience some form of vulnerability. This can result in people not feeling comfortable or safe to access and use services, further embedding chronic illness and health inequity.

Equipping clinical teams with the resources to properly engage and support vulnerable clients through the service continuum, from accessing services, preventative care and

[12] https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction

treatment is needed. This can be assisted by employing lived experience staff to help services better understand the client experience and to identify and respond to barriers different communities face.

This approach was recently demonstrated when cohealth's Oral Health Team partnered with the Community Connector[13] program to improve the accessibility of oral health services for public housing high rise communities in north-west Melbourne. Clinicians worked alongside bi-cultural workers with lived experience of the communities they were targeting to understand and respond to barriers. The bi-cultural workers have deep knowledge of the community and could locate vulnerable residents disconnected from healthcare services and support them to access the care they needed. The teams worked together to review resources and develop promotional material that would help residents better navigate the eligibility criteria, and identify language that was more accessible to community.

Conversations started between different teams; cohealth's Oral Health and Engagement teams, which in turn started a new outreach program.

The goal of this program is to address inequity in availability and accessibility of dental services for public housing residents. It requires more than just conversations; it needs co-design, trialling new service delivery ideas, culturally aware and professionally equipped staff, safe and secure spaces for cohealth teams and clients.

A pop-up dental pilot in the Melbourne suburb of Braybrook provided cohealth with evidence of new ways of working that improve uptake and reduced fail to attend rates to zero. Building on this, we started another round of outreach work in 2023, working with public housing estates in north-west Melbourne, offering check-ups and treatment in a dental truck and oral health and service access education for community and staff. Through the work of bi-cultural workers with lived experience in public housing settings, hard to reach residents are accessing onsite oral health after 10 plus years of no access - a big success for the program. This significant gap in access is not surprising given the evidence of low health literacy and access issues for residents in public housing.

To eradicate inequity non-traditional approaches, delivering services where people are, is required resulting in higher engagement and enthusiasm. This works for clients and staff working in outreach teams.

Unfortunately, the specialised skills and innovative approaches to community engagement and provision of care are not generally recognised in funding models. Additional resources are required to support these approaches that increase access to, and effectiveness of, services.

Specialised skills and knowledge are also needed to provide appropriate and culturally safe care to other population groups, for example people with serious mental health issues, people experiencing homelessness, and Aboriginal and Torres Strait Islander communities. Many of the clients cohealth works with experience multiple vulnerabilities,

[13] https://www.cohealth.org.au/community-connectors/

and require additional time and skill. Responding effectively in this way requires additional resourcing. In our experience, it is public oral health providers who provide care to these groups, with private providers often reluctant to work with people with complex social circumstances.

Similarly, the public sector incurs additional costs related to using interpreting services to ensure high quality care for people who speak languages other than English. Again, funding models do not adequately resource this work, including the additional time appointments take interpreters are used.

In geographic areas that include a high proportion of people experiencing disadvantage, such as the areas cohealth works in, people are more likely to be experiencing financial hardship and be unable to afford even small co-payments, impacting on the financial sustainability of services.

It is vital that access to public dental care is improved so that all who need it are able to obtain the care they need in a timely way, and that people's oral health status is not determined by their income. This could be achieved by:

- Enhancing the capacity of the public dental system to respond to need by increasing federal and state investment in the sector
- Reforming public dental funding arrangements to:
    - promote preventative oral health care
    - ensure that public funding models cover the additional and full costs of providing care to diverse groups, such as interpreters, longer appointment times, outreach, and engagement activities
    - develop nationally consistent guidelines on eligibility and priority groups to ensure public dental services reach those with the greatest need
- Working with diverse communities to ensure service promotion, access arrangements and models of care promote access and culturally safe care.

Recommendations:

3. **Review funding models and develop more sophisticated approaches to ensure public dental services, including prevention, emergency care and ongoing treatment, are accessible to those who most need it.**
4. **Develop and fund community engagement initiatives that work with the communities facing the greatest barriers to oral health care to improve access to care.**

c) The interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services

Responsibility for public dental services is shared between the different levels of government. States and territories are responsible for delivering services, while both levels of government provide funding. Currently the Federal Government provides $107m per year for adult dental services through the Federation Funding Agreement (FFA), and funding for the Child Dental Benefits Scheme. In 2020-21 states and territories provided

$946m for public dental services.[14] Assoc Prof Matthew Hopcraft, CEO of Australian Dentists Association Victoria Branch, has observed that this means:[15]

- Around 50 per cent of children aged 0-17 years are eligible to access $1,052 every 2 years for dental treatment through the Child Dental Benefits Schedule.
- Around 30 per cent of adults are eligible to access state-run public dental services. Inadequate funding means that most public dental services have long waiting times for general dental care, and only a fraction of those eligible for public dental care actually receive it.

Not only is public funding insufficient to ensure that everyone who is eligible can receive care, but interactions between the systems cause further inefficiencies.

The Federation Funding Agreement between the Commonwealth and Victoria is renewed on a year by year basis, and is not confirmed until around March in the financial year that it must be spent. As a service provider we then have only three months to spend the funding associated from the Agreement, and the service system cannot ramp up quickly enough to effectively deliver this. This is an annual process, which means that cohealth – and no doubt other providers – faces challenges planning staffing and service provision, which in turn leads to inefficient use of public funds.

It is unclear whether this delay originates at the Federal or state level, or a combination of the two, but these processes need to be improved.

It is vital that funding agreements, including the FFA and state agreements with providers, are for a longer period to enable planning and employment of staff on longer term contracts. While we welcome the 2023-24 Federal budget two-year funding extension, the ideal is for 3-5 year single funding agreements that are inclusive of all funding sources. Indeed, the Productivity Commission's 2017 report, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, recommended seven-year funding terms for contracts in child and family services to overcome the same problems.[16] This would enable us to employ staff on longer contracts, build our services and ensure service continuity over a much longer period of time. This in turn would improve access to services, particularly for underserved groups.

In addition to longer funding periods, funding must be confirmed well prior to the start of the funding period to enable planning and ensure staff retention.

Despite the established connections between oral health and general medical health the two systems often work in isolation from each other and have separate training, funding, regulatory and administrative systems. This adds to system complexity and can be detrimental to people's health.

Oral health care should be recognised as an integral component of primary health care – the first contact an individual with a health concern has with the health system.[17]

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[14] https://matthopcraft.substack.com/p/how-is-public-dental-care-funded
[15] https://matthopcraft.substack.com/p/how-is-public-dental-care-funded
[16] Productivity Commission 2017, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, Report No. 85, Canberra.
[17] https://www.aihw.gov.au/reports/primary-health-care/primary-health-care-in-australia/contents/about-primary-health-care

However, oral health care tends to be absent from any discussion of the broader health system. For example, it was not mentioned in the report of the Strengthening Medicare Taskforce[18], and receives only passing references in *Australia's Primary Health Care 10 Year Plan 2022-2032*[19] and the *National Preventive Health Strategy* 2021–2030.[20]

d) The provision of dental services under Medicare, including the Child Dental Benefits Schedule

Despite the vital importance of oral health to a person's overall health and wellbeing, dental services provided under Medicare are very limited. From the time of Medicare's introduction, dental services have been excluded. Concerns about the additional cost and the possibility of having to fight the dental profession at the same time as winning doctors contributed to the exclusion of dentistry from Medicare.[21] Commonwealth involvement in oral health care has been sporadic since then.

The Child Dental Benefits Scheme (CDBS) commenced operation on 1 January 2014. It aims to address declining child oral health, and target Commonwealth expenditure on dental services to children in greater financial need.[22] The program provides eligible children aged between 0 -17 years access to up to $1,052 over 2 calendar years in benefits for basic dental services. Children are eligible if they or their parent receives certain payments from Services Australia, including Family Tax Benefit Part A and Parenting Payment.[23] Approximately 50 per cent of Australian children are eligible for CDBS.

CDBS is an important program to increase access to dental care for lower income children, and establish sound oral health care from a young age. However, only 30-40 per cent of eligible children access it. While evidence shows that the CDBS has increased access to dental care, a significant proportion of eligible children don't access it, and there are underserved populations that require urgent additional support to access dental services.[24]

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[18] https://www.health.gov.au/resources/publications/strengthening-medicare-taskforce-report?language=en

[19] https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032

[20] https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030?language=en

[21] https://matthopcraft.substack.com/p/how-is-public-dental-care-funded

[22] https://www.health.gov.au/resources/publications/report-on-the-fourth-review-of-the-dental-benefits-act-2008?language=en

[23] https://www.servicesaustralia.gov.au/eligible-payments-for-child-dental-benefits-schedule?context=22426

[24] Storman, N and Sexton, C (2022) *Has the Child Dental Benefits Schedule improved access to dental care for Australian children?* Health and Social Care in the Community, Volume 30, Issue 6 https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.13803

Issues contributing to the low access of CDBS include:

- Limited community awareness of the program
- Some private providers promote that they provide 'free' services for children. In reality, there is a maximum payment under the CDBS, and the scheme covers specific services. Once the child's CDBS allocation is used up, the service stops, unless the parents can afford fees. Parents are unable to make an informed decision about the best use of CDBS funding and can find that their child is only at the very early stages of a course of care.
- Families then turn to public providers to complete care, however, as the CDBS component has by then been exhausted, State funding is used for remaining treatment.
- Private providers also may charge a gap fee which parents are not aware of, result in financial difficulties for families and/or a reduction in treatment.

The CDBS requires greater promotion to eligible families, including working with diverse communities. There is also a need for improved transparency regarding costs, and planning for meeting any costs over the CDBS cap.

Programs that only provide benefits to children also fail to address their needs as they grow older, nor the needs of adult family members and individuals. Regular dental check-ups and care needs to continue be affordable and accessible throughout the lifetime to prevent later oral health issues. Including dental services in Medicare would allow low income families to continue their dental treatment into adulthood.

e) The social and economic impact of improved dental healthcare

The Grattan Institute's 2019 report *Filling the gap: A universal dental scheme for Australia* outlines the many costs of poor dental healthcare:

- Pain, discomfort and isolation
- Worsening of general health conditions such as diabetes and cardiovascular disease
- Effect on mental health
- Costs on the broader health system, including additional GP visits and avoidable hospital admissions

At cohealth we hear every day about the serious impact delayed oral health care has on people's lives. Examples from our services illustrating the ways deferring care impacts on health and wellbeing, and lead to more costly dental procedures include:

- A resident attending one of cohealth's pop-up dental clinics at the public housing high rise in Carlton highlighted they had not been to the dentist in over 10 years out of fear of the cost. As a result, they experienced long term pain and tooth decay and had to access emergency dental care. Early intervention and treatment would have been better for this person's health, and reduced the need for more costly treatment.

- A cohealth Peer Worker reported withdrawing from social activities out of embarrassment and to avoid the stigma attached to having missing teeth. Their front teeth were replaced through subsidised dental care, increasing their confidence in public spaces. After their teeth were replaced they felt comfortable returning to the workforce and interacting with the community again. The social impact poor teeth can have on an individual's mental health should not be overlooked.

As with other health conditions, providing oral health care, prevention and education early reduces costs to individuals and the health system in the longer term. Significant economic gains would be achieved from improving dental health care.

f) The impact of the COVID-19 pandemic and cost-of-living crisis on access to dental and related services

The COVID-19 pandemic, and the public health measures introduced to limit its spread, significantly restricted the provision of both public and private dental care. For significant periods of time in Victoria dental care was restricted to emergency care only, resulting in reduced access to care. In relation to children, a study of CDBS access in 2020 showed significantly fewer dental services provided compared with the same periods in 2019.[25] The study authors conclude that:

> 'The COVID-19 pandemic has had a significant impact on the provision of dental services to children from lower socioeconomic backgrounds who already experience higher levels of dental disease and disadvantage in accessing dental care. Although the restriction of dental services was deemed necessary in order to minimize the risk of transmission of COVID-19 in the dental setting, the impact of these restrictions on oral health will be long lasting. Given the chronic and progressive nature of dental disease, the deferral of necessary dental care is likely to contribute to poorer oral health and long-term problems for many Australians.'

In Victoria this restriction of dental services resulted in a significant increase to waiting lists, with people on existing lists waiting longer, new people being added to lists while people were not being taken off and people who were receiving treatment being shifted to a 'return to service post COVID-19' waiting list.

The Victorian Government has provided significant additional funding to try and reduce the impact of COVID-19 on waiting times. Given significant workforce shortage in the public sector, and the very short timeframes and nature of the funding, the provision of vouchers for clients to use in the private sector was the only option for cohealth and most other community dental agencies. This works well for people who have simple treatment needs and easy access to a private dentist. However, for many people in cohealth's catchment access to private dentists is limited. Their oral health needs are complex and not easily met through a voucher system, and continuity of care is affected. We

[25] Hopcraft M, Farmer G. *Impact of COVID-19 on the provision of paediatric dental care: Analysis of the Australian Child Dental Benefits Schedule*. Community Dent Oral Epidemiol. 2021 Aug;49(4). https://pubmed.ncbi.nlm.nih.gov/33314322/

anticipate that waiting lists will again rise, with these people returning to the public system which still has the same level of capacity. While the additional funding to reduce waiting lists due to COVID-19 was welcome, sustained investment is required to strengthen the public dental system and improve oral health outcomes.

The cost-of-living crisis is placing many people and families under enormous financial strain. In such circumstances spending on essentials such as housing, utilities, food and education are prioritised. Eighteen per cent of Australians in 2016-17 delayed or skipped dental care because of cost, so it is reasonable to assume that even more people will be foregoing dental care as a result of the cost-of-living crisis. The personal and economic costs of forgone dental care will be exacerbated.

g) Pathways to improve oral health outcomes in Australia, including a path to universal access to dental services

Any pathway to improve oral health outcomes must acknowledge the structural drivers of poor oral health such as trying to live on a low income, homelessness and insecure housing, precarious employment and experiences of discrimination and racism. It must be recognised that while access to care does influence health outcomes, only a small degree of oral health is attributable to the utilisation of dental services. Addressing the building blocks of good health is vital to improve all health outcomes, including oral health outcomes. cohealth urges the Committee to recommend the government take urgent action to reduce poverty (particularly by increasing the rate of JobSeeker payment), invest in social housing, ensure people have suitable, secure employment, and address racism and discrimination.

Nonetheless, it is also imperative that access to dental services is improved for people who currently face barriers to care. cohealth supports approaches that lead to universal access, such as including oral health care in Medicare. As well as improving access to oral health care, this would have the additional benefit of bringing the mouth into the rest of the health system, treating the body as the whole it is.

Nonetheless, we recognise that this will involve significant change and cost (although cost must be assessed against the wider economic benefits of improving oral health). As such, a staged approach to moving towards universal care would be pragmatic. It is vital that the main recipients of benefits are those for whom dental care is currently out of reach, and who have the poorest dental health. Perversely, universal services can compound health inequities as those with the greater resources and higher health literacy access services, while those with the greatest need can still miss out on the services they are entitled to.

Early stages of moving to universal dental services must focus on improving the dental health of those with the greatest need, including older people, people with disabilities, people with serious mental health conditions, people who experience homelessness, refugees and asylum seekers, children and young people in out of home care, and people on low incomes. Specific provisions need to be developed to address the barriers faced by these groups, including:

- Ensuring co-payments do not create a barrier to access. Even the small co-payments applicable to public dental clients can create a barrier to access
- Rectifying the distribution of providers, which are currently more available in higher socio-economic areas
- Provision of interpreting and translating services
- Provision of longer appointment times, and specialised training, to work with clients with complex needs, such as disability, serious mental health conditions, or experiences of homelessness
- Capacity to provide outreach services to engage community members and take services to underserved communities
- Employing community navigators or lived experience workers to engage with community members

As described above, it is vital that non-traditional approaches are developed to ensure that services reach those who face barriers to access. Addressing inequity in the availability and accessibility of dental services requires more than just consulting with groups, it needs co-design, trialling new service delivery ideas, culturally aware and professionally equipped staff, and safe and secure spaces.

i) Workforce and training matters relevant to the provision of dental services

The public dental sector in Victoria is experiencing significant workforce shortages across all professions: dental assistants, oral health educators, oral health therapists with adult scope, dental technicians, dental prosthetists, and dentists. These shortages are more marked in regional and rural areas. Due to limited public sector funding the salaries offered to public professionals is less than in the private sector. Public dental services are therefore at a significant recruitment disadvantage. This is exacerbated in Victoria where dentists working in the public sector are paid less than those in other states.[26] Without rectifying these pay inequities it will remain difficult for public oral health services to attract and retain the staff they require.

cohealth urges the development of a workforce strategy that addresses shortages of all disciplines, retention strategies that foster supported career paths within the sector, and ensures sufficient workforce in rural and regional areas.

A workforce that reflects the community it works in helps make services accessible and people feel safer and more comfortable using. As cohealth Oral Health Team members have observed:

- 'Their fears, doubts and anxieties subside when they realise I speak their language'
- 'Many clients are from my cultural background. Just being able to talk to them in our language helps them trust and feel comfortable with me'

Reviewing and reimagining the workforce structure to explore alternative workforce models could enhance the scope and reach of public dental services. Similar work has occurred in other sectors, enabling services to more quickly reach those who need them.

[26] https://www.bitemagazine.com.au/why-victorias-public-sector-dentists-arent-happy/

For example, during COVID-19 non-immunisation nurses administering vaccinations and COVID testing was performed by a range of different health professionals. While there have already been changes in oral health, such as oral health therapists with adult scope, there may be further alternatives that enhance the delivery of care. It would be particularly valuable to determine what the population groups who receive public oral health care need to enhance their access to services. For example, would bi-cultural workers or community connectors with training in oral health provide a useful addition to oral health teams? Should there be roles dedicated to screening, to ensure that people are seen in order of need, and what qualifications would be required?

cohealth suggests the government work with community members, oral health providers, professional associations, education providers, and funding bodies to examine if innovative workforce structure changes could increase access to care.

Public services also rightly expect their staff to have the training to work effectively with their local communities. cohealth, for example, requires oral health staff to undertake additional training in areas such as: mental health first aid; de-escalation; CPR; diversity and inclusion; and working with interpreters. Funding models should include provision for this additional training.

Public dental services provide vital training to oral health students across all disciplines. This needs to be appropriately resourced to ensure that students have a quality learning experience, and that patients receive quality care, delivered by students who are overseen by an experienced demonstrator. Graduate programs should also be developed and funded, as they are for many other health disciplines, recognising that new graduates need to consolidate their skills. Frequently students trained in the public sector move to the private sector once they have qualified, as they can earn higher incomes there. Improving public sector remuneration would assist public oral health services to retain the staff they have trained.

Recommendation:

5. **Ensure public oral health funding models and enterprise bargaining agreements deliver competitive employment conditions for oral health practitioners**

k) Any related matters

Gaining and maintaining of accreditation standards, as assessed by an external provider, is a requirement of funding for public providers. This is not a requirement for private providers, who via health insurance rebates and vouchers are also accessing public money. Accreditation requires significant resourcing, which should be acknowledged in funding for public providers.