

The National Oral Health Plan (AHMC 2004b) reported that the ability of the public and private dental sectors to provide the dental services demanded by Australians is threatened by a worsening national shortage of dental providers.

Setting the scene

The majority of dental services in Victoria are provided by private practitioners and paid for by clients with or without the assistance of private health insurance. The Australian Dental Association (2003) estimated that the average cost of private dental treatment is about \$300 for a course of care, putting private dental care out of the reach of many Victorians. Following withdrawal by the Commonwealth Government, only the Victorian Government now supports the delivery of public dental care for children and disadvantaged adults in Victoria. Despite significant increases in expenditure over recent years, a gap remains between Victoria's oral health requirements and the number of clinicians available to meet them.

The National Oral Health Plan (AHMC 2004b) reported that the ability of the public and private dental sectors to provide the dental services demanded by Australians is threatened by a worsening national shortage of dental providers. 'By 2010 there will be 1,500 fewer oral health providers (general and specialist dentists, dental therapists, dental hygienists, oral health therapists, prosthetists and dental assistants) than will be needed just to maintain current levels of access. (Spencer, Teusner, Carter, Brennan 2003)'

Victoria's public dental service

Dental Health Services Victoria (DHSV) is responsible for delivering dental care directly at the Royal Dental Hospital of Melbourne, as well as through a small number of Dental Health Services Victoria-managed dental health services and the School Dental Service. It is also responsible for subcontracting to Community Health Services under conditions set by the department. The Royal Dental Hospital of Melbourne operates 16 general dental chairs, 72 teaching chairs, 45 specialist chairs and 6 oral surgery chairs. The hospital has four operating theatres, of which three have been commissioned.

Community Health Services provide public dental care that are community-based and delivered in either fixed or mobile clinics, but there are also outreach services to some schools, supported residential services and residential aged care facilities. (See Appendix 1 for a list of community clinics.) In some cases, dental care is provided by private clinicians through voucher schemes.

Public dental services provide routine and urgent care. People seeking urgent care are assessed, triaged and managed using the Emergency Demand Management Strategy. People triaged as requiring urgent care are offered an appointment and those who require routine care are placed on the waiting list. Agencies are required to manage waiting lists in accordance with departmental policies.

The community dental services and the School Dental Service (SDS) are currently managed as separate services, although in many clinics they are physically co-located. The funding streams differ and there is separate reception and administration for the School Dental Service and community dental services. Patient records are not shared and there are often different opening times for the services in the same clinic. Consumables and maintenance are also managed separately.

The complexity of these arrangements can create confusion for staff and patients alike and results in inefficiencies. There is significant opportunity to enhance dental services and create a better working environment, especially for the School Dental Service staff, by integrating the community and school dental services.

There is also a lack of integration of dental services and other primary health services and programs provided in community dental clinics. Generally community dental services have not adopted service coordination principles and do not utilise service coordination tools.

Services for children

Children up to the age of 12 have priority access to public dental care. Priority access is also provided to children aged 13–17 who are dependants or holders of health care or pensioner concession cards. Primary-school-aged children are offered services on a recall basis that depends on their need. The service is free for dependants or holders of a health care or pensioner concession card. For other families, the service costs \$27 for a course of care per child (up to a maximum of \$108 per family).

Services for adults

Health care and pensioner concession cardholders and their dependants over the age of 18 are eligible for public dental care. The service costs \$22 per visit, up to a maximum of \$88 for a complete course of care. Dentures generally cost around \$105.

Specialist services

Specialist services are provided at the Royal Dental Hospital of Melbourne and certain community dental clinics. A referral to these services is necessary. The co-payment required varies based on treatment needs.

Dental teams

Dental teams are made up of dentists, dental therapists, dental hygienists, dental assistants and dental prosthetists. All members of the dental team contribute to Victoria's public dental system by delivering quality services to patients based on their age and needs. This range of expertise allows team members to deliver the most appropriate care for each client.

Education and training

Clinical training of the dental team occurs at the Royal Dental Hospital of Melbourne and community dental clinics. The department provides bonded scholarships for Bachelor of Dental Science, Bachelor of Oral Health and Bachelor of Oral Health Science students. In addition, the department provides funding to the University of Melbourne and La Trobe University to support pre-clinical training in the Bachelor of Oral Health and Bachelor of Oral Health Sciences. Dental Health Services Victoria provides introductory programs for overseas-trained dentists, a professional development program for the dental team and a mentoring program for Bachelor of Dental Science graduates.

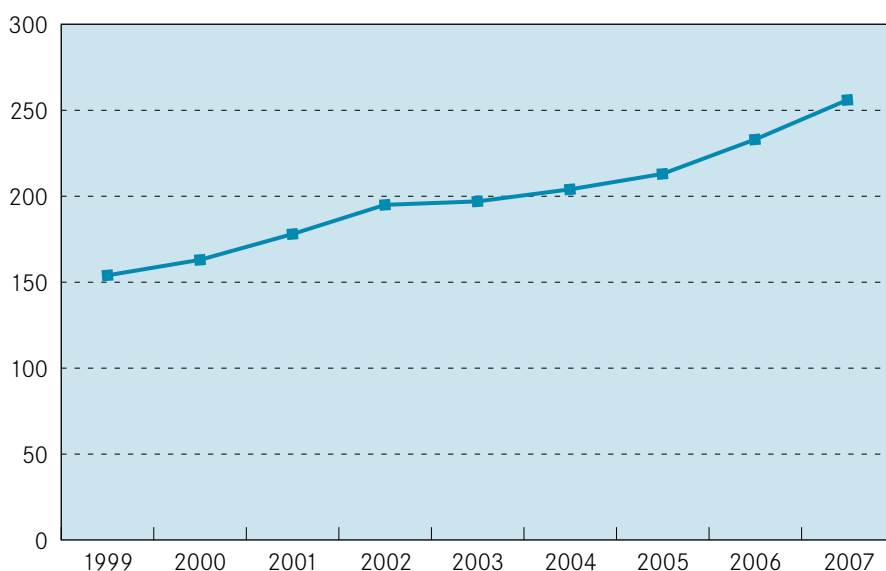
More extensive information and policies relating to the public dental system can be found on the Dentistry in Victoria website at www.health.vic.gov.au/dentistry.

Recent achievements

More facilities

Between December 2005 and December 2006, five new community dental clinics were opened, bringing the total number to 68. This allowed an additional 26 dental chairs to be opened, increasing the number of dental chairs in Victoria to 241. This includes 16 community dental chairs at the Royal Dental Hospital of Melbourne. The total number of chairs will further expand to 256 in 2007 (Figure 1), a 66 per cent increase in community chairs over this eight-year period.

Figure 1: Community dental chairs, 1999–2007

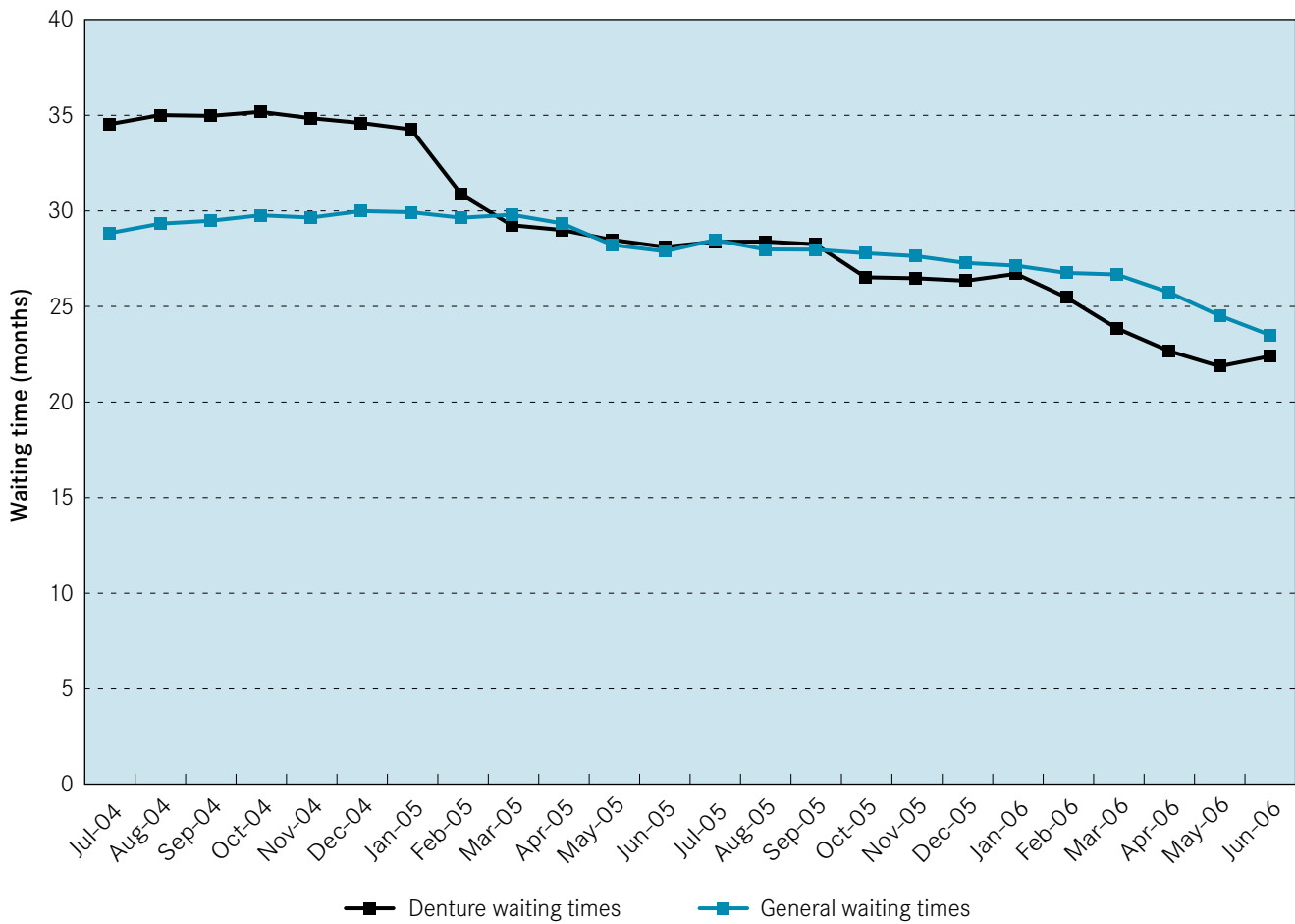


Reduced waiting times

From June 2005 to June 2006, the average time to treatment for dentures decreased from 28 months to 22 months, while the average time to treatment for non-urgent dental care decreased from 28 months to 23 months.

In 2005–06, there were 478,087 visits to community dental clinics, an increase of 52,894 or 12 per cent over the previous year. From January to June 2006, 242,801 people visited community dental clinics – an increase of 25,190 or 12 per cent compared with the same period the previous year. From June 2005 to June 2006, the average time to treatment for dentures decreased from 28 months to 22 months (20 per cent), while the average time to treatment for non-urgent dental care decreased from 28 months in June 2005 to 23 months in June 2006 (16 per cent) (Figure 2).

Figure 2: Adult waiting times for non-urgent dental care, 2004–06



Up-to-date treatment times for each community clinic can be found through the Victorian Government Health Information website at www.health.vic.gov.au/yourhospitals/dental.

Fluoridation

The value of fluoridation is unquestionable. The World Health Organization has concluded that ‘community water fluoridation is safe and cost-effective and should be introduced and maintained wherever socially acceptable and feasible’ (WHO 1994). Much of rural Victoria, however, is yet to be fluoridated, resulting in needless caries and severe complications including hospitalisation. In 2005, the Secretary of the Department of Human Services requested the relevant water authorities to fluoridate the drinking water supplies for Moe, Morwell, Warragul Sale, Traralgon, Horsham, Wangaratta and Wodonga (Figure 3). This has been implemented in the majority of locations. Other towns to receive fluoridated drinking water in 2006 were Wallan and Robinvale.

Workforce initiatives

Workforce shortages continue to affect the public dental system, particularly in rural areas where shortages are also felt in the private sector. Ongoing workforce initiatives include statewide professional development, mentor support for recent graduates, accommodation and travel assistance for dentists moving to rural areas, significant rural allowances and an international recruitment campaign.

Support for education initiatives has been extended substantially since 2005–06 to increase the supply of dental professionals. The Government has invested heavily in the establishment of the Bachelor of Oral Health Science at La Trobe University Bendigo and expanded bonded scholarships and funding for clinical placements and training at La Trobe University and the University of Melbourne. Up to 26 new scholarship recipients will be working in the rural public sector at graduation each year as a result of these initiatives. The Government has also recently announced the establishment of a second dentistry program at La Trobe University Bendigo. The program will include clinical training at community dental clinics and bonded scholarship places will also be offered to students.

Children's oral health

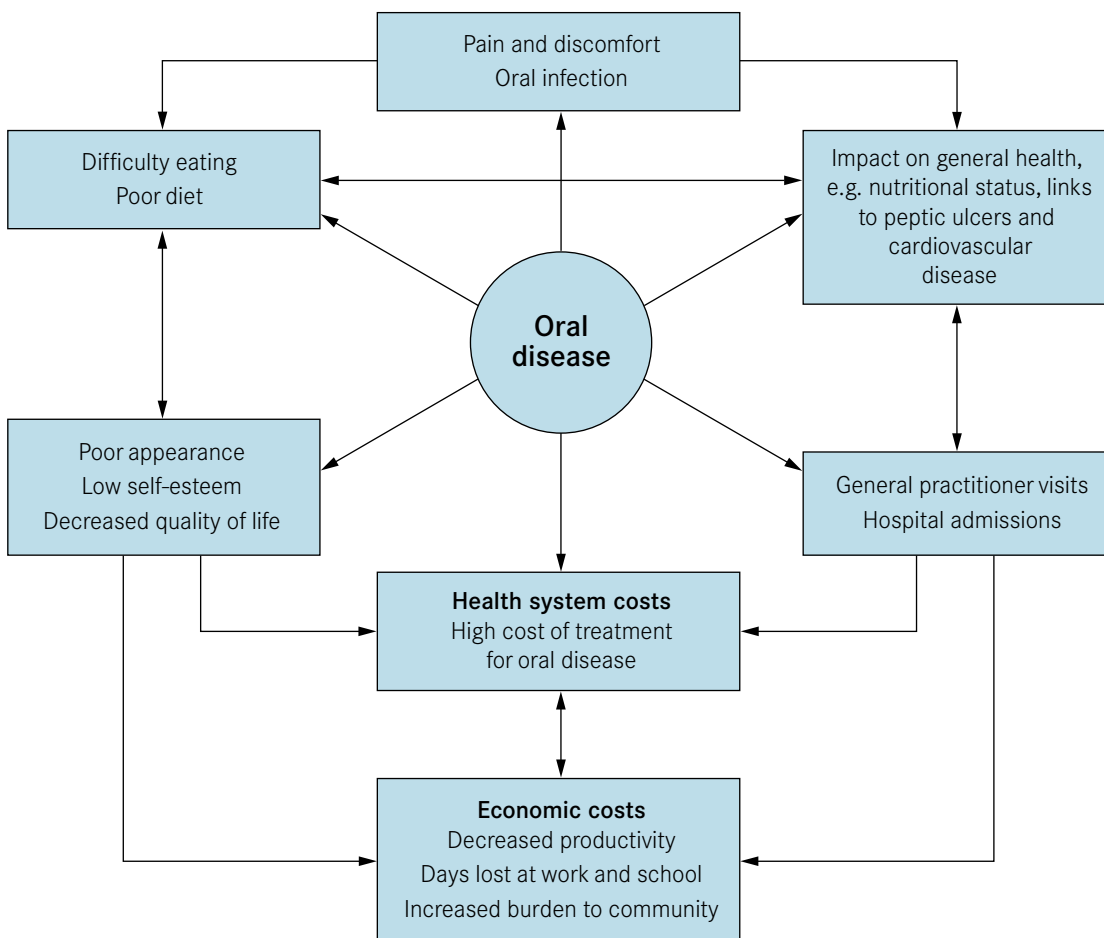
Since 2003 there has been a focus on the oral health of children under preschool age. The Government invested in initiatives that increase access for kindergarten children to dental care. Children under primary school age are eligible for priority access at community dental clinics. In addition, health promotion to children aged 0–5 years focuses on strategies that promote early childhood oral health practices and increase the oral health promotion skills of primary health care and education professionals working with infants and young children.

Smiles 4 Miles oral health promotion program operates in Neighbourhood Renewal and Best Start communities. Children under school age and their families who are at high risk to oral disease are targeted with prevention and treatment initiatives. The program has been operating since 2003–04 in Corio-Norlane, Moe, Morwell, Churchill-Traralgon and Broadmeadows, and in 2005 expanded into Wimmera-Horsham, Sale-Wellington and Ballarat-Daylesford. Funding was approved in 2005–06 for six more sites: Warrnambool, Hamilton-Portland, Shepparton, Wodonga and Peninsula.

Why good oral health is important

Oral health is fundamental to overall health, wellbeing and quality of life. A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. The impact of oral disease is not only on the individual through pain and discomfort and the broader impact on their general health and quality of life, but also on the nation generally through health system and economic costs (Figure 4).

Figure 4: Impact of oral disease



Internationally, WHO (2006) ranks Australia 17 among OECD countries for adult dental caries, a relatively poor performance in light of Australia's much better performance on other leading health indicators such as life expectancy.

Dental caries are the second most costly diet-related disease in Australia, with an economic impact comparable with that of heart disease and diabetes (AHMAC 2001). Approximately \$5.1 billion was spent on dental services in Australia in 2004–05, representing 5.8 per cent of total health expenditure. In Victoria, approximately \$1.5 billion was spent on dental services in 2004–05, representing 6.9 per cent of total health expenditure (AIHW 2006).

Periodontal disease contributes to cardiovascular disease, preterm birth and low birth weight. Oral disease is also associated with aspiration pneumonia, hepatitis C, HIV, infective endocarditis, otitis media and nutritional deficiencies in children and older adults (AHMAC 2001).

Caries and periodontal disease account for 90 per cent of all tooth loss. Brennan and Spencer (2004) estimated that 11 million Australians have new decay each year.

Despite significant improvements in the oral health of children in the last 20–30 years, there are persistent high levels of oral disease among Australian adults (AIHW 2002a). Poor oral health in this country is most evident among Aboriginal and Torres Strait Islander people, people on low incomes, rural and remote populations, and some immigrant groups from non-English speaking backgrounds, particularly refugees (AHMAC 2001).

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Children's oral health

The state of Victoria's children report (DHS 2006b) recently reported on children's oral health. Good oral health in childhood contributes to good oral health in adulthood, with less decay and reduced loss of natural teeth. A range of preventive factors (water fluoridation, improved diet and oral hygiene, and regular brushing) contributes to oral health in childhood. The availability and affordability of dental services may also influence the dental health of children (AIHW 2005).

The report presents data taken from the Victorian Child Health and Wellbeing Survey 2006 and the School Entrant Health Questionnaire 2006. Parents were asked in the Victorian Child Health and Wellbeing Survey to rate their child's oral health. Just over three-quarters of children (77.1 per cent) aged six months to 12 years were reported to have excellent or very good oral health; however, children living in rural areas had notably poorer oral health.

As Table 1 shows, children living in rural areas were more likely than those living in metropolitan areas to have had toothache, a filling, dental treatment in hospital under general anaesthetic, or a tooth extracted because of a dental problem.

Table 1: Oral health status of children in rural and metropolitan areas, 2006

	Rural (%)	Metropolitan (%)	Victoria (%)
Child has (ever) had toothache	31.2	23.1	25.4
Child has (ever) had a filling	25.2	18.0	20.0
Child has (ever) had a tooth extracted	11.4	6.5	7.9
Child has (ever) had any dental treatment in hospital under general anaesthetic	7.2	3.1	4.2

Source: Victorian Child Health and Wellbeing Survey, 2006

The state of Victoria's children report also identified the following relevant findings for child oral health:

- Children aged 2–12 years living in rural areas were much less likely to drink tap water than children living in metropolitan areas.
- Just under three-quarters of children aged 2–7 years were reported to use low-fluoride toothpaste.
- While the majority of parents said they actively assisted their children under seven years of age with toothbrushing, just less than one-fifth of parents reported they never did so.
- Children were more likely to have seen a private dentist at their last dental visit (64 per cent) than a dentist from the School Dental Service (27 per cent) or from other government or community dental services (7.5 per cent).
- Nearly one-third of children aged six months to 12 years had never seen a dentist, and younger children were much more likely to have never seen a dentist than older children.
- The most common explanation for not having seen a dentist (50.5 per cent of children) was that there was no reason to visit (for example, the child had healthy teeth and gums). The second most common reason was that the child was considered too young to need dental services (31 per cent). A minority of parents (5 per cent) identified cost as the main factor.
- Parents of Indigenous children were more likely than parents of non-Indigenous children to be concerned about their children's teeth. However, Indigenous children were less likely than non-Indigenous children to have visited a dentist in the last one to two years.

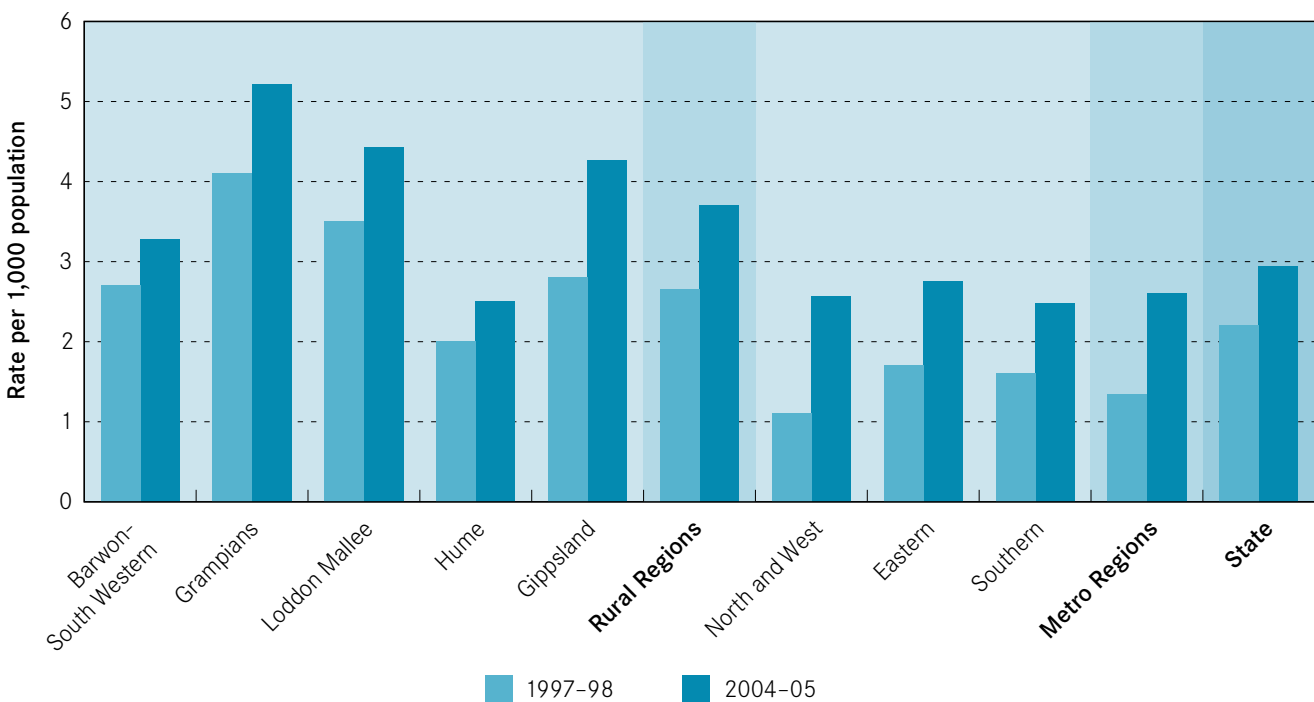
Dental ambulatory care sensitive conditions

The department has recently analysed hospital admissions in Victoria caused by dental ambulatory care sensitive conditions (ACSCs).² Dental ACSC admissions have the highest rate of all ACSC admissions for under-18-year-olds and the second-highest rate for all ACSC admissions for all ages. Most admissions are same-day and the average number of bed-days for all dental ACSC admissions is relatively low (1.83 days in 2004–05).

In 2004–05, dental caries or associated conditions accounted for over 80 per cent of dental ACSC admissions, and 95 per cent of ACSC admissions for 0–9-year-olds. These admissions resulted in removal of teeth in over 75 per cent of cases. These extractions could all have been prevented with earlier treatment.

Younger children and rural people are more likely to be admitted for dental care. Over the last decade, dental ACSC admissions have risen across the state and in all regions (see Figure 5).

Figure 5: Dental ACSC admissions by DHS region, 1997–98 and 2004–05

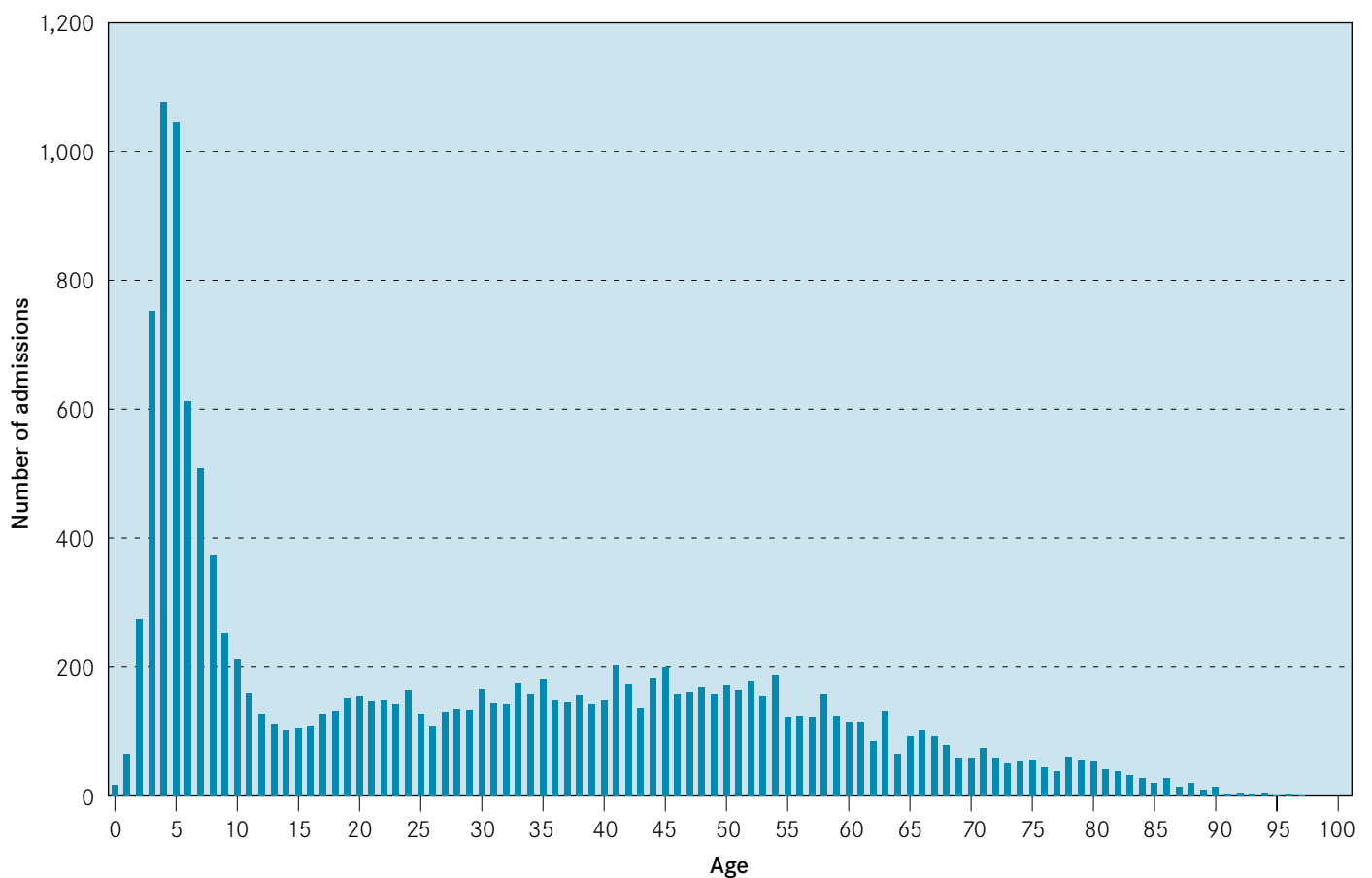


Source: Victorian Admitted Episodes Dataset

There is a significant concentration of dental ACSC conditions in the 2–10-year-old age range, as shown in Figure 6. This is primarily due to the difficulties of managing more complicated dental treatment with young children in a dental clinic chair and the preference of dentists to carry out these treatments using a general anaesthetic.

² Ambulatory care sensitive conditions are conditions for which hospitalisation is thought to be avoidable with the application of public health interventions and early disease management, usually delivered in an ambulatory setting such as primary care. High rates of hospital admissions for ACSCs may provide indirect evidence of inadequate public health programs, problems with patient access to primary health care, inadequate skills and resources, or disconnection with specialist services.

Figure 6: Dental ACSC admissions by age, 2004–05



Source: Victorian Admitted Episodes Dataset

There is a significant difference in ACSC admission rates between regions across Victoria. Access to fluoridated water in the catchment and the proportion of households living in poverty are significant predictors of the difference (see Appendix 2). Dental ACSC admissions were significantly higher in those catchments with lower access to fluoridated water supply and where the proportion of households in poverty was higher.

This analysis demonstrates the value of providing fluoridated water supplies in reducing dental disease and subsequent need for treatment, especially for treatment in hospitals. The analysis also demonstrates the importance of providing access to dental services for families and individuals on low incomes.

