



**APOH has Conducted a Critical Marginal Seats Survey of the Dental Policies of Labor, Coalition, Green and Democrat Candidates.** *All parties chose to respond centrally.*

### **The APOH Survey and Analysis Identifies:**

- **Strengths and Weaknesses in Coalition and Labor Dental Policies**
- **Policy Gaps**
- **Critical Role of the Greens and Democrats in Driving Structural Reform**
- **Commitment by All Parties to Improving Dental Health**

### **Current Labor and Coalition Policies**

Labor proposes reinstating funding to States similar to the Keating Dental Scheme discontinued in 1996. Funding of \$290M for 1M consultations is planned over 3 years. The Coalition supports newly expanded dental Medicare provisions for people with chronic diseases up to \$2,125 per year per person.

### **The Coalition Dental Medicare Policy**

#### **Strengths:**

- Medicare is an uncapped fund, so that there is no limit on expenditure.
- For people with chronic disease, the Coalition policy offers up to \$6,375 of dental treatment over a 3 year period

#### **Weaknesses:**

- Need for pre-existing medical chronic disease and referral by a medical practitioner are unnecessary barriers to accessing care

***APOH Chairman Hans Zoellner says: "If you have diabetes or heart disease, \$6,000 of dental Medicare over 3 years will be great, but most people don't have chronic illnesses and can still end up one of 32,000 preventable dental hospitalizations a year"***

***"If Medicare can cover spectacles, why shouldn't essential dental services be covered? It makes no sense to keep dentistry out of the Medicare mainstream."***

### **The Labor Policy of Giving States \$290M for 1 Million Consultations:**

#### **Strengths:**

- State funding is inadequate so improved funding for the public dental system is required

#### **Weaknesses:**

- The current \$290 M Labor proposal is less than the old Keating scheme, and needs to be increased to \$636M to allow for inflation and a 29% increase in demand for public dental services
- States like NSW with half per capita funding compared with Qld are not expected to increase their own investment, effectively rewarding negligent and punishing diligent States.
- Only 83,000 people per year out of 650,000 on the waiting list will be helped, because most people need 4 appointments for a course of care (250,000 people out of 1M appointments over 3 years = 83,000/year)
- An average patient will only receive a maximum of \$1,160 of dental treatment over 3 years
- Waiting lists after 3 years will still be 630,000, based on projected increased demand for public services due to the ageing population.

***Zoellner says: "Labor policy might help public patients, but will struggle to cope with demands of the ageing population. More than twice as much money is needed" "If you can get past Medicare barriers, the Coalition policy is 5 times more generous per person"***

Of concern to APOH is Labor's intention to discontinue the current dental Medicare initiative, which only started a few days ago (Nov 1), because they feel it has defects and had poor uptake in an earlier form.

***Zoellner says: "Why does Labor want to scrap dental Medicare instead of fixing it? If they think nobody will use it, why not just leave it and see how it goes?"***



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## Policy Gaps

### **Dental Faculties Need Targeted Funding to Build the Dental Workforce**

A projected shortage of at least 1,500 dental clinicians by 2010 requires not just money for new dental schools, but funding to attract and retain dental academics in badly degraded dental faculties.

***Zoellner says: "Few dentists go into academia, which involves at least 3 to 4 years of living on a shoe-string doing a PhD, and pays about half the salary of private practice."***

Funding to dental schools also fails to allow for the high level of student supervision. Unlike any other clinical university course, dental students do irreversible procedures on patients, and this requires intense clinical supervision by dentists.

***Zoellner says "Who is their right mind would want to be treated by a dental student without proper supervision? Dental schools need extra funding to pay for clinical mentors."***

### **Dental Internships are Needed to Build up the Public Dental System and Improve Training**

Dental internships have been recommended by APOH as well as a 1998 Senate Inquiry, a 2005 NSW Upper House Inquiry, and the Australian Dental Association. A dental internship would improve training, expand the public dental system, and also provide improved rural public dental services.

The Greens and Democrats agreed with APOH that dental internships should be introduced with rural rotations to help rural communities. Labor was unclear, indicating a need for but not specifying policies to address the dental workforce. The Coalition made no comment regarding internships.

***Zoellner says: "Britain, the USA and even Brazil and Bangladesh have some form of dental internship - Why should Australia lag behind the rest of the world? Dental internship is the most sensible way to quickly expand the public system, get some rural services going, and improve training"***

### **Greens and Democrats Recognize a Need for Urgent Structural Reform**

Only the Greens and Democrats indicated clear appreciation of a need for urgent structural reform.

***Zoellner says: "Dentistry is a mess and needs urgent reform. Whoever wins Government, the Greens and Democrats will have an important job pressing for change"***

### **All Candidates Committed to Improving Dental Health.**

***Zoellner says: "Commitment to the idea of improved dentistry is a good start, but needs further commitment to policies for actual change"***

### **APOH Calls For Policy To:**

- Expand dental Medicare to include all essential dental services
- Improve the proposed Commonwealth Dental Scheme by adjusting for inflation and accounting for the increased demand for public services, committing at least \$636M over 3 years
- Establish a dental internship, to improve training, expand the public workforce and increase rural services
- Improve funding to established dental faculties, so that they can attract and retain the academics needed to build the dental workforce

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#### Media Inquiries:

APOH is an independent think-tank and advocacy group for improved dental services comprised of a wide representation of stake-holders and experts. APOH can best be contacted via the Chairman: A/Prof Hans Zoellner: hzoellne@mail.usyd.edu.au, Mobile 0403 785 783



# **Synopsis of Critical Marginal Seats Survey of Election Dental Policy: *All Labor, Coalition, Green and Democrat Candidates, as well as Party Leaders, and Health and Education Ministers and Shadow Ministers***

Survey Issued 21 October 2007  
Results Returned by 3 November 2007

**Seats Surveyed: Kingston SA, Wakefield SA, Makin SA, Hindmarsh SA, Adelaide SA, Bonner Qld, Moreton Qld, Blair Qld, Herbert Qld, Longman Qld, Flynn Qld, Braddon Tas, Bass Tas, Hasluck WA, Stirling WA, Swan WA, Cowan WA, Solomon NT, Corangamite Vic, Bendigo Vic, Parramatta NSW, Wentworth NSW, Lindsay NSW, Eden-Monaro NSW, Bennelong NSW, Dobell NSW, Macquarie NSW, Richmond NSW, Banks NSW, Barton NSW, Lowe NSW, Page NSW - All Parties Chose to Respond Centrally**



## Detailed Synopsis of Response to APOH Election Dental Policy Survey

APOH conducted a survey issued on October 21 October 2007, of Labor, Coalition, Green and Democrat candidates in all critical marginal seats, and received a central response from all political parties. Leaders of all parties were also surveyed, as were the Health and Education Ministers and Shadow Ministers.

A background document was provided to all candidates surveyed, and is appended to the end of this survey summary.

The below table summarizes the detailed responses to individual questions posed by APOH, to which APOH requested Agree / Disagree answers.

Neither Labor or Coalition parties provided Agree / Disagree answers, but did nonetheless indicate the general direction of their policies, while responses from the Democrats were occasionally qualified.

Original survey response sheets can be obtained from APOH by contacting the Chairman, A/Prof Hans Zoellner:  
 email: hzoellne@mail.usyd.edu.au  
 Mobile: 0403 785 783

| Questions Posed to Candidates / Party  | Responses to Questions  |  |                  |
|--|---|--|------------------|
|  | Labor   | Coalition  | Democrats Greens |
| 1<br>Federal government is responsible for Medicare and training the dental workforce                | Agree   | Implicit agreement. Cite recent investment in new dental facilities, Medicare and Health Insurance Rebate scheme | Agree            |
| 2<br>The federal government has responsibility to properly fund dental facilities in universities    | Agree   | No comment, but agreement implied by reference to Federal investment in universities                             | Agree            |
| 3<br>State governments are responsible for delivering public dental services                         | Agree. but indicate that the Federal government also has a share of responsibility to ensure fair access. | Agree  | Agree            |
| 4<br>Dental disease causes significant suffering for Australian citizens and can be life-threatening | Agree   | No comment made, but response appears to imply agreement   | Agree            |



|  | Disagree   | Disagree   | Disagree  |
|--|--|--|---|
| 5<br>It is reasonable for the 5% to 10% of dentists working in the public system to be responsible for treating 35% to 50% of the population eligible for public dental services         | Disagree and indicate significant shortages in public health workforce.  | Indirect comment provided that the States are responsible for public dental services | Disagree  |
| 6<br>The state public system should focus on dental services for people who have medical problems, and who because of their illness are unable to be treated in private dental practices | Agree some Australians with specific medical conditions have difficulty accessing private services. Believe public system should provide access to those unable to access care under private system.<br><br>No clear statement regarding possible re-focusing of the role of public system | No comment made  | Disagree. Believe in universal access to publicly funded health services. Suggest refocus would cause funds to flow from public system to private. Concern for out of pocket expenses if there were Medicare. |
| 7<br>Structural reform is urgently required to improve access to dental services   | Acknowledge inequities in access to care, for example rural areas and believe policy measures needed to ensure fair and equal access for all Australians.<br><br>Do not indicate what policies they suggest  | No comment made  | Agree   |

**Response to questions 1-7 testing views regarding State and Federal responsibilities, and the need for urgent action.**

There was good agreement that the Federal government is directly responsible for Medicare and dental Faculties, and that States are responsible for delivering public dental services, although Labor saw a role for the Federal Government in ensuring fair access and the Coalition noted the importance of the private health insurance rebate.

Although there was general recognition that dental disease is a significant problem, and that the public dental system does not have enough dentists to cope with demand, there was little consensus on how urgent the issue is and what to do about it.

Labor says the public system should be available for those who are unable to access private dental care while the Democrats believe in universal access to public dentistry, but neither Party indicated how the public system with only 10% of dentists could ever cope with up to half of the Australian population eligible for public dentistry.



The Coalition commented that public services are a State responsibility, and the Greens agreed with APOH that the public system should focus on providing care for people medically unable to access private dental services, with Medicare supporting otherwise healthy people for private dental services.

A need for urgent structural reform was recognized by the Democrats and Greens, with Labor making no direct comment other than a need for policy to address unequal access to services, and the Coalition made no direct reference to a need for urgent reform.

***APOH calls upon both Coalition and Labor to recognize the need for urgent structural reform in the Australian dental system, extending dental Medicare, establishing dental internships, and focusing attention of the public system on people who are medically unfit for treatment in private practice settings***

|   |   |   |            |       |       |
|---|---|---|------------|-------|-------|
| 8 | Dentists should work as interns for the public dental system for one to two years after graduating, and before being registered for private dental practice | Unclear if agree. Indicate a need for comprehensive and strategic national policies for dental workforce.<br><br>However, make no comment regarding interns or what specific policies are proposed for workforce development                                | No comment | Agree | Agree |
| 9 | Dental interns should be required to rotate to rural areas to improve rural dental services   | Unclear if agree. Indicate concern for inequities of access for rural and other Australians, and need for comprehensive and strategic national policies for workforce.<br><br>However, no specific comment regarding interns or what policies are proposed. | No comment | Agree | Agree |

**Response to Questions 8-9 to evaluate views regarding introduction of a dental internship**

Dental internships have been recommended by APOH, a 1998 Senate Inquiry, a 2005 NSW Upper House Inquiry, and the Australian Dental Association. A dental internship would improve training, expand the public dental system, and also provide improved rural public dental services.

The Greens and Democrats agreed with APOH that dental internships should be introduced with rural rotations to help rural communities. Labor was unclear in its response, indicating a need for policies to address the dental workforce but not specifying what



these policies should be, while the Coalition did not address the issue of internships.

***APOH urges both Labor and Coalition to commit to establishment of a dental intern program.***

|    |  |   |  |   |       |
|----|--|---|--|---|-------|
| 10 | The Federal Labor plan to allocate \$290M for public dental services to the states will make a substantial difference to dental health                                   | Agree   | Disagree. Suggest Labor plan has same problems of discontinued Keating scheme. Say it did not work, helped State governments more than people, and encouraged states to neglect dental services. | Agree   | Agree |
| 11 | Medicare is a fair and effective way for the federal government to fund private health services  | No comment. Statement of concern regarding the 650,000 waiting list and indication that Labor proposes a \$290M commonwealth dental scheme for 1M consultations                       | No comment. However, agreement implied by comments regarding dental Medicare. Also refer to the private health insurance rebate of \$343M value.   | Agree   | Agree |
| 12 | Recently improved dental Medicare provisions for people with chronic diseases will help people currently unable to afford dental treatment                               | Disagree. Cite poor design and uptake of ECP program. Also indicate government has failed to address problems of program. Indicate no confidence extended program will be any better. | Agree. Also refer to \$345M private health insurance rebate estimated to be spent on dental services.  | Agree   | Agree |
| 13 | Core dental services such as treatment of active infection, pain and prevention should be included in Medicare, irrespective if the person has any other chronic disease | No comment. Statement of concern regarding the 650,000 waiting list and indication that Labor proposes a \$290M commonwealth dental scheme for 1M consultations                       | No comment. Refer to provision of basic dental services in context of current arrangements via ECP   | Qualified agreement. Support free dental health care. | Agree |

**Response to Questions 10-13 to probe views of current Labor and Coalition policies, as well as the possibility of expanding Dental Medicare**

Labor advocates a Commonwealth Dental Scheme similar to that introduced by Keating and discontinued by the current Government, while the Coalition advocates newly introduced expanded dental Medicare provisions for people with chronic disease.

Not surprisingly, Labor and Coalition strongly disagreed with each other's policies.

Surprisingly, however, Labor did not appear to express full support for the general principle of Medicare. Labor also argued that the Coalition had failed to address problems with poor design and uptake of the dental Medicare system.



The Coalition on the other hand argued that the current Labor plan has the same problems as did the discontinued Keating scheme, saying it did not work, helped State governments more than people, and encouraged states to neglect dental services.

The Greens and Democrats supported both Labor and Coalition proposals, as well as expanded dental Medicare, although the Democrats qualified their support for dental Medicare in that they believe it should provide free dental service.

***APOH Regarding Coalition Dental Medicare Policy:***

*Medicare is an uncapped fund, so that there is no actual limit on expenditure.*

*For people with chronic disease, the Coalition policy offers up to \$6,375 of dental treatment over a 3 year period*

*APOH supports this scheme, but believes that it should not be limited to people with separate chronic disease, and that the need for referral by a medical practitioner should be removed.*

***APOH Regarding the Currently Proposed Labor \$290M Scheme:***

*The current \$290 M Labor proposal is about 30% less than the old Keating scheme, adjusted for inflation.*

*There is no expectation that states like NSW (spending half per capita on dental services compared with Qld) increase their own investment.*

*Since the average course of dental care requires 4 appointments, 1 million dental consultations promised by Labor will help only 250,000 out of 650,000 people on the waiting list over 3 years, being just 83,000 people per year.*

*The maximum support an average patient will receive over 3 years in the current Labor plan is \$1,160 of dental treatment*

*It is projected that by 2010, there will be a 10% increase in demand for public dental services compared with 2007, and a 29% increase compared with 2000. Because of this, APOH calculates that the waiting list after 3 years of the current Labor proposal will be about 630,000, close to current levels.*

*APOH estimates that to recreate the effect of the old Keating Commonwealth Dental Scheme, at least \$212M per year is needed, being \$636M over three years and \$346M more than Labor is currently offering.*

*APOH sees merit in increased support for the public dental system, but believes such funding must be substantially increased to accommodate the above concerns.*



**APOH Compares the Coalition and Labor Policies**

*The Coalition policy offers uncapped funding over a 3 year period of up to \$6,375 per person, compared with \$1,160 per person by Labor. From this, the coalition policy is approximately 5.5 times more generous per person than the Labor proposal.*

*However, the Coalition policy is limited to people with chronic disease and requires referral by a medical practitioner, both of which APOH feels are unnecessary barriers to service.*

*The Labor proposal to reinstate the old Keating system has merit in that public services require adequate funding which they are not currently receiving from the States.*

*However, Labor has not allowed for inflation, and is about 30% less than the old Keating scheme, and also is insufficient to allow for the increased demand for public services created by the ageing population.*

**APOH calls on the Coalition and Labor to:  
 Expand dental Medicare to include all essential dental services**

**Improve the proposed Commonwealth Dental Scheme by adjusting for inflation and accounting for the increased demand for public services, committing at least \$636M over 3 years.**

|    |  |  |  |       |       |
|----|--|--|--|-------|-------|
| 14 | Increased federal funding to dental schools is justified if it helps improve the dental workforce    | Agree. Cite support for recent government initiatives in establishing new dental schools.<br><br>No reference to need to increase funding to established schools | Agreement implied by reference to funding for new dental schools and rural placement. Also cite significant research funding.<br><br>However, no clear statement of a need for improved funding for established dental schools | Agree | Agree |
| 15 | The quality of the dental workforce is related to the quality of dental academics and dental schools | Agree  | No direct comment, but do cite increased investment in new dental schools and substantial dental research spending   | Agree | Agree |
| 16 | Dental academics with post-graduate training should be   | No comment. Refer instead to intention to seek to ensure   | No comment   | Agree | Agree |



|  |   |   |       |       |
|--|---|---|-------|-------|
|  | offered salaries higher than recently graduated junior dental clinicians              | appropriate supply and distribution of health care workers for needs of community, seemingly irrelevant to the question of attracting and retaining dental academics. |       |       |
| <p><b>Response to Questions 14-16 relating to inadequate funding to dental faculties and an inability to attract and retain dental academics needed to train the dental workforce</b></p> <p>Both Greens and Democrats agreed that increased academic funding for dental schools and academics was needed. However, neither Labor nor Coalition had policies to increase funding for established schools. Both Labor and Coalition indicated support for new rural dental schools, while the Coalition referred to funding for rural clinical placements and dental research, important for academia.</p> <p><b><i>APOH encourages both Labor and Coalition to establish policies recognizing the need to increase funding of established as well as new dental faculties.</i></b></p> |   |   |       |       |
| 17   | If elected to federal government, I undertake to work towards improving dental health | Agree   | Agree | Agree |
| <p><b>All candidates committed to improving dental health</b></p> <p><b><i>APOH is pleased that all candidates committed to improving dental health, but seeks improved dental policies to ensure that this actually happens</i></b></p>   |   |   |       |       |



# **The Association for the Promotion of Oral Health**

## **Background Document**

**Provided to All Candidates Approached for  
Federal Election Dental Policy Survey**



## Executive Summary

### Background

- An inability to sufficiently expand the dental workforce has produced a market failure for dental services. Demand greatly outstrips supply and generates high costs.
- The public system is unable to attract more than 5 -10% of dentists, and will remain unable to deliver service to more than 5-10% of the population, despite 35-50% being eligible.
- The public dental system is needed for the treatment of patients with medical conditions precluding safe dental service in private practice environments (eg:dementia, cerebral palsy, haemophilia, transplant recipients, severe mental health disorders).
- The public dental system is a State responsibility, but is important for training the dental workforce which is recognized as a Federal responsibility.
- Although 90% of dental service capacity is found in the private sector, almost half the population is unable to afford access to regular private dental services.
- Because of inadequate access to private and public dental services, many people have only sporadic dental treatment.
- Sporadic dental treatment fails to deliver preventive and maintenance therapies necessary to prevent dental emergencies and hospitalizations (30,000-50,000 hospitalizations / year).
- The dental market failure can not be overcome till the dental workforce is restored in a sustainable way.
- Funding to dental faculties does not recognize the high cost of dental training, so that dental faculties are chronically under-funded.
- There are insufficient dental academics to staff existing and new dental faculties, in part because academic careers are unattractive compared with private practice.

### Recommendations

- **Change the role of the public dental system from an emergency service for the poor to a high quality service for the medically complex**, with otherwise healthy patients being treated in the private sector where there are more dentists available.
  - *This does not require additional funding*
  - *This does require expansion of dental Medicare*
  - *This also requires Federal leadership of States delivering dental services*
- **Establish dental internships** to double the Public Dental Service capacity and improve training
  - *Required Federal investment for internships is modest*
  - *National registration to commence in 2008 provides opportunity to introduce internships*
- **Establish dental Medicare benefits** to provide access to private dental services for people unable to afford treatment but who can be safely managed in private practice settings
  - *Dental Medicare can be focused upon aspects of dentistry which will improve health outcomes but have relatively low cost*
  - *Simplified payment schedules could be used to control costs for dental Medicare*
  - *Medicare supported service by therapists and hygienists can reduce hospitalizations and aspiration pneumonia*
- **Provide additional funding to dental faculties** to rebuild the workforce
  - *Funding is needed to train, attract and retain dental academics*
  - *Improvement in physical academic infrastructure is needed*



## Background

### ***The Association for the Promotion of Oral Health (APOH)***

APOH is a broadly based think-tank and advocacy group comprised of stake-holders across dental and other health professions, as well as industry and community groups. APOH is entirely independent and self-funded, with a total membership of about 300 people. **APOH is most easily contacted via the Chairman, A/Prof H Zoellner** by mobile phone on 0403 785 783, or via email on [hzoellne@mail.usyd.edu.au](mailto:hzoellne@mail.usyd.edu.au).

### ***Failed Dental Services Are the Consequence of a Market Failure***

Failure to train sufficient dental workforce has caused a market failure for dental services, with supply unable to meet demand, as well as high service prices. The cost of private practice service is high, while public institutions are unable to compete with private practice to staff public services and academic training facilities.

Large portions of the public are consequently unable to afford private dental services, while the public system is also unable to provide sufficient care.

This is the fundamental basis for a high incidence of preventable dental hospitalizations, emergency presentations, unacceptable waiting times and poor dental health outcomes.

Short and long term strategies are needed to overcome this market failure.

### ***The Public Dental System Will Remain Unable to Deliver Bulk Dental Services to the Poor***

An attempt by the public system to satisfy unmet demand for 35% to 50% of the population unable to afford private dental services has failed, with long waiting lists and times.

Part of the reason for this failure, is that the dental workforce shortage limits capacity of the public system to attract and retain clinicians, with a dentist vacancy rate of from 10% to 20%.

Since only 10% of the dental workforce is required to treat from 35% to 50% of the population in the public sector, the public system will continue to fail in provision of comprehensive dental care. The acuity of the problem is exacerbated by a concentration of severe dental disease in those seeking public services. This is particularly severe in rural areas, which have insufficient public and private dental practitioners.

### ***The Public Dental System Is Most Appropriate for Treatment of Patients with Conditions Precluding Safe Private Dental Services***

People with dementia, cerebral palsy, severe psychiatric disease, haemophilia, leukaemia, organ transplantation, HIV-AIDS and many other disorders are rarely able to find private dental surgeries able or willing to treat them safely.

For this reason, the public dental system plays a critical role in providing treatment for severely medically compromised people.

### ***The Public Dental System is Needed to Train the Dental Workforce***

In addition, the public dental system is appropriate for training dental clinicians, particularly since the ageing and increasingly medically complex population demands higher levels of medical competency in dental graduates, and medically complex patients gravitate to the public system.



***Almost Half the Population is Unable to Afford Access to Private Dental Services Where 90% of the Dental Service Capacity is Found***

Almost half the population reports an inability to afford basic dental care, and although many of these people are eligible for public dental service, the small size of the public sector limits access to such services, while treatment is rarely comprehensive or ongoing. An inability to access either public or private dental services results in sporadic dental treatment focussed on pain management.

***Sporadic Dental Treatment Results in Poor Health Outcomes and Increased Hospitalizations***

All dental treatment requires ongoing care and maintenance, with replacement of fillings, regular periodontal cleaning, and control of any new disease.

Sporadic dental service results in worse health outcomes with increased preventable hospitalizations, and also has the effect of wasting earlier investment in dental treatment through the extraction of filled but not maintained teeth.

There are from 30,000 to 50,000 preventable hospitalizations for dental infection per year, with a number of these being for life-threatening dental infection. Admission to occupy expensive intensive care beds is common.

Mechanisms must be found to provide access to regular dental treatment in the private sector, where 90% of the dental workforce is found, in order to prevent dental hospitalization.

***The Dental Market Failure Can Not Be Overcome Till the Dental Workforce is Restored***

The market failure for dental services will continue till such time that the dental workforce is restored.

***Funding to Dental Faculties is Insufficient***

A major challenge is that current funding arrangements to Universities do not recognize the high cost of dental training.

This high cost results in large part from the intense supervision required of undergraduate dental students performing irreversible procedures on patients. Graduates are currently required to be "registration ready", so that universities act as de-facto registration authorities and are obliged to provide very high levels of technical training. No other undergraduate clinical course involves such intense clinical supervision.

***There Are Insufficient Numbers of Dental Academics***

There is an additional difficulty, in that the general dental market failure makes an academic career unattractive relative to private or even public clinical practice, so that there are insufficient dental academics to fully staff existing and recently established dental schools. This problem is not confined to Australia, but is global in extent.



By way of comparison, a dental academic having completed undergraduate training, usually several years of general practice experience, 3 to 4 years of PhD training, and perhaps also 3 to 4 years of specialist clinician training, can expect to commence formal employment as a lecturer with a salary roughly half that of a new dental graduate.

Junior lecturers are greatly discouraged by the yearly graduation of dental students into salaries significantly higher than those enjoyed by the lecturer.

Because very significant financial penalty is paid by dentists working in universities, insufficient numbers are attracted to academic work, so that those who do work for universities have excessive teaching loads. The high teaching loads greatly hamper research productivity, which is the basis for university promotion. Junior dental academics often fail to progress in their careers, and after 5 to 10 years of low salary leave academia for private practice.

This unsustainable situation must be addressed in order for the dental workforce to be properly established and appropriate dental services made available.

## Recommendations

Identical challenges are faced in Medicine and other areas of health, but several mechanisms apply to Medicine which limit the impact of the market failure. We believe that application of these mechanisms to Dentistry would greatly improve dental health outcomes.

A number of inter-related strategies are suggested below which if implemented, will greatly alleviate the short term difficulties, and also provide a basis for high quality sustainable long term health outcomes.

### **Change The Role of the Public Dental System From an Emergency Service for the Poor to a High Quality Service for the Medically Complex**

Public dental services require support sufficient to deliver dental treatment in a timely manner to people unable to safely managed in private practice, as well as to provide high quality training for the dental workforce.

APOH proposes structural reform shifting the role of public dental services to the specific management of patients with complex disease precluding safe treatment in private practice. The public system already has this role, but is currently hampered in this core responsibility by impossible demands to see large numbers of more medically fit people.

#### *The Changed Role is Readily Accommodated in the Current Public Dental Service and Will Result in Demonstrated Success of the Public Dental System*

As outlined above, the public system can never succeed at delivering sufficient basic dentistry to large portions of the population, but can be successful if its role is more properly defined as the management of those who can not be safely treated in private practice.



*The Changed Role Does Not Require Additional Federal Funding But Does Require Expansion of Dental Medicare and Federal Leadership*

This would require little if any new Federal funding, but would require expansion in Dental Medicare to support people who can be safely treated in a private practice environment, but who are currently on public dental waiting lists. Also, there is a need for the Federal Government to provide leadership and coordination for this change in State service delivery.

**Introduction of Dental Internships Would Double Public Dental Service Capacity and Improve Training**

Introduction of a dental internship would greatly expand the number of clinicians in the public sector. Also, because of the challenging nature of such work, there would be significant improvement in clinical training, so that interns leaving for private practice would be better prepared for an increasingly medically complex private practice environment.

Internships could be introduced on a voluntary basis, and expanded over a five year period to become mandatory.

Rotation of senior interns to rural areas would improve rural dental services.

*Required Federal Investment for Internships is Modest*

Only a modest investment in physical infrastructure, intern salaries, and attractive conditions for a small number of senior clinician mentors would be required. These costs could reasonably be born by States, with some assistance from the Federal Government for infrastructure and establishment of the necessary structured clinical training programs.

APOH estimates that this could be achieved with an investment in the order of \$300M to \$450M per year, and that if a 2 year internship were slowly phased in over a five year period, the public dental workforce would approximately double in size, sufficient to satisfy community need. (For a detailed implementation plan prepared for NSW, please contact APOH)

**Establish Dental Medicare Benefits to Provide Access to Private Dental Services for People Sufficiently Medically Fit for, But Unable to Afford Private Dental Treatment**

*Dental Medicare Can Be Focused Upon Aspects of Dentistry Which Will Improve Health Outcomes But Have Relatively Low Cost*

Dental Medicare payments for: prevention, caries control, treatment of pain, and basic dentures would greatly increase access to care for people who could be safely seen in private practice settings.

*Simplified Payment Schedules Could Be Used to Control Costs for Dental Medicare*

Some objection to this proposal from private dental practitioners is anticipated, reflecting the nature of the current market failure. Medicare has partly controlled a comparable market failure in Medicine, and APOH suggests a similar effect is likely in Dentistry.

Payments based on time and complexity of treatment, rather than on a per-service basis as currently practiced for private dental health insurance, would greatly reduce the cost of Dental Medicare and also simplify administration.



Currently, if four simple small amalgam fillings are done in a “quadrant” (one quarter of the jaw), necessitating only one appointment and one or two injections over a 30 minute period, the payment is equivalent to that for four separate appointments for four separate people. APOH’s suggested Medicare payment strategy based on treatment time and complexity is rational, simple, and seems more readily justifiable than current arrangements.

*Medicare Supported Service by Therapists and Hygienists Can Reduce Hospitalizations and Aspiration Pneumonia*

Dental therapists and hygienists would require lesser Medicare payments compared with more highly trained dentists, but would nonetheless work in teams under the supervision of dentists to ensure patient safety.

By controlling disease at an early stage, increased regular preventive services by therapists and hygienists would significantly reduce the need for dental hospitalizations. Importantly, hygienist treatment of the aged and demented would greatly reduce aspiration pneumonia, which is a major health problem and common cause of death in this group.

Federal leadership to establish uniform arrangements for the registration, range of practice, and professional referral arrangements across Australia is required, but readily achieved with the National level registration to be introduced in 2008.

***Additional Funding to Universities with Dental Faculties to Expand the Workforce***  
*Direct Funding to Train, Attract and Retain Dental Academics*

Expansion of the dental workforce requires correction of current failures in dental academic funding.

An approximate doubling in recurrent funding to dental faculties is needed to restore currently severely degraded dental schools. This funding is required to train, attract and retain the dental academics needed to properly train the dental workforce. This must be sufficient to not only make wages and conditions attractive relative to a career in private practice, but also to support research activity necessary for high quality dental education.

*Improvement in Physical Training Infrastructure*

In addition, significant investment in physical training infrastructure is needed. The corresponding expansion in dental training capacity will permit rational expansion in the number of students studying dentistry, hygiene and therapy, for restoration of the dental workforce.

*Long Term Solution of the Dental Market Failure Necessitates Academic Investment*

An expansion in dental clinician numbers is the only way in which the current market failure in dentistry can be overcome in a sustained way. This necessitates the improved academic infrastructure suggested above.