



2009-10 Pre-Budget Submission

March 2009

Authorised by
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Table of Contents

Executive Summary	2
1. Introduction	3
2. About the Australian Dental Association	4
3. Dental Workforce and Education	5
3.1 Summary of recommendations	5
3.2 Recommended initiatives	5
3.3 Supporting information	7
4. Access to Dental Care	9
4.1 Commonwealth-Funded National Oral Health Plan	9
4.2 Indigenous Oral Health	11
4.3 Older People	13
4.4 Children and Adolescents	15
4.5 People with Special Needs	17
4.6 Department of Veterans' Affairs	19
4.7 Congenital Anomalies of the Dentition	20
5. Oral Health Promotion	22
5.1 Summary of recommendations	22
5.2 Recommended initiatives	22
5.3 Supporting information	22
Appendix – Dental Health Expenditure	24
State and Territory Oral Health Budgets	26
References	28



Executive Summary

- Urgent attention is required to ensure improved dental health delivery to Australians. The oral health of the Australian population is mixed. Many in the community enjoy good oral health, supported by timely access to high quality dental care. By contrast, others in the community suffer from poor oral health, spending excessive periods – sometimes years – waiting to receive basic dental care in our public system.
- Internationally, WHO (2006) ranks Australia 17th among OECD countries for adult dental caries.¹ Groups among the adult population whose oral health is particularly poor include older people, Aboriginal and Torres Strait Islander peoples, people living in rural and remote communities and people with special needs.
- The Australian Dental Association (ADA) believes that the Commonwealth, States and Territories should do more to address poor oral health. As the States and Territories appear not to be meeting the needs of large sections of the community, the Commonwealth must take up a leadership role, and work cooperatively with the States and Territories or take over public dentistry to deliver basic dental services to the financially disadvantaged to ensure that the minimum standard of dental health is achieved throughout the community.
- The ‘blame game’ must stop and it is now time to have Federal dental plans that effectively assist those most in need.
- An impasse seems to have been reached between the Federal Senate which wishes to retain the Medicare Enhanced Primary Care Scheme² and the Government’s call for the introduction of an ill-defined and underfunded Commonwealth Dental Health Program. An effective compromise between the conflicting positions espoused would be to accept the ADA’s long held recommendation to **limit eligibility of Federal dental schemes to financially disadvantaged Australians and to focus attention to those groups**. This would prove to be an effective way to not only provide many more Australians with access to dental care, but would also help alleviate the dire position of public dental waiting lists.³
- The ADA’s Pre-Budget Submission outlines a clear plan to improve the oral health of the Australian population. In some areas we repeat calls made in our 2008-09 submission, while in others we highlight new areas for action. In both cases, this submission identifies areas where investment by the Commonwealth Government would lead to significant improvements in oral health for many in need in the Australian community.

ADA recommendations for additional expenditure in 2009-10

Item	Additional funding for 2009-10 (\$)
Dental Workforce and Higher Education	\$26,395,000
Commonwealth-Funded National Oral Health Programs (additional to \$290m pledge)	\$192,000,000
Indigenous Oral Health	\$2,000,000
Older People	\$10,550,000
Children and Adolescents	\$153,500,000
People with Special Needs	\$29,750,000
Department of Veterans’ Affairs	\$4,500,000
Additional items for Medicare - Anomalies of the Dentition	\$9,452,000
Oral Health Promotion	\$6,500,000
TOTAL	\$434,647,000

1. Introduction

The Australian Dental Association (ADA) is pleased to present its Pre-Budget Submission to the Federal Government for the 2009-10 financial year.

This submission contains a range of recommended budget and policy initiatives for the consideration of Government and provides the context and background that have led to these recommendations.

The submission has been structured to comprise sections on each major policy area considered important by the ADA and is summarised as follows:

- Dental Workforce and Higher Education
- Access to Dental Care
 - Commonwealth-Funded National Oral Health Program
 - Indigenous Oral Health
 - Older People
 - Children and Adolescents
 - People with Special Needs
 - Department of Veterans' Affairs
 - Additional Items for Medicare – Congenital Anomalies of the Dentition
- Oral Health Promotion

By way of background information, this submission also provides a summary on dental health expenditure from the report *Health Expenditure Australia 2006-07*, and contains a summary that compares expenditure by each State and Territory (see Appendix).

We trust the Government will consider the recommendations of ADA Inc. favourably and would welcome the opportunity to discuss the submission in further detail if requested.



*Dr Neil D Hewson
Federal President
Australian Dental Association Inc.*

19 March 2009



2. About the Australian Dental Association

- The Australian Dental Association (ADA) is the peak national professional body representing about 11,200 registered dentists and dental students engaged in clinical practice.
- The ADA represents the vast majority of dental care providers.
- ADA members work in both the public and private sectors. The primary objectives of the ADA are to encourage the improvement of the health of the public and to promote the art and science of dentistry.
- The ADA is celebrating its centenary in 2009.
- Further information on the activities of the ADA and its Branches can be found at www.ada.org.au.

3. Dental Workforce and Education

- Continued development of dental workforce training is critical to ensuring that optimal patient care requirements are met into the future.
- Existing training places are now more than required, however funding is required for dental clinical infrastructure and support for academic staff.
- The ADA proposes a range of budget measures designed specifically to address areas of challenge and/or pressure points in this important area.

Snapshot

- Clinical infrastructure is required for increased student numbers.
- Difficulties in attracting and retaining teaching staff impacts dental workforce development.
- Graduates generally eschew the public sector in favour of more attractive private sector employment, thus adversely impacting public sector service levels and waiting lists.

3.1 Summary of recommendations

The ADA recommends the following budget items for consideration:

Initiative	Details	Total
3.2.1	Clinical training infrastructure	\$20,000,000
3.2.2	Dental Workforce Review	\$75,000
3.2.3	Academic staff support	3 academic positions per dental school (total 18 positions) at \$150,000 per position \$2,700,000
3.2.4	Regional student dentistry scholarship	25 scholarships at \$25,000 per student \$625,000
3.2.5	Rural Student Placement Support Scheme	\$5,000 for 200 students \$1,000,000
3.2.6	Dentist relocation support	25 relocations at \$25,000 per relocation \$625,000
3.2.7	Additional Commonwealth-supported dental student places	30 places at \$18,000 per student \$540,000
3.2.8	Clinical placement year	
3.2.9	Debt forgiveness	10 students - 25% CSP debt discount per year (based on \$32,000 student debt) \$80,000
3.2.10	HECS reimbursement	\$250,000
3.2.11	Rural Bonded Scholarship	\$250,000
3.2.12	Rural retention scheme	\$250,000
TOTAL		\$26,395,000

3.2 Recommended initiatives

Further detail on the initiatives listed in 3.1 appears below. The ADA encourages Government to consider the recommendations in their entirety.

3.2.1 Dental clinical training infrastructure

Significant funding is required to increase dental clinical positions/chairs to accommodate the dramatic increase in student numbers. Placing such clinics in rural and remote areas would assist with dental workforce maldistribution problems.



3.2.2 Initiate Dental Workforce Review

Government to undertake a comprehensive Dental Workforce Review in order to estimate the industry's future workforce needs to then support and establish appropriate education and training resources. The review would examine:

- ratios of general dentists/dental specialists/allied dental personnel;
- comparison of rural schools/expanding existing schools with peripheral rural clinics;
- ideal dentist/population ratios;
- future public patient funding proposals and their impact; and
- where rural patients currently access their dental services.

3.2.3 Increase academic staff support

Government to provide financial assistance directly to existing fully accredited schools of dentistry to assist with recruitment and retention of academic staff to alleviate shortages in the current academic dental workforce.

3.2.4 Regional student dentistry scholarship

Create further scholarships for dental students from rural and remote parts of Australia as one measure to address the maldistribution of dentists. (The ADA advocates the creation of RAMUS-type scholarships for dental students.)

3.2.5 Rural Student Placement Support Scheme

Fund rural placement schemes for students from all dental schools to allow students to gain enhanced real-life practical clinical experience and concurrently support public dental service provision in rural and regional areas.

3.2.6 Extension of medical practitioner relocation program to dentists

Extend the existing relocation program available for medical general practitioners and specialists to dentists to relocate to areas of dentist shortage in regional, rural and remote areas.

3.2.7 Increase in Commonwealth-supported dentistry student places

Increase the number of Commonwealth-supported (formerly HECS) places in the long established dental schools for Australian dental students by a total of 30 places nationally to replace fee-paying places and therefore not leave new graduates with a high debt on graduation.

3.2.8 Clinical placement year

Fund a clinical placement year for graduating university and overseas-trained dentists, for graduating dental hygienists and dental therapists. This placement year, to be served mainly in the public dental sector (although some private rural placements should be considered in areas of special need) would ensure better trained practitioners and increase access to dental care for public sector patients and significantly reduce waiting lists.

This initiative will also require additional infrastructure and mentors to be provided by the States and Territories.

A structured program is being devised by the ADA for presentation to the Minister for Health later in the year. No estimate funding is available.

3.2.9 Introduce Graduate Rural & Regional Employment Incentive

Provide a moratorium or debt forgiveness incentive for all dental graduates who in turn agree to provide their services in regional, rural and remote areas or in the public sector. The extent of the moratorium or debt forgiveness should reflect the period of time the dental graduate undertakes practice in these particular areas. The longer the period of guaranteed service in regional, rural or remote areas, the greater the moratorium or debt forgiveness.

3.2.10 Extend HECS Reimbursement Scheme to dentistry graduates

The HECS Reimbursement Scheme, available to medical students, should be extended to dental students to encourage graduates to take up placements in rural and regional Australia.

3.2.11 Extend Rural Bonded Scholarship program to dentistry graduates

The Rural Bonded Scholarship, available to medical students, should be extended to dental students to encourage graduates to take up placements in rural and regional Australia.

3.2.12 Introduce Rural Dentists Retention Scheme

Introduce Rural Dentists Retention Scheme whereby the Government provides financial payment to the practitioner as an incentive to remain practising in remote regions. Such funding might assist the practitioner meet the common concern that many have as to the quality of education that may be available to their children in rural regions. A payment provided might offset boarding school fees that may need to be incurred for the practitioner's child(ren) to achieve the level of education the practitioner considers their child(ren) should receive.

3.3 Supporting information

3.3.1 Workforce

The five long established Australian dental schools have increased the intake of dental students in recent years, and four new schools have been or are being established. While the ADA is confident overall that dental workforce needs will be met in the future, it is still concerned that not enough is being done to rectify problems with Australians accessing dental care, particularly in rural and remote areas and in the public sector. This distribution of the current dental workforce is negatively impacting on the delivery of services in areas of need.

According to Australia's National Oral Health Plan,⁴ the impact of this distribution means:

"... [M]any Australians access dental care, if it is available at all, only in emergencies or when advanced oral disease is present. This leaves little opportunity for preventive care and oral health promotion, and treatment tends to focus on extraction rather than restoration of teeth."

In 2005, there was an estimated 10,074 practising dentists, which represented a ratio of 49.5 dentists per 100,000 population.

Workforce shortages are most significant in areas away from metropolitan centres, for example:

- Major cities – 58.6 dentists per 100,000 population
- Inner regional – 34.6 dentists per 100,000 population
- Outer regional – 28.5 dentists per 100,000 population
- Remote/Very remote – 19.8 dentists per 100,000 population⁵

The impact of workforce shortages is also felt strongly in the public sector. Of the 10,074 practising dentists, 83.0% worked in the private sector.⁶ A vacancy rate of 20.2% for general dentists and 16.8% for specialist dentist positions has been reported in the NSW public sector.⁷ Such shortages add to the difficulty experienced in accessing care by the reported 500,000 Australians on public dental waiting lists, with an average waiting time of 27 months.⁸ State and Territory governments need to improve public sector working conditions. An intern program will also help boost the public sector.

3.3.2 Training

Resources need to be allocated to ensure the proper training of currently enrolled students.

Dental schools are facing the immediate difficulty of attracting and retaining teaching staff, a trend that is common in most developed countries.⁹ This is largely due to the gap between academic salaries and remuneration for dentists working in private practice.¹⁰ The recently created dental schools at Charles Sturt University, La Trobe University, Bendigo and James Cook University's (JCU) Cairns campus may assist in increasing the number of practising dentists. However, before that can be properly achieved such universities will need to address the (worldwide) shortage of dental academics. We are concerned that if this issue is not addressed, the schools (both new and long established) will not be able to provide the quality education required to maintain the standards required for Australian dental services.

The simple creation of more dental graduates will not necessarily solve distributional issues in rural areas. The concept of opening schools regionally has been based on the premise that graduates will remain in the area where they are educated and practise there. The ADA feels that unless the dentists are also sourced from these areas there is, in fact, no evidence to indicate that the additional places created will do other than attract students from any region of the country to enter the faculty and on graduation return to metropolitan areas to practise. If, however, this education experience was supplemented by way of provision of some financial incentive to have these students remain in these rural and remote regions, then this may go a long way to solving these problems.

The ADA, at the time, expressed concern about the announcement to provide funding to JCU for the creation of a new dental school. The ADA believed that the stated intention of seeking to train students at Cairns and Townsville with a view to them practising in this area is ill conceived. Investment of this funding in long established schools with provision of financial incentives to students to practise in remote areas would seem to be a much more effective long term solution.

In order to estimate future workforce needs and so establish the appropriate education and training resources, the ADA believes a comprehensive Dental Workforce Review is necessary. Once such a review is completed, possible modifications to existing training can be undertaken tailored to the needs identified.

3.3.3 Higher education

Today's generation of dental students are graduating with higher debts than previous generations. According to the University of Melbourne's Vice Chancellor, Glyn Davis, funding to Australian universities is one-third less today than in the mid-1970s. Among OECD countries, Australia is the only country where government funding per student has fallen since 1995.¹¹

The ADA is concerned at the extraordinary cost of dental degrees as revealed in the 2008 Good Universities Guide. According to the Guide there are 111 university degrees costing over \$100,000 and 13 degrees costing over \$150,000. Dentistry is in the higher bracket.

As the table below shows, a Commonwealth-supported dental student studying at the University of Sydney will graduate with a debt of \$54,686. The equivalent student, who receives Government support during their undergraduate degree, but then pays the full upfront fee for their graduate dental degree, will graduate with a debt of \$146,154. A dental student who pays the full upfront fee for both their undergraduate and graduate studies would commence their working life with a \$190,176 debt. These figures have increased since then. The ability to be able to afford this debt is restricting access to schools to the wealthy. Ability, not wealth, ought to be the real determinant of who can study dentistry.

Student contribution to dental degree – University of Sydney 2007

Year	Commonwealth-supported place (\$)	Combined Commonwealth support and full-fee (\$)*	Domestic full-fee paying place (\$) (both degrees)
3-year undergraduate Science Degree	\$21,354	\$21,354	\$65,376
4-year graduate BDent Program	\$33,332	\$124,800	\$124,800
Total cost	\$54,686	\$146,154	\$190,176

Source: <http://www.usyd.edu.au/fstudent/undergrad/apply/costs.html> - accessed 16 August 2007

* These figures are based on the assumption that the student's first 3-year undergraduate Science Degree was a Commonwealth-supported place.

While the ADA does not believe that the prospect of these higher student debts will necessarily reduce the number of students applying to study dentistry, it is nonetheless concerned that dental graduates – commencing their professional career with significant student debts – will seek employment based more strongly on earning capacity. These will usually be in the big cities in private practice and graduates will be less likely to work in areas of need, such as the public sector, where remuneration is lower than in the private sector. If graduates eschew the public sector in favour of the private sector, trends in the maldistribution of Australia's dental workforce will widen and public sector waiting lists will continue to grow.

A study by Silva *et al*¹² found that the decision by recent dental graduates to move into the private sector is motivated by a range of factors, including continuity of patient care, work environment, a broader range of clinical experience and remuneration.

A disparity in wages exists for dentists working in the private sector compared to those in the public sector. Recent graduates who work in the NSW private sector can earn significantly higher wages (\$101,100)¹³ than those in the New South Wales public sector (\$65,649).¹⁴

4. Access to Dental Care

- Assumption of a leadership role by the Federal Government in improving access to dental care for those financially disadvantaged in Australia is essential.
- There are large public waiting lists for general dental care from public dental services and currently the average time on a waiting list is 27 months.

Snapshot

- Lack of access to dental care experienced by financially disadvantaged Australians is of great concern to the ADA.
- Federal funding for dental care must be targeted to financially disadvantaged Australians and not be provided universally.
- Utilisation of private dental practices is essential to meet demand.

4.1 Commonwealth-Funded National Oral Health Plan

4.1.1 Summary of recommendations

The ADA recommends the following budget items for consideration:

Initiative	Details	Total
4.1	Additional funding required in addition to stated pledges to date of \$290m	\$192,000,000
Total		\$192,000,000

4.1.2 Recommended initiatives

Further detail on the initiatives listed in 4.1.1 appears below. The ADA encourages Government to consider the recommendations in their entirety.

Difficulties exist for some financially disadvantaged sectors of the community to access dental services due to cost. Federal funding should be directed to those members of the community and not be made universally available.

An impasse has been reached between the Federal Senate which wishes to retain the Medicare Enhanced Primary Care Scheme¹⁵ and the Government's call for the introduction of an ill-defined and underfunded Commonwealth Dental Health Program. An effective compromise between the conflicting positions espoused would be to accept the ADA's long-held recommendation to **limit eligibility of Federal dental schemes to financially disadvantaged Australians and to focus attention to those groups**. To do this the ADA suggests:

4.1.2.1 Funding rules be established

Federal funding of dental care should be directed solely to the financially disadvantaged. The priority given to spending within this group should be based upon patient dental health information and waiting list demand. Funding should assist the financially disadvantaged (e.g., concession card holders). The establishment of the Dental Benefits Schedule via the Dental Benefits Act should facilitate this.

4.1.2.2 Access to private sector services

Private sector dentists should be utilised to deliver services, where the public sector is under resourced.

4.1.2.3 Eliminate variations in public dental schemes

A common model of dental schemes is required. Currently there is a plethora of schemes available for funding of public sector dental services. To enhance acceptance by the profession and provide the same benefits to the public all over Australia, a common model should be developed. Integration within the one over-riding Plan would ease the administrative and budgetary burden of State and Territory dental services, as delivery of care provided by Federal funding will be able to be coordinated through the one scheme.



Within the over-riding Plan, specific targeted projects of dental care would then form sub-sets of this Plan. The existing Teen Plan, for example, would be brought within the single program. It would then represent one specific targeted group eligible for care. Other targeted funding to specific groups with their own sub-set of eligibility criteria could then be created.

A uniform method of funding for services under the Plan should be created. Whilst bulk billing may be an option for the patient/dentist, the ability to seek a co-payment from the patient must be provided; as exists now in the Teen Dental Plan and EPC Scheme.

Statistical data obtained through the provision of services under the Plans could then be used as the basis for future oral health campaigns. As announced by the Government, prevention programs are a worthwhile investment as such campaigns will reduce the long-term financial health burden. General health would be likely to improve as there is demonstrable evidence to relate oral health and general health.

4.1.2.4 Design should be compatible with State and Territory aims

Funding provided should not be in lieu of State and Territory funding of dental care. Benchmarks for access to Federal funding need to be created that ensure retention, or in some cases increases, of the level of State and Territory funding. It should also ensure States and Territories remain the first point of access with Federal funding being targeted to financially disadvantaged groups.

4.1.2.5 Annual fee limits

To create some certainty of funding, an annual fee limit should be imposed on dental care costs payable to individuals under the Scheme.

4.1.2.6 Private health cover

Any co-payment required to be paid for services should be capable of rebate under private health insurance.

4.1.2.7 Funding required

The current pledge of funding of \$290 million over four years is inadequate. It equates with the level of Federal funding made available in 1996. Since then:

- the Australian population has increased by approximately 20%;
- CPI increases have been in the order of 29%; and
- waiting lists have also increased dramatically.

4.2 Indigenous Oral Health

- Aboriginal and Torres Strait Islander people experience greater levels of disease and disability.
- According to *The Oral Health of Aboriginal and Torres Strait Islander Children*, poor dental health, including dental decay, is more common among Aboriginal and Torres Strait Islander children than other Australian children.¹⁶
- Less than 5% of remote Aboriginal and Torres Strait Islander pre-school children brush their teeth regularly.¹⁷

Snapshot

- Special initiatives are required to bridge the gap in Aboriginal dental health.

4.2.1 Summary of recommendations

The ADA recommends the following budget items for consideration:

Recommendation	Sub-total	Total
Oral health training for Aboriginal health workers	\$1,000,000	\$1,000,000
Vocational training assistance for Aboriginal dentists	\$700,000	\$700,000
Fluoridation facilities		\$300,000
Creation of 15 AGI Dental Teams for equivalent of six months each year		*
Total		\$2,000,000+

4.2.2 Recommended initiatives

Further detail on the initiatives listed in 4.2.1 appears below. The ADA encourages Government to consider the recommendations in their entirety.

4.2.2.1 Involve Aboriginal health workers

There must be a focus on provision of care through the involvement of Aboriginal health workers. Aboriginal health workers need to receive oral health training which focuses on oral health promotion; then later additional vocational and higher education places should be set aside to increase the number of Aboriginal and Torres Strait Islander people working in oral health.

4.2.2.2 Recognise cultural sensitivities

Cultural sensitivities and understanding of the Indigenous population make it important that Aboriginal and Torres Strait Islanders are trained as dentists. Scholarships are required to encourage this.

4.2.2.3 Develop partnership

A collaborative partnership agreement is needed between the Department of Health and Ageing (DoHA) and State and Territory services to determine division of service delivery and funding and to ensure accountability.

4.2.2.4 Initiatives developed need to include:

- Provision for a comprehensive examination of all remote Indigenous children aged from 2-15 years.
- Support for the roll-out of the new information management system to collate comprehensive oral health data on each child and to monitor and evaluate the progress of the follow-up services.
- Delegate the responsibility for examining and treating all 2-4 year-olds other than those living in remote homeland communities to State and Territory remote dental teams.
- Delegate the responsibility for services to all 5-15 year-olds and 2-4 year-olds living in remote homeland communities to Australian Government Intervention (AGI) Dental Teams.
- Set up an appropriate number of AGI Dental Teams to complete the Follow-Up Program by the end of 2009.



- Equip AGI Dental Teams with mobile equipment and all necessary support systems.
- AGI Dental Teams comprised of a dentist, dental hygienist or dental therapist, dental assistant, an administrator and a local Indigenous community liaison worker.
- Provision will need to be made for substantially increasing access to general anaesthetic procedures.
- Investigate fluoridating the water of small communities and/or introduce school-based preventive programs in conjunction with the suppliers of food and drink to ensure that there is a reduction in the foodstuffs affecting oral and general health.
- A service agreement be implemented to ensure the continuation of a sustainable oral health service to Indigenous children in remote communities.
- A comprehensive primary health care program must also be implemented to complement the clinical services.

4.2.3 Supporting information

4.2.3.1 Factors contributing to the poor oral health of Aboriginal and Torres Strait Islander people are:

- Poor access to dental care in communities in remote parts of Australia.
- Fewer dental services are available and people are required to travel further to obtain care.^{18,19}
- Lack of access to fluoride – fluoridation of drinking water is successful in preventing dental decay.²⁰ Rural and remote communities are less likely to be fluoridated.
- Greater exposure to risk factors such as smoking, poor diet, alcohol, stress and trauma.²¹⁻²³
- Social exclusion, unemployment, stress and addiction, all of which contribute to poor health, including poor oral health.²⁴⁻²⁶
- Changing lifestyle patterns – a change from a traditional diet (high in fibre and low in saturated fats and sugar) to one high in sugar, saturated fats and refined carbohydrates.^{27,28}

4.2.3.2 ADA representatives have recently been involved with the DoHA and the Helping Hands project with AGI teams to tackle the huge problems of Indigenous oral health throughout the Northern Territory. The inability to be able to manage these children in all but an emergency response highlighted the failure to provide an adequate and sustainable public oral health system.²⁹

4.3 Older People

- The prevalence of tooth decay, gum disease and oral cancer for people aged over 65 years is higher than for the general population.
- The number of people aged over 65 years is projected to rise from 2.2 million in 1997 to 4 million by 2021.
- As people get older their ability to look after themselves diminishes.
- As people get older decreased mobility and reduced income impacts on their ability to access care.

Snapshot

- Older people are retaining their natural teeth in greater numbers than before.
- Older people experience a range of oral health problems at greater rates than the general population.
- The need for greater prevention and care must therefore be addressed as a matter of priority.

4.3.1 Summary of recommendations

The ADA recommends the following budget items for consideration:

Recommendation	Sub-total	Total
Oral health examination for residents in aged care accommodation (assuming 60,000 examinations annually)	\$100 per examination	\$6,000,000
Development of oral health plan for each person in residential accommodation	\$2,000,000	\$2,000,000
Oral health training manual	\$250,000	\$250,000
Portable dental equipment	\$2,000,000 plus \$3,000,000 per year to support	\$2,300,000
Total		\$10,550,000

4.3.2 Recommended initiatives

Further detail on the initiatives listed in 4.3.1 appears below. The ADA encourages Government to consider the recommendations in their entirety.

4.3.2.1 Leadership needed

The Commonwealth Government should provide leadership to implement the range of initiatives outlined in Australia's National Oral Health Plan.

4.3.2.2 Health assessments, oral hygiene programs and transportation to be provided.

In so doing provide:

- Improved oral health assessments through the Home and Community Care program and the Aged Care Assessment Service.
- Improved oral hygiene programs to assist older people to live independently in the community.
- Ensure that oral health is taken into account when developing a care plan for people in residential accommodation.
- More affordable transport to enable older people to attend dental appointments.
- Greater funding for public dental care.



4.3.3 Supporting information

- 4.3.3.1 In 1979, 60% of older people had no natural teeth. By 1989, this had fallen to 44% and is expected to drop to 20% by 2019.³⁰
- 4.3.3.2 Teeth extractions associated with gum disease increase with age.³¹ Many residents in residential care facilities have compromised oral health and high levels of oral disease.
- 4.3.3.3 The Australian Institute of Health and Welfare's, *Residential Aged Care in Australia 2006-2007: a statistical overview*, at 30 June 2007, stated there were 170,071 operational residential aged care places, an increase of 3,780 compared with 30 June 2006.³²
- 4.3.3.4 Oral diseases and related conditions can lead to pain, problems with speech, discomfort when eating certain foods and concerns about self appearance.³³
- 4.3.3.5 The South Australian Dental Service has initiated two innovative and significant projects, the *Oral Health for Older People: Nursing Home Care Program* and the *Better Oral Health in Residential Care Project*. More of these initiatives must be examined and plans put in place universally to address the oral health needs of people in residential aged care facilities.

4.4 Children and Adolescents

- Dental caries is the single most common chronic disease among children.³⁴
- In 2002, over 47% of six year-olds had cavities in their baby teeth. On average, for every six year-old child in Australia there were approximately two decayed, missing or filled baby teeth.
- Over 42% of 12 year-olds have cavities in their permanent teeth.
- Trends showing a decline in childhood oral health status were also reported in a national survey, *The Child Dental Health Survey, Australia 1999: Trends across the 1990s*.³⁵

Snapshot

- Decay rates of primary teeth (baby teeth) across children of all age groups increased during the period from 1996-1999.
- A surge in hospitalisations and general anaesthetic procedures for young children requiring dental treatment must be addressed.

4.4.1 Summary of recommendations

The ADA recommends the following budget items for consideration:

Recommendation	Sub-total	Total
Provision of additional funding to supplement school dental services – estimate only	\$290,000,000 (Federal Government to contribute 50%)	\$145,000,000
Funding for oral health promotion activities – estimate only	\$2,500,000	\$2,500,000
Additional funding for the increase in incidence of school dental services	\$12,000,000 (Federal Government to contribute 50%)	\$6,000,000
Total		\$153,500,00

4.4.2 Recommended initiatives

Further detail on the initiatives listed in 4.4.1 appears below. The ADA encourages Government to consider the recommendations in their entirety.

Additional Government funding should be allocated to:

4.4.2.1 Children under 12

Funding so that all children below 12 years of age, who come from families which suffer economic hardship, can access and receive an oral examination and treatment. \$290 million is required to provide up to one million additional dental consultations and treatments for persons in the age group 1 to 11 years. This is based upon the same rebate level being available as is available in the Teen Dental Plan.

4.4.2.2 Increase school dental services

Provide additional funding for the increase in the incidence of school dental services throughout the country.

4.4.2.3 Increase oral health promotion

Oral health promotion that targets adolescents should be developed in conjunction with the ADA which has considerable experience in such campaigns. It should take into account risk factors – such as poor diet, eating disorders, soft drink consumption, obesity and smoking – which contribute to poor adolescent oral health.



4.4.3 Supporting information

- 4.4.3.1 The report, *Oral Health of Aboriginal and Torres Strait Islander Children*, shows that poor dental health, including dental decay, is more common among Aboriginal and Torres Strait Islander children than other children, and that Indigenous children who are less well off and those in rural and remote areas are most affected. Hospitalisation for treatment of dental decay is at higher rates among Aboriginal and Torres Strait Islander children.
- 4.4.3.2 In 2002, over 47% of six year-olds had cavities in their baby teeth. On average, for every six year-old child in Australia there were approximately two decayed, missing or filled baby teeth.
- 4.4.3.3 Decay rates of primary teeth (baby teeth) across children of all age groups increased during the period from 1996-1999.
- 4.4.3.4 A surge in hospitalisations and general anaesthetic procedures for young children requiring dental treatment has also been evident.

4.5 People with Special Needs

- ‘Special needs’ refers to people with intellectual or physical disability, or medical or psychiatric conditions, which increase their risk of oral health problems or increase the complexity of their oral health care.³⁶
- People with special needs experience much higher levels of oral disease, with considerably less access to treatment.
- Little is being done by governments to redress this.³⁷

Snapshot

- Governments must ensure that special needs patients who often lack resources are targeted for publicly-funded dental services as this group deserves and requires the best possible health and dental care.
- Treatment required by many special needs patients is beyond the capacity of the private surgery setting of dental practitioners.

4.5.1 Summary of recommendations

The ADA recommends the following budget items for consideration:

Recommendation	Sub-total	Total
Training carers/health workers	\$2,000,000	
Funding for provision of services (estimating provision of services to the value of \$450 per patient and provision to 50,000 patients per year)	\$22,500,000	
Subsidising dental treatment in private practice (\$175 per patient to 10,000 patients per annum)	\$1,750,000	
Building special facilities in public clinics	\$2,500,000	
Educating and developing the capacity of the dental workforce	\$1,000,000	
Total		\$29,750,000

4.5.2 Recommended initiatives

Further detail on the initiatives listed in 4.5.1 appears below. The ADA encourages Government to consider the recommendations in their entirety.

4.5.2.1 Means-tested scheme creation

Creation of a means-tested scheme specifically targeting delivery of care to special needs patients.

4.5.2.2 Increased funding

Direct Government funding to ensure people with special needs enjoy improved oral health by:

- Training carers/health workers in oral hygiene and diet for people with special needs.
- Funding dentists and hygienists to provide dental services for people with special needs in clinics, institutions and in their homes.
- Subsidising such dental treatment in private practice.
- Building special facilities in public clinics.
- Educating and developing the capacity of the dental workforce (including fostering of a multidisciplinary approach) to provide care to people with special needs.
- Provision of services to this group could form an additional subset to the CDH Plan outlined earlier in this submission.

4.5.3 Supporting information

4.5.3.1 Australia's National Oral Health Plan highlights the following points:³⁸

- There are approximately 2.4 million people aged 65 years of age or under in Australia with at least one disability or long-term health condition.
- 6% of Australians are reported to have severe/profound disabilities.⁴⁰
- Expert opinion estimates that around one million people would be in the 'special need' category for oral health.
- People with special needs experience higher levels of oral health disease and poorer access to oral health care than the general population.
- For many people with special needs, socio-economic disadvantage adds to their risk of oral disease and difficulties in accessing dental care.
- Access to dental care is difficult for those with special needs, particularly for those in community-based housing.
- Treatment can also be more difficult when care is obtained, due to complex medical conditions, physical and behavioural barriers to oral health.

4.5.3.2 The dental profession's limited ability to provide care to certain special needs groups (due to it being beyond the capacity of the private surgery setting) exacerbates this inequity in access to care in so far as, currently, special needs groups are receiving predominantly emergency care, not general dental care.

4.5.3.3 More patients are therefore requiring treatment through hospital admission or under general anaesthesia (GA). Public sector health services information has revealed there is limited access to GA facilities/theatre sessions/specialist anaesthetist staff often required to provide such treatment.

4.5.3.4 There are many special needs patients who are best treated in a hospital setting or a dedicated clinic. There is a need for both the public and private sectors to work together to improve access to care for these patients.

4.6 Department of Veterans' Affairs

- Dentists respect the contribution made by veterans to our country and are proud to be able to provide their services to them.
- The current level of fees payable for dental services by the Department of Veterans' Affairs (DVA) for veterans and their entitled dependants is so grossly inadequate, dentists may no longer be able to afford to provide services to these people, thus depriving them of adequate dental care.

Snapshot

- Due to the scale of fees payable for DVA services, DVA patients may not be able to continue to receive the treatment they deserve.
- Most dentists treating veterans do so at a significant reduction to their normal fee levels.
- Fees for services to veterans and their families should be at normal fee levels.

4.6.1 Summary of recommendations

The ADA recommends the following budget items for consideration:

Recommendation	Sub-total	Total
Increase to scale of fees	6% increase	\$4,500,000

4.6.2 Recommended initiatives

Further detail on the initiatives listed in 4.6.1 appears below. The ADA encourages Government to consider the recommendations in their entirety.

4.6.2.1 Review of fees

An immediate review of fees paid for DVA services be undertaken to create fees at a level commensurate with ADA Fee Survey results and other health index variations.

4.6.2.2 Annual review

Annual review of fees to occur so dental fee scales equate to customary fee levels charged by dentists.

4.6.3 Supporting information

4.6.3.1 The DVA exploits the benevolent nature of the dental profession and other health providers that provide services to this group by consistently setting low scales of fees for services and providing annual adjustments to those fee scales at levels below the CPI.

4.6.3.2 Recent increases of a little over 2% to already reduced scales of fees are grossly inadequate.

4.6.3.3 Most dentists treating veterans do so at a significant reduction to their normal fee levels. For many, it is increasingly uneconomic to treat DVA patients and already, unfortunately, some dentists have reduced their patient list or ceased to perform work for veterans. Members of the ADA (comprising over 90% of Australian dentists) have expressed their concern.

4.7 Congenital Anomalies of the Dentition

- Many Australians suffer congenital dental abnormalities.
- The more common of these is Amelogenesis Imperfecta (AI) (inherited disorders of tooth enamel) with a prevalence of 1:4000 births.
- Defects in the structure and function of dentine known as Dentinogenesis Imperfecta (DI) occurs in approximately 1:8000 children.

Snapshot

- Congenital anomalies of the dentition occur in 1:6000 births.
- Congenital anomalies cause catastrophic structural, functional and aesthetic defects.
- Individuals with these anomalies have reduced quality of life, self esteem and social functioning.
- Anxiety and cost are the two main barriers to seeking appropriate treatment.
- Outcomes are significantly improved if preventive and restorative care is implemented early.

4.7.1 Summary of recommendations

The ADA recommends the following budget items for consideration:

Recommendation	Sub-total	Total
Pre-school	Estimated total number for Australia = 50 Mean cost of treatment per child = \$2,500	\$4,500,000
Primary school	Estimated total number for Australia = 90 Mean cost of treatment per child = \$4,300	\$387,000
High school	Estimated total number for Australia = 200 Mean cost of treatment per child = \$15,000	\$3,000,000
Young adulthood	Estimated total number for Australia = 180 Mean cost of treatment per child = \$33,000	\$5,940,000
Adulthood	Ongoing maintenance will be essential, particularly for those individuals with full mouth rehabilitation requirements	
Total		\$9,452,000

4.7.2 Recommended initiatives

Further detail on the initiatives listed in 4.7.1 appears below. The ADA encourages Government to consider the recommendations in their entirety.

4.7.2.1 Funding through MBS

The Commonwealth Government provides funding through additional MBS items for treatment as outlined in the table above.

4.7.2.2 Funding to be directed to:

- Pre-school – Principally preventive and protective restorative treatment.
- Primary school – Principally preventive and protective restorative treatment, for example, fissure sealants, cast onlays on first permanent molars and minimal preparation anterior veneers to prevent tooth tissue loss, sensitivity and caries whilst simultaneously improving aesthetics.
- High school – Principally orthodontic with ongoing preventive and some protective restorative treatment, for example, orthodontic treatment prior to final full mouth rehabilitation. For certain types of AI, late orthodontic treatment and orthognathic surgery is required to manage the associated significant skeletal discrepancies. Ongoing minimal preparation of composite restorations is required for both prevention of wear and maintenance of aesthetics.

- Young adulthood – Principally prosthetic rehabilitation with some late orthodontics and orthognathic surgery.
- Adulthood – Ongoing maintenance will be essential, particularly for those individuals with full mouth rehabilitation requirements.

4.7.3 Supporting information

- 4.7.3.1 The genetic aetiology of these conditions creates a disproportionately high burden of care for a small number of families.
- 4.7.3.2 There is an increased risk of dental caries, tooth wear and periodontal disease.
- 4.7.3.3 In the long term, these individuals will require comprehensive full mouth rehabilitation, the outcomes of which are optimised by good paediatric oral healthcare.

5. Oral Health Promotion

- Support for oral health promotion will have a very positive effect on the long term dental and general health of all Australians.
- Oral disease and general health are linked.⁴¹
- Prevention and early detection of oral disease will reduce overall health expenditure.

Snapshot

- Common oral diseases such as tooth decay and oral cancers are largely preventable.
- Early detection and interception greatly improves costs and outcomes.
- Investment in prevention and education programs will lead to enhanced oral and general health for Australians and result in greater long term savings in expenditure for future health care.

5.1 Summary of recommendations

The ADA recommends the following budget items for consideration:

Recommendation	Sub-total	Total
Funding for initial roll-out of dental health information to 12-17 year-olds		\$4,500,000
Provide supplementary funding to organisations promoting oral health		\$2,500,000
Total		\$6,500,000

5.2 Recommended initiatives

Further detail on the initiatives listed in 5.1 appears below. The ADA encourages Government to consider the recommendations in their entirety.

5.2.1 Commence funding of oral health promotion

Invest in health promotion programs which focus on risk factors that contribute to poor oral health.

5.2.2 Fluoridation

The benefits of fluoridation should be promoted.


Water fluoridation should be adopted as part of a Government's health policy and should be implemented in non-fluoridated communities.

5.2.3 Support oral health promotion

Provide supplementary funding to existing promoters of oral health promotion.

5.3 Supporting information

- 5.3.1 Education of individuals as to the importance of oral health will avoid the serious consequences of bad oral health and would result in significant savings in future dental care costs.

- 
- 5.3.2 Contemporary oral health promotion recognises that many diseases – such as heart disease, stroke, cancer, diabetes, periodontitis and tooth decay – share common risk factors including smoking, poor diet, alcohol, stress, hygiene and trauma and common health factors such as improved diet and exercise.^{42,43}
 - 5.3.3 Social class, education, income, lifestyle, environmental factors, psychological stress and oral health behaviour are associated with variables of oral health status.⁴⁴
 - 5.3.4 Successful Government campaigns such as *Sun Smart* and QUIT demonstrate the benefits of prevention.
 - 5.3.5 There is no Federal Government funding of oral health promotion.
 - 5.3.6 Solid scientific evidence exists that water fluoridation has proven to be an efficient, effective and equitable public health measure for reducing the prevalence of dental decay in all age groups.

Appendix

Dental Health Expenditure Australia 2006-07

According to a new report released by the Australian Institute of Health and Welfare, *Health Expenditure Australia 2006-07*, growth in health expenditure is keeping pace with the economy.

Health expenditure comprises recurrent and capital expenditure on hospitals, medical services, dental services, patient transport services, other health practitioner services, community and public health services, medications, aids and appliances, health research and the administrative systems that support these services.

Total expenditure on health in Australia reached \$94 billion or \$4,507 per person in 2006-07, an estimated rise of \$7.3 billion since 2005-06.

After adjusting for inflation, the increase was 4.8%, which is similar to the average annual growth rate of 4.9% over the previous decade.

The growth in expenditure on health was similar to the growth in spending on all goods and services. As a result, the health expenditure to Gross Domestic Product (GDP) ratio remained at 9%, the same as in 2005-06 and 2004-05.

Almost 70% of health expenditure in Australia was funded by governments, with the Australian Government contributing \$40 billion (42%), and state, territory and local governments contributing \$25 billion (26%). The remaining \$29 billion (31%) was funded by individuals, private health insurers, and other non-government sources. Although the Australian Government has consistently been the largest single source of funds over the period 1996-97 to 2006-07, its funding share has declined in recent years. The peak was 44% in 2000-01.

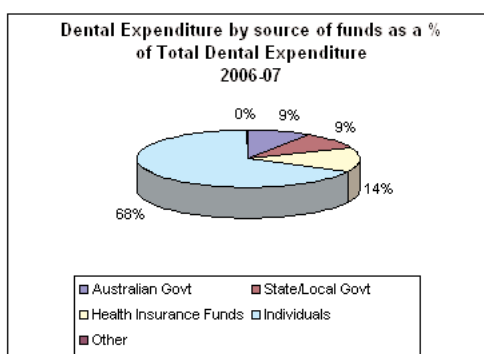
The three major areas of health expenditure - hospitals, medical services and medications - accounted for 72% of all recurrent spending on health in 2006-07, which was similar to the pattern of expenditure seen over the last decade.

Dental services

The total amount spent on dental services in 2006-07 was \$5.7 billion. This represents 6.1% of the total health expenditure.

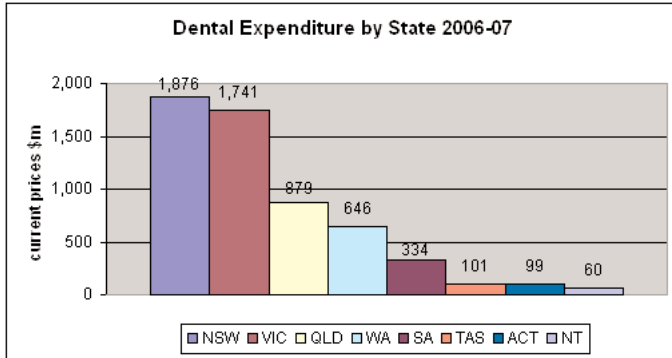
Individuals funded 67.3% of the \$5.7 billion spent on dental services in 2006-07 and 18.2% or \$1.0 billion was funded by Government. For the period 2003-04 to 2006-07, real growth in dental services expenditure averaged 1.8% per year - 2.4 percentage points below the annual real growth in total recurrent health expenditure of 4.2%. The majority of dental services (90.4% or \$5.2 billion) were provided by private providers, with the remainder by state and territory government providers (9.6% or \$0.5 billion).

A breakdown of dental expenditure by source of funds as a percentage of total dental expenditure is shown in the figure below.



Source: AIHW *Health Expenditure Australia 2006-07*.

A breakdown of dental expenditure by State is shown in the figure below.



Source: AIHW Health Expenditure Australia 2006-07.

A full copy of the report can be downloaded from: www.aihw.gov.au/publications/hwe/hea06-07/hea06-07.pdf



State and Territory Oral Health Budgets 2008-09

	2008/2009 State & Territory Dental Budgets (\$)	Population as at June 2008 ¹	Per capita dental expenditure (\$)
Tasmania	\$23,084,000	498,200	\$46.33
Northern Territory	\$9,480,000	219,900	\$43.11
Queensland	\$150,000,000	4,279,400	\$35.05
South Australia	\$56,000,000	1,601,800	\$34.96
Western Australia	\$63,380,000 ²	2,163,200	\$29.30
Victoria	\$139,300,000	5,297,600	\$26.29
Australian Capital Territory	\$8,491,599 ³	344,200	\$24.67
New South Wales	\$150,000,000	6,967,200	\$21.53
Total	\$599,735,599	21,374,000	\$28.06

Notes

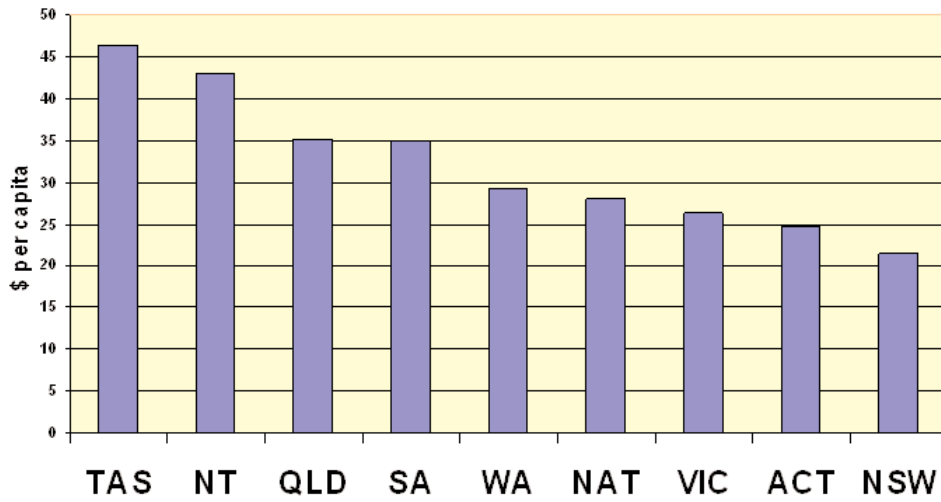
- A. Funding in Column 2 is funding allocated by state and territory governments and does not include funding from the Commonwealth Government under the Enhanced Primary Care (EPC) Medicare dental benefits, Commonwealth Dental Health Program (CDHP), or Medicare Teen Dental program.
- B. This information was sourced from publicly available information or by contacting state and territory public dental services.

¹ Australian Bureau of Statistics, 3101.0 Australian Demographic Statistics, June 2008 (released 2 December (<http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0>))

² Includes \$6.2M in income

³ Includes \$816,935 miscellaneous user charges

State and Territory Public Oral Health Budgets 2008-09




Source: Australian Dental Association (NSW Branch).



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