Australian Dental and Oral Health Therapists' Association Inc

Environmental Scan – Dental Services

Environmental Scan and Situational Analyses

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Acronyms and abbreviations

AATSIHS	Australian Aboriginal and Torres Strait Islander Health Survey
ACOSS	Australian Council of Social services
ACT	Australian Capital Territory
ADA	Australian Dental Association
ADOHTA	Australian Dental and Oral Health Therapists' Association
AHMAC	Australian Health Ministers' Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AITEC	Australian Information technology Engineering Centre
ARCPOH	Australian Research Centre for Population Oral Health
ARCPOH	Australian Research Centre for Population Oral Health
CDBS	Child Dental Benefits Schedule
CDDS	Chronic Disease Dental Scheme
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
COTA	Council on the Ageing
DBA	Dental Board of Australia
DMFT	Decayed/Missing/Filled Teeth
EPC	Enhanced Primary Care
GP	General Practitioner
HWA	Health Workforce Australia
NGOs	Non-government organisations
NOHPDG	National Oral Health Plan Development Group
NPA	National Partnership Agreement
NRHI	National Rural Health Alliance
NSW	New South Wales
OHPA	Oral Health Professionals Association
PAH	Potentially Avoidable Hospitalisations
PHAA	Public Health Association of Australia Inc
WHO	World Health Organization

Preamble

Purpose and scope of the environmental scan and situational analysis

This environmental scan and situational analysis is the first step in bringing together all potential factors in the Australian Dental and Oral Health Therapists Association's (Association, ADOHTA) environment that can effect policy changes to how dental services is provided in Australia.

This scan makes maximum use of the work already done or commissioned by the Association and publicly available work of other professional peaks, government bodies such as the former Health Workforce Australia (HWA) or by health departments.

Terminology

We use the terms 'oral health' and 'oral disease' in this paper to align the language with that of the recent AIHW publications cited, and the National Oral Health Plan consultation draft where oral health includes teeth and other oral structures.

We use the term 'oral health practitioner' to encompass dental therapists, oral health therapists and dental hygienists (in line with the Health Workforce Australia (HWA 2014) report Australia's Future Health Workforce - Oral Health.

Main messages

Oral health

The importance of good oral health to general health and wellbeing is well recognised in evidence based policy and programs in Australia and globally. Poor dental health can negatively affect a person's ability to eat, speak, and socialise; it can also exacerbate other conditions such as cardiovascular diseases, diabetes, stroke and pre-term low birthweight births.

Poor oral health is among the four most common chronic health problems in Australia. The cost of poor oral health extends beyond individual and community costs to the broader health system and the economy.

Because of the significant health effects and costs of oral diseases, and because they can be prevented, oral diseases are included among the chronic diseases for which Australian Government has invested in surveillance.

Needs

Three out of 10 adults have untreated tooth decay and four out of 10 young children still experience tooth decay. Four out of 10 Australian adults see a dentist once a year for a check-up. People in priority population groups have high rates of poor oral health and find it more difficult to access and afford/pay for oral health care.

OHP workforce

The skills, knowledge and training of oral health practitioners is extensive. Over time, oral health practitioners have become bachelor degree trained professionals, with post graduate pathways to further qualifications becoming available in the tertiary education system.

OHPs represent a group of nationally accredited health professionals with the skills and capability to meet the increasing demand for oral health care. The development of OHPs has been supported by successive governments because, like allied health professionals, they increase the capacity in the system to provide a model of care in which curative dentistry is appropriately balanced with oral health promotion and oral diseases prevention strategies.

OHPs provide oral health assessment, examination, diagnosis, treatment, management, preventive services and referral to children, adolescents and young adults up to age 26, and, with additional training, for people of all ages. Their scopes of practice may include restorative and fillings treatment, tooth removal, oral health promotion, periodontal/gum treatment, and other oral care to promote healthy oral behaviours. Currently, they may only work within a structured professional relationship with a dentist. Their scopes of practice are due for review in 2017.

Legislation, policy, funding and data

Legislation

Policy

- In August 2015, the Council of Australian Governments Health Council endorsed the National Oral Health Plan 2015-2024.
- State and Territory governments are responsible for public oral health services for children and eligible adults. These services include school dental services provided to children and young people without referral from a dentist. Variation exists in State and Territory policies about age limits of clients whose services may be delivered by an OHP.

Funding

- The Australian Government, through Medicare, funds general and specialist dentists, and dental prosthetists. Dentists can use their Medicare provider numbers to claim Medicare

rebates on services provided by oral health practitioners. The Child Dental Benefits Schedule (replacing the Medicare Teen Dental Plan from January 2014) and the current National Partnership Agreement (NPA) Adult Public Dental Services (2015-16) are the two current national oral health preventive funding programs. Under the NPAs, the Australian Government plays a role in funding dental services and State and Territory governments are responsible for delivering the public dental program for children and eligible adults. The NPAs on public dental services replaced programs for low income adults.

- The greatest share of the costs of oral health in Australia is borne by clients/patients whose out-of-pocket expenses amounted to 57% of the total expenditure in 2011-12. The remaining expenditure was 13% for direct Federal Government outlay, 9% for state and local levels of government, 6% for the Federal Government for health insurance premium rebates, and 15% for health insurance funds (NOHPDG 2014).

Data

- The Australian Government has invested in oral health status, oral health service utilisation and expenditure, oral health workforce surveillance data and trend analysis and reporting (e.g. data analysed most recently by the Australian Institute of Health and Welfare 2014 and Health Workforce Australia 2014). These reports also outline a number of current limitations of the data.
- Medicare data (e.g. from the previous Chronic Disease Dental Scheme and teen dental programs 2007-2012, and from veterans' programs 2006-2012 and general and specialist dentists, dental prosthetists) showing services provided by category and item number (but to our knowledge, not by provider type), and benefits/rebates paid by Medicare.
- Medicare data for preventive service item numbers that are provided by OHPs are represented under dentists' provider numbers and cannot currently be disaggregated to show utilisation and costs of services delivered by OHPs.
- Public Dental Directors/Jurisdictions collect child dental health data, public sector utilisation patterns and typical service usage.
- Workforce data are available quarterly from the Dental Board of Australia (DBA) showing the numbers of registered dentists (generalists and specialists), oral health practitioners (by profession) and dental prosthetists, and from the Australian Health Practitioner Regulation Agency 2012 labour force survey. Data analyses are available from the Australian Institute of Health and Welfare (AIHW) showing the distribution of oral health practitioners (using a generalist registration category which differs from that of the DBA) by remoteness in 2012.

Access to decision makers in the last 5 years

ADOHTA submissions sampled for review for the purposes of this environmental scan informed the reader about the need and rationale for:

- Medicare provider number for OHPs
- OHP status independent of dentists.

They were directed to federal, state and territory health ministers and their departments.

Key decision makers re Medicare provider number processes

Key decision makers relevant to obtaining Medicare provider numbers for ADOHTA member professions are Federal Government representatives in Medicare and sections responsible for provider numbers etc, the senior public servants who advise Ministers who in turn advise Cabinet about changes to who has provider numbers. Key stakeholders are ADOHTA members, employers and employer groups including State and Territory governments. Other potential stakeholders are

peak Aboriginal and Torres Strait Islander health and public health advocacy bodies, key academics in population health and wellbeing, key public health associations, and the medical and dental associations and colleges.

Key issues

Key issues relevant to accessing OHP scope of practice changes and Medicare provider numbers are well articulated in the consultation draft of the National Oral Health Plan 2015-2024, recently endorsed on 15 August 2015 by the Council of Australian Governments Health Council, and soon to be released to the public.

The key issues are:

1. Equity of access and affordability of oral health services for the whole of population and the priority needs groups.

   Key drivers are mal-distribution of the oral health workforce, oral health practitioner limited scopes of practice and the need to fund out-of-pocket costs.

2. Oral health practitioner satisfaction and concern about:

   - lack of opportunity to use all their skills
   - decreasing the capacity to attract and retain this workforce because of perceptions of it as undervalued, poorly remunerated, lacking a career path.

   Key drivers of this issue relate to changes for ADOHTA members that would contribute to improved access to preventive health services, by increasing the capacity of OHPs and dentists in the private sector so that they are all working to a full scope of practice within team models of primary health care, and remuneration.

3. Health system as a whole

   The health system could benefit from efficiencies in oral health service delivery (as seen in other allied health professions) by enabling oral health professionals to work in private practice as independent members of the primary health care team. This has the potential to contribute to the:

   - maintenance and improvement of the quality and safety of oral health services (e.g. reduced wait times, closer to home, more culturally appropriate, clear referral pathways at a local level)
   - maintenance and improvement of the oral health status of the population and at risk groups
   - cost effective delivery of oral health prevention services by the most appropriate workforces, ensuring tax payers have value for money.

   Key drivers of this issue are: tertiary education models and clinical placement availability, professional registration, continuing professional development and mentoring programs, scope of practice, models of care and funding models that allow oral health practitioners to work to their full scope of practice, surveillance data as it pertains to the nature, extent, contribution and cost of services delivered by workforce, economic modelling and estimates of the cost and cost savings associated with a Medicare provider number for registered oral health practitioners.

Environmental Scan and Situational Analysis

Section 1 Oral health and oral health care trends in Australia

Poor oral health can impact a person's ability to eat, speak, and socialise; it can also exacerbate other conditions such as cardiovascular diseases, diabetes, stroke and pre-term low birthweight. Oral health, affects not only the individual, but also the broader health system and economy (National Oral Health Plan Development Group 2014).[1]

> *Oral health is a state of being free from chronic mouth and facial pain, oral and throat cancer, oral sores, birth defects such as cleft lip and palate, periodontal (gum) disease, tooth decay and tooth loss, and other diseases and disorders that affect the oral cavity.*
>
> World Health Organisation 2015 [2]

Oral diseases such as dental caries, periodontal disease, tooth loss and oral cancer represent an important part of general health. The burden of chronic conditions is Australia's biggest challenge (AIHW 2014a).[3] Chronic diseases result not only in personal and community costs, but also in a significant economic burden because of the combined effects of health-care costs and lost productivity from illness and death. Risk factors for oral diseases include unhealthy diet, tobacco use, harmful alcohol use, and poor oral hygiene.

Costs data

Oral diseases are included among the chronic diseases for which the Australian Government has invested in surveillance, because of the significant health effects and costs of oral diseases, and because they can be prevented (AIHW 2014a).[4] Poor oral health is among the four most common and costly chronic health problems in Australia as shown in Box 1 below (AIHW 2014).

Box 1 The four most common and costly chronic diseases in 2008-09 and allocated expenditure (excerpt from Australia's Health 2014, AIHW 2014)

Most costly disease groups in 2008–09	Amount ($ billion)	% of total allocated health expenditure
Cardiovascular diseases	7.74	10.4
Oral health	7.18	9.7
Mental disorders	6.38	8.6
Musculoskeletal	5.67	7.6

(a) Data are for Australasia, i.e. Australia and New Zealand.

Sources: ABS 2013a, 2013c; AIHW 2013; Britt et al. 2013; IHME 2013.

[1] National Oral Health Plan Development Group (2014). Australia's National Oral Health Plan: Healthy Mouths Healthy Lives 2015-2024 (consultation draft)

[2] World Health Organisation web page. Accessed 5 September 2015 at: http://www.who.int/topics/oral_health/en/

[3] Australian Institute of Health and Welfare (2014a). Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW

[4] *Ibid* (AIHW 2014a)

Overall oral health care expenditure increased from 2012-13 to 2013-14 (see Table 1). As shown in Table 1, non-government expenditure on oral health care (clients patients, health insurance funds) was 74.66% in 2012-13 and 77.69% in 2013 -14 of total oral health care expenditure. Total government funding on health expenditure for dental services declined from 25.35% in 2012-13 to 22.31% in 2013-14. See Appendix 1 for a matrix of government funding programs.

The greatest share of the costs of oral health in Australia was borne by clients/patients, whose out-of-pocket expenses amounted for 58.19% of the total healthcare expenditure on dental services in 2012-13, and 59.86% in 2013-14 (AIHW 2015).[5]

Table 1 Health expenditure by source for dental services in Australia, 2012-13 and 2013-14

Funds	2012-13 (*%*)	2013-14 (*%*)
Australian Government		
DVA	100 (*1.14*)	109 (*1.22*)
Health and other[6]	843 (*9.68*)	503 (*5.64*)
Premium rebates[7]	606 (*6.96*)	664 (*7.45*)
State and local	657 (7.55)	713 (*8*)
Total	**2,207 (*25.35*)**	**1,989 (*22.31*)**
Non-government		
Clients/patients	5,066 (*58.19*)	5,336 (*59.86*)
Health insurance funds	1,396 (*16.03*)	1,547 (*17.35*)
Others[8]	37 (*0.42*)	43 (*0.48*)
Total	**6,500 (*74.66)***	**6,925 (*77.69*)**
Total health expenditure	**8,706**	**8,914**

Source: AIHW Health Expenditure Australia 2012-13; 2013-14[9] [10]

Private health insurance

Of the total health expenditure on oral health care in 2013-14 (when the client/patient out of pocket costs were approximately 60%), health insurers funded approximately 17% of the expenditure on oral health care. Data are publicly available on 21 Australian Dental Association (ADA) item numbers.

[5] Australian Institute of Health and Welfare (2015b). Health expenditure Australia 2013–14. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.

[6] 'Health and other' comprises Australian Government Department of Health funded-expenditure such as on MBS and Pharmaceutical Benefits Schedule (PBS), and other Australian Government expenditure such as for the nation al Specific Purpose Payments (SPP) associated with the National Healthcare Agreement and health-related National Partnership (NP) payments, capital consumption, estimates of the medical expenses tax rebate, and health research not funded by Health.

[7] 'Premium rebates' includes the rebate on health insurance premiums that can be claimed either directly from the Australian Government through the taxation system or it may involve a reduced premium being charged by the private health insurance fund.

[8] 'Others' includes expenditure on health goods and services by workers compensation and compulsory third-party motor vehicle insurers, as well as other sources of income (for example, rent, interest earned) for service providers.

[9] Australian Institute of Health and Welfare (2014b). Health expenditure Australia 2012–13. Health and welfare expenditure series no. 52. Cat. no. HWE 61. Canberra: AIHW

[10] *Op cit* 5 (AIHW 2015a)

In 2013-14, private health insurers paid $2.2 billion for dental services of the $4.3 billion they paid for all general treatment services. Insurers pay more benefits for dental services than any other type of general treatment, amounting to 51.6%, followed by optical at 17.4%. While consumers are aware of gaps between dental charges and the amount paid by their health insurer, there is little information available about average dental charges[11].

Information on the ADA item numbers and the state and territory rebates 21 of the private health insurers paid for those items in 2014 is presented at Appendix 2.

Burden of disease indicators

Avoidable hospitalisation rates

The most common conditions identified by the AIHW that were responsible for potentially avoidable hospitalisations (PAH) were diabetes complications, chronic obstructive pulmonary disease (COPD) and dental conditions (Katterl *et al* 2012).[12] [13]

> *The Australian Institute of Health and Welfare (AIHW) described potentially avoidable hospitalisations (PAHs) as "admissions to hospital that could have potentially been prevented through the provision of appropriate non-hospital health services". The AIHW classify PAHs into three main types: Vaccine-preventable, chronic and acute conditions. In 2009-10, PAHs related to chronic conditions were the most common, due mainly to the high rates of hospitalisations for diabetes complications (24% of all PAHs). Moderately high rates of PAHs were also reported for chronic obstructive pulmonary disease (COPD), dehydration and gastroenteritis, and dental conditions (9-10% of all PAHs).*
>
> *Several independent groups of researchers have shown that poor access to primary health care is strongly related to higher rates of PAHs. In Australia, data on PAHs are collected routinely by the AIHW6 and used as an indicator of primary health care accessibility and effectiveness.*
>
> Katterl *et al* 2012 p 5[14] [15]

In 2009 – 2010, the number of PAHs for dental health conditions was 60,251 (8.7% of all PAHs), making dental conditions the fourth leading cause of PAHs, after diabetes, COPD, dehydration and gastroenteritis (Katterl *et al* 2012).[16] Higher proportions of PAHs for dental health conditions were reported for children under 15 years compared to adults in 2001/2002, with 24% of children and 13% of adults aged 15 – 44 years hospitalised (Katterl *et al* 2012).[17] In the period 2011 -2013, the National Hospital Morbidity Database showed that more Aboriginal and Torres Strait Islander

[11] http://www.privatehealth.gov.au/healthinsurance/whatiscovered/averagedental.htm

[12] Katterl R, Anikeeva O, Butler C, Brown Lynsey, Smith B, Bywood, P (2012 Health expenditure Australia 2013–14. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.). Potentially avoidable hospitalisations in Australia: causes for hospitalisations and primary health care interventions. PHCRIS Policy Research Review, Adelaide: Primary Health Care Research & Information Service (PHCRIS)

[13] Hospitalisations data are presented as either admissions or separations. A 'separation' refers to the formal process whereby an in-patient (admitted patient) leaves a hospital or other health care facility after completing an episode of care.

[14] Katterl R, Anikeeva O, Butler C, Brown Lynsey, Smith B, Bywood, P (2012). Potentially avoidable hospitalisations in Australia: causes for hospitalisations and primary health care interventions. PHCRIS Policy Research Review, Adelaide: Primary Health Care Research & Information Service (PHCRIS)

[15] A number of caveats were provided by the authors for both the data and "interpreting analyses". Refer to p 5. Importantly, Katterl *et al* 2012 "…caution that higher rates of hospitalisation are not necessarily due to poor access to primary care, but in some circumstances may reflect better access. That is, hospitalisation may occur as a result of better detection of impairments in the primary health care setting"

[16] *Op cit* 13 (Katterl *et al* 2012)

[17] *Op cit* 13 (Katterl *et al* 2012)

peoples were hospitalised for dental conditions than were non-Indigenous Australians: the rate of hospital separations per 1000 population was 4 for Aboriginal and Torres Strait Islander Australians compared with 3 separations per 1,000 population for non-Indigenous Australians (Australian Health Ministers' Advisory Council 2015).[18]

> *The current high rate of hospitalisation for acute dental conditions suggests that patients are not receiving timely and effective diagnoses and interventions in the primary setting. Hence, it is likely that PAHs for acute dental conditions represents a lack of access to, or uptake of, primary dental health care.*
>
> Katterl *et al* 2012 p 25[19]

Further work by health economists may be warranted to estimate/model the cost to the system of preventing PAHs for dental conditions.

In addition, other AIHW data are available to provide a picture of the prevalence of preventable but untreated dental conditions. In 2010, three out of 10 adults had untreated tooth decay and four out of ten young children still experienced tooth decay (AIHW 2014, NOHPDG 2014).[20] In its latest publication on the trends in oral health and dental care in Australia, the AIHW (2014), using data from 1977 to 2010, reported that Australia's oral health had improved over this period. There had been a gradual improvement on key measures surveyed (e.g. the average number of children's baby teeth affected by decay reduced and between 1987-88 and 2004-05 the average number of teeth affected by decay (caries) decreased from 1994 to 2010).[21] "The proportion of people aged 15 years and over reporting any adverse oral health impact generally rose from survey to survey, with exceptions in 2002 and 2010", for example:

- *From 1977 to 1995, data from examination of school-aged children in school dental services suggests there was a steady drop in the average number of children's baby teeth affected by decay. There has, however, been a gradual rise from 1996* [to 2010].
- *Between 1987–88 and 2004–06, national surveys reported a decrease in the average number of teeth affected by decay (caries experience) in adults.*
- *From 1994 to 2010, the proportion of people aged 15 and over reporting any adverse oral health impact generally rose from survey to survey, with exceptions in 2002 and 2010. The proportion ranged between 31.4% (1994) and 39.9% (2008).*

AIHW 2014c p 6[22]

The greatest burden of oral disease is associated with socially disadvantaged and marginalised groups including:

- Aboriginal and Torres Strait Islander people
- people living in regional and remote areas

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[18] Australian Health Ministers' Advisory Council (2015). Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report. Canberra: AHMAC

[19] *Op cit* 13 (Katterl *et al* 2012)

[20] The most common measure of unmet need for oral health treatment is the rate of untreated tooth decay

[21] Deciduous caries experience (DMFT) is recorded as the number of deciduous (baby) teeth that are either decayed (d), missing (m) because of dental caries or filled (f) because of dental caries. … Permanent caries experience (DMFT) is recorded as the number of permanent teeth that are either decayed (D), missing (M) because of dental caries or filled (F) because of dental caries, and is also based on the WHO protocol (AIHW 2014, p 2)

[22] Australian Institute of Health and Welfare (2014c). Oral health and dental care in Australia: key facts and figures trends 2014. Cat. no. DEN 228. Canberra: AIHW

- people who are socially disadvantaged or on low incomes
- People with additional or special needs
  - frail older people
  - people with a disability
  - people with mental illness
  - people with complex medical needs (NOHPDG 2014).[23]

Aboriginal and Torres Strait islander people and adults who are socially disadvantaged or on low incomes have more than double the rate of poor oral health compared with the general population.

Accessing primary oral health care

There are two main reasons a person may visit a dental professional[24] – for routine check-ups and for an established dental problem. Generally, people who seek regular and routine care report lower rates of extractions and relatively low rates of fillings (Ellershaw & Spencer 2011).[25]

Overall, dental visiting patterns has improved from 1994 to 2010 (AIHW 2014).[26] A recent survey in 2013 –14 found a slight decrease in the overall trends for dental visiting in the last 12 months, where one in two (50%) adults made a dental visit in the previous 12 months (ABS 2014).[27] [28]

Risk groups experience inequities in oral health status and access to appropriate and affordable services. In the general population, people who experienced difficulty in accessing an oral health practitioner may avoid/delay their dental visits. As shown in Figure 1, people who reported difficulty in accessing a dentist varied according to:

- place of residence (29% resided in the outer regional and remote Australia)
- having a disability (23.2%)
- having a mental condition (18.7%)
- having a long term health condition (18.6%)
- age (19.7% were over 75 years and over)
- type of family (around 20% from a one parent family)
- education (19.5% were people aged 18 years and over whose highest qualification was Year 12 or below) (ABS 2015).[29]

[23] *Op cit* 1 NOHPDG (2014)

[24] All the data reviewed did not distinguish types of "dental professionals". We assume when the term 'dental professional' is used, it may refer to dentists (generalists and specialists), dental prosthetists or OHPs, and possibly auxiliary oral health staff (eg dental assistant).

[25] Ellershaw AC, Spencer AJ (2011). Dental attendance patterns and oral health status. Dental statistics and research series no. 57. Cat. no. DEN 208. Canberra: AIHW

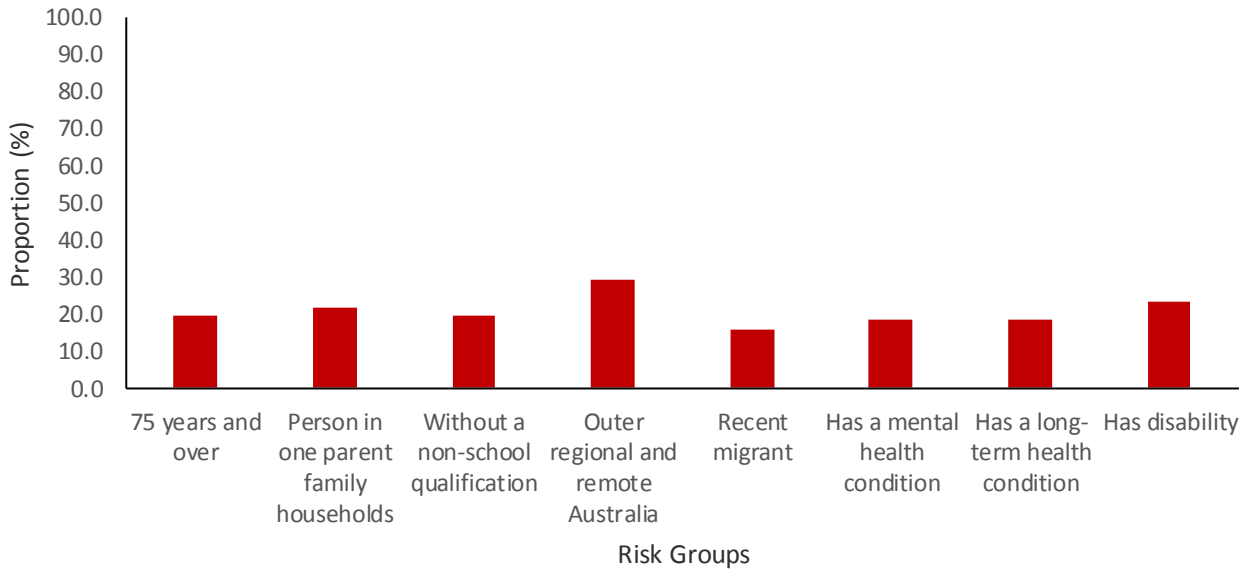
[26] *Op cit* 21 (AIHW 2014c)

[27] Australian Bureau of Statistics (ABS) (2014). Patient Experiences in Australia: Summary of Findings, 2013-2014. Cat no. 4839.0. Canberra: ABS

[28] The 2013 –14 data were gathered using different survey instruments and samples from the 1994 -2010 data.

[29] *Op cit* 26 (ABS 2014)

Figure 1 Proportion of people by risk groups who had experienced difficulty accessing a dentist in 2014



Source: General Social Survey (GSS): Summary Results, Australia 2014[30]

Despite gradual improvements in Australia's oral health from 1977 to 2010, and from 1996 to 2010, data on dental visiting showed a decline: "…the proportion of people aged 15 and over who made a dental visit in the previous 12 months increased from 56% in 1994 to 62% in 2010" (AIHW 2014 p 8).[31]

The national funding programs through which OHP services are financed include the Child Dental Benefits Schedule (which replaced the Medicare Teen Dental Plan from January 2014) and the current National Partnership Agreement (NPA) Adult Public Dental Services (2015-16). The NPAs on public dental services replaced programs for adults with low incomes. Under the NPAs, Commonwealth Government plays a role in the funding dental services and the state and territory governments are responsible for delivering the public dental program for children and eligible adults.[32] A large proportion of service delivery is conducted in the private sector by dentists and OHPs. These services are financed by patients themselves, rebates and private insurers. For further detail relating to private health insurers and rebatable amounts for dental services provided please refer to appendix 2.

Barriers to accessing services remain cost and distance to travel to services especially for some groups with priority health needs (people with low incomes, people who are socially disadvantaged, older, have a disability, identify as Aboriginal and Torres Strait Islander, live in rural and remote locations. More dentists per capita work in metropolitan centres, leaving these centres oversupplied and outer regional and remote populations underserved.

Indigenous Australians

Data from the 2012-13 Australian Aboriginal and Torres Strait Islander Health Survey (AATSIHS) to inform analyses of the extent to which Indigenous Australians accessed oral health services.

[30] The 2014 General Social Survey did not include people living in very remote and discrete Aboriginal and Torres Strait Islander communities in their sample

[31] *Op cit* 21 (AIHW 2014c)

[32] See Appendix 1 for a matrix of government oral health programs and funding

These analyses were conducted by the AIHW (2015) and are summarised here:

Indigenous Australians were less likely to have consulted a dental professional. In 2012–13, among Indigenous people aged 2 and over:

- *14% had never seen a dental professional—a significantly higher proportion than for all Australians (5%)*
- *two-fifths (41%) had consulted a dental professional in the previous 12 months—a significantly lower proportion than for all Australians (48%)*
- *a significantly higher proportion in remote areas (21%) had never seen a dental professional compared with those in non-remote areas (12%)*

AIHW 2015 p 131[33]

Among Indigenous Australians aged 2 years and over who had ever seen a dental professional:

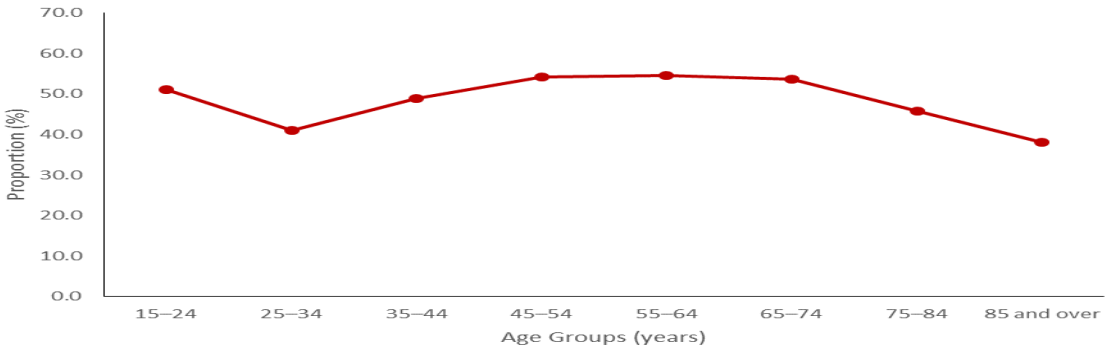
- *33% had their last dental consultation at a private dental practice, 30% at a government dental clinic, 16% at a school dental service, 16% at an Aboriginal Medical Service or community clinic, 2% elsewhere and the remainder (2%) said they did not know*
- *the proportion last consulting a dental professional at a private dental practice was significantly lower in remote areas (13%) than in non-remote areas (38%)*
- *the proportion last consulting a dental professional at an Aboriginal Medical Service or community clinic was significantly higher in remote than non-remote areas (31% compared with 12%) (AIHW analysis of 2012–13 AATSIHS)*

AIHW 2015 p 132[34]

Age group differences

In 2010, the proportion of adults who had visited a dental professional in the last 12 months increased with age. More people aged 65 years and above had visited a dental professional in the last 12 months (66.9%) than those in the age group of 45 – 64 years (63.6%) (AIHW, Harford & Islam 2013).[35] More than half of the people in each age group shown in Figure 2, were likely to visit a dental service in the last 12 months; people aged 25 to 34 years were least likely to visit a dental professional (41%); and more than 45% of people aged 75 – 84 years reported that they had made a visit to a dental professional at least once in the previous 12 months (ABS 2014).[36]

Figure 2 Proportion of people by age group who made a dental visit in the last 12 months for 2013 -2014



Source: Patient Experience Survey: Summary of Findings, 2013 – 2014

[33] *Op cit* (AIHW 2015)

[34] *Op cit* (AIHW 2015)

[35] AIHW, Harford JE & Islam S (2013). Adult oral health and dental visiting in Australia: results from the National Dental Telephone Interview Survey 2010. Dental statistics and research series 65. Cat. no. DEN 227. Canberra: AIHW.

[36] *Op cit* 25 (ABS 2014)

Barriers to accessing oral health services

Barriers to accessing oral health care include:

- the availability of oral health providers in rural and remote locations
- the cost of oral health care (AIHW 2014).[37]

The cost of oral health in Australia has been disproportionately funded by patients whose out-of-pocket expenses amounted to 58% of the total health expenditure on dental services in 2012-13 (AIHW 2014)[38] and approximately 60% in 2013-14 (AIHW 2015).[39]

Indigenous Australians

The results of the 2012-13 AATSIHS indicate that for Indigenous Australians the main barriers to accessing oral health services were remoteness and cost:

- *among Indigenous people aged 2 and over, 1 in 5 (20%) reported that they had needed to go to a dentist in the previous 12 months but did not, with those in non-remote areas significantly more likely to report this than those in remote areas (22% compared with 15%)*
- *cost was the most commonly reported reason for not visiting a dentist in the previous 12 months—this was reported by 43% of Indigenous Australians aged 2 and over who had needed to see a dentist in the past 12 months but did not. There were some differences by remoteness:*
  - *in non-remote areas, cost was the most common reason (47%), followed by being too busy (including work, personal and family responsibilities) (21%)*
  - *in remote areas, the most commonly reported reasons were lack of availability in the area (31%) and cost (25%).*

AIHW 2015 p 132 [40]

Remoteness differences

Findings from the National Dental Telephone Interview Survey 2010 and the Patient Experience Survey 2013 –14 suggest that adults were less likely to visit a dental professional at least once over the last 12 months if they were living further away from urban areas. As shown in Figure 3, adults who lived in major cities (63.1%) were more likely to have make a visit to a dental professional in the previous 12 months than those who lived in inner (55.7%) and outer regional areas (54.1%), as well as remote/very remote areas (45.8%) in 2010 (AIHW, Harford & Islam 2013).[41] This represents an almost 20% difference between people living in the major cities and remote/very remote. The distribution of access by remoteness appears to closely mirror the distribution of the workforce by remoteness as seen in Section 2 Box 2 below.

[37] *Op cit* 21 (AIHW 2014c)

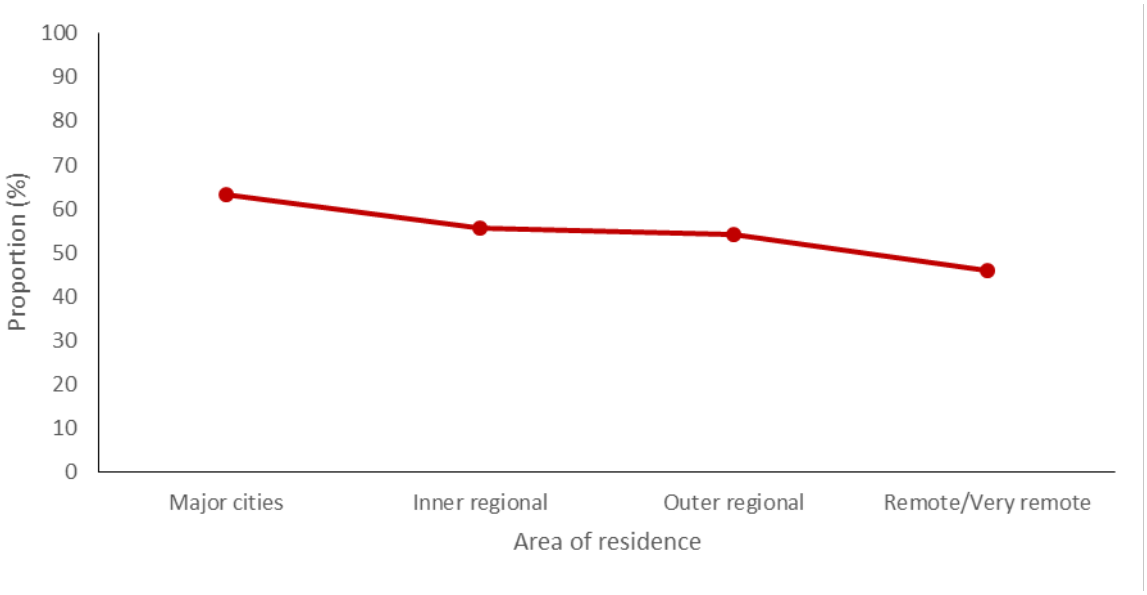
[38] *Op cit* 9 (AIHW 2014a)

[39] *Op cit* 5 (AIHW 2015)

[40] *Op cit* 33 (AIHW 2015)

[41] *Op cit* 35 (AIHW, Harford & Islam 2013)

Figure 3 Proportion of people by area of residence who had visited a dental service in last the last 12 months in 2010



Source: National Dental Telephone Interview Survey 2010

ABS data analyses suggest a similar pattern - more adults who lived in major cities made a visit to a dental professional in the last 12 months (51.4%) than did those who lived in the inner regional (46.4%) and outer regional/remote/very remote areas in 2013 –14. (43.5%) (ABS 2014).[42]

In the general population, the likelihood of avoiding/delaying a dental visit due to cost is lower for adults who reside in the major cities. For example:

- In 2010, approximately 30% of adults surveyed who lived in the major cities reported that they avoided/delayed their visit to a dental professional due to cost, when compared with 62.2% of adults living in the outer regional/remote/very remote areas (AIHW, Harford & Islam 2013).[43]
- In 2013 –14, 18.3% of adults surveyed who lived in the major cities avoided/delayed making a visit to a dental professional because of cost, when compared with 24.8% of adults living in the outer regional/remote/very remote areas who delayed/avoided making a dental visit because of cost (ABS, 2014).[44]

Although the findings mentioned above were gathered from two different surveys, they may suggest that the proportion of adults avoiding/delaying a dental visit had declined in the period of 2010 to 2014.

In the general population, most people reported avoiding/delaying their dental visit because of cost. Nearly 40% of the adults surveyed experienced financial barriers or hardship associated with dental visiting, as follows. The proportion of people who associated dental visiting with financial barriers or hardship ranged from 27.4% in 1994 to 39.6% in 2005. The trend remained relatively stable from 2005 to 2010.

[42] *Op cit* 25 (ABS 2014)

[43] *Op cit* 35 (AIHW, Harford & Islam 2013)

[44] *Op cit* 25 (ABS 2014)

Income differences

In the general population, people from higher income households were more likely to make a dental visit in the last 12 months than those in the lower income households, for example:

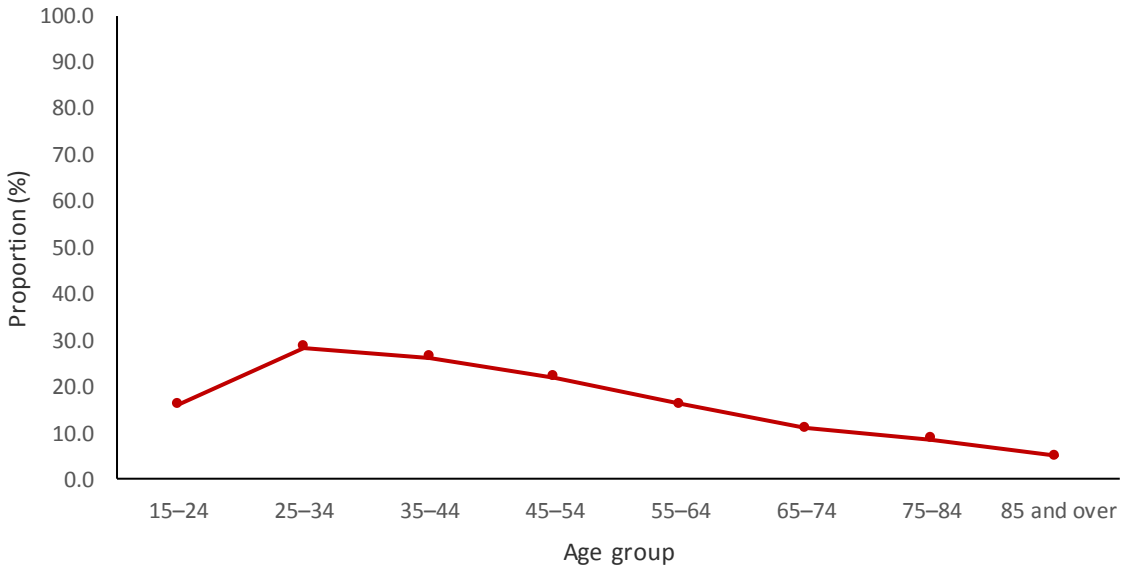
- Around 50% of people with a household income of less than $12,000 per year made a visit to a dentist in the previous 12 months compared to the 67% of those with a household income of at least $100,000.
- Those in the with a household income of less than $12,000 per year were also less likely to visit the dentist in the past 2 years than those in the higher income of at least $100,000 (34% compared to 16%) (AIHW 2014c).[45]

Higher income earners were less likely to avoid/delay a dental visit due to cost than lower income earners. More than 48% of those with an annual household income of less than $30,000 avoided/delayed making a visit to a dental professional due to cost, when compared with 15.8% of adults with a household income of more than $110,000 per year in 2010 (AIHW, Harford & Islam 2013).[46]

Age group and cost barriers differences

The likelihood of avoiding/delaying dental visits due to cost was higher for those in their mid to late twenties when compared with children and older adults (Chrisopoulos & Brennan, 2013).[47] In 2014, nearly 30% of people within the age group of 25 to 34 years old avoided/delayed seeing a dental professional due to cost. The proportion of people who reported avoiding/delaying dental visits due to cost is shown by age group in Figure 4 (ABS 2014).[48]

Figure 4 Proportion of people by age group who delayed or avoided a dental visit due to cost in 2013 - 14



Source: Patient Experience Survey: Summary of Findings, 2013 –14

[45] *Op cit* 21 (AIHW 2014c)

[46] *Op cit* 35 (AIHW, Harford & Islam 2013)

[47] Chrisopoulos S, Luzzi L, Brennan, DS (2013). Trends in dental visiting avoidance due to cost in Australia, 1994 to 2010: an age-period-cohort analysis. *BMC health services research, 13(1*), 381.

[48] *Op cit* 25 (ABS 2014)

Section 2 Oral health practitioner workforce

Oral Health Practitioners represent a group of nationally accredited health professionals with the skills and capability to meet the increasing demand for oral health care. The development of OHPs has been supported by successive governments because, like allied health professionals, they increase the capacity in the system to provide a model of care in which curative dentistry is appropriately balanced with oral health promotion and oral diseases prevention strategies.

The skills, knowledge and training of oral health practitioners is extensive.

Australian universities offer Dental Board of Australia (DBA) approved three year bachelor degrees in oral health therapy and dental hygiene. People who complete the three-year degrees in oral health therapy or dental hygiene are also able to register as oral health therapists and undertake work in the dental therapist scope of practice as well as the dental hygienist scope of practice. Oral health therapists and dental hygienists can examine, diagnose and provide preventive and periodontal treatment to people of all ages. The Bachelor of Oral Health Therapy at the University of Newcastle graduates oral health therapists with an adult scope of practice. La Trobe University and the Central Queensland University institutions offer the Graduate Certificate in Dental Therapy (Advanced Clinical Practice). All approved programs lead to registration as an OHP. [49]

Three-year DBA approved bachelor degree programs include health sciences, human biology, anatomy and physiology, microbiology, pathology, oral medicine, dental medicine, pharmacology, dental materials, periodontics, risk factors, aetiology of disease, oral biology (cariology and periodontology, orthodontics, pediatric and geriatric dentistry, special needs dentistry, behavioural sciences, health policy and sociology, oral health promotion and education, research, dental public health, preventive dentistry, community dentistry, minimal intervention, dental radiography, restorative dentistry, local anaesthesia and clinical practice (including examinations, diagnosis and treatment planning), and oral health care delivery within their scopes of practice. These programs include a period of clinical experience, usually in public hospitals and university facilities.

National registration has been in place since 2010. In order to practise, dentists, dental prosthetists and OHPs are required to hold 'general' registration with the DBA (on behalf of Australian Health Professionals Registration Agency [AHPRA]) and must comply with all DBA standards. The National Law[50] requires the same level of professional responsibility and quality standards of care of OHPs as it does from dentists, dental specialists and dental prosthetists; all OHPs must have their own professional indemnity insurance and radiation licences. The DBA sets out the registration standards and eligibility criteria for the professions in Australia. The DBA has determined that only dental therapists with additional training from the accredited programs at la Trobe University, Central Queensland University and Newcastle University can treat people over the age of 25.

A revised scope of practice registration standard came into effect on June 30, 2014. It affirms a preventive model with *direct* access to primary preventive dental providers such as OHPs working autonomously in collaborative and referral models with dentists in community settings, in the team approach to care. It removed the term "supervision' from the standard so that it better reflected the way that dental and oral health therapists had always worked. Primary preventive oral health care can be integrated into general health services such as programs targeting chronic disease (e.g. diabetes services; residential and home-based aged care; juvenile justice; disability services;

[49] Health Workforce Australia (2014). Australia's future health workforce – Oral Health – detailed report. Adelaide: HWA

[50] The National Law refers to the Health Practitioner Regulation National Law. Under the National Law, there is a range of registration categories under which a dental practitioner can practise in Australia. AHPRA's operations are governed by the National Law which come into effect on 1 July 2010. The law applies in each State and Territory. More information about the National Law can be found through: http://www.dentalboard.gov.au/Registration.aspx

outreach and hospital-based oral health services). Like other allied health professionals in primary care, OHPs must still work in a structured relationship with a dentist. These changes have allowed primary oral health providers to move into private practice, but do not on their own allow the full benefit to the system and individuals to be realised. The standard is to be reviewed in 2017.

Workforce numbers and distribution

Between 1994 and 2010 the supply of oral health practitioners grew. In the period 2011-2012 the rate of dentists per 100,000 of population was estimated to have increased from 55 to 57 dentists.

The Dental Board of Australia statistical data on registered general dental practitioners show that the number of dental practitioners with general registration in June 2015 was 21,209.[51] Of these, approximately 20% (4,064) were oral health practitioners:

- 1,139 were oral health therapists
- 1,373 were dental hygienists
- 1,063 were dental therapists
- 483 were both dental hygienists and dental therapists
- 6 were both dental therapists and oral health therapists.[52]

In 2011 workforce projections conducted by the AIHW estimated that the annual number of OHPs graduating from Australian institutions would increase to 335 by 2015. Data on future demand have not taken into consideration models of care which include OHPs practising independently, or issues of maldistribution of the dentist workforce.

> *Over the projection period 2006-2025, the number of practising:*
>
> - *oral health therapist numbers will increase the most, more than 460%, from 371 to 2,117*
> - *dental hygienist numbers are expected to more than double, from 674 to 1,458*
> - *practising dental therapist numbers are projected to decrease by 61%, from 1,171 to 443.*
>
> *Overall, the number of oral health practitioners per 100,000 population is expected to increase by 52%, from 10.8 oral health practitioners per 100,000 population to 16.2 by 2025.*
>
> AIHW 2011 p 2[53]

The Australian Government funded the Voluntary Dental Graduate Year Program and the Voluntary Oral Health Therapist Program to target oral health workforce shortages in rural and remote areas. The funding for the programs was ceased because less than 5% of participants were undertaking placements in rural and remote regions. Some believe that this may have been contributed to by a decrease in employment opportunities in the rural and remote areas "because the NPA funding was cut just as many were completing their graduate year." (Cole 2015).[54]

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[51] Dental practitioners within the DBA general registration category include dentists, dental prosthetists, dental hygienists, oral health therapists, dental therapists

[52] Dental Board of Australia Report: Quarterly Registration Statistics June 2015. Accessed 6 September 2015 at: http://www.dentalboard.gov.au/About-the-Board/Statistics.aspx

[53] Australian Institute of Health and Welfare (2011). Oral Health practitioner labour force projections, 2006-2025

[54] Cole D (2015). Viewing the mouth as part of the body: Why dental health funding is important. Australian Health and Hospitals Association webpage accessed 6 October 2015 at: https://ahha.asn.au/news/viewing-mouth-part-body-why-dental-health-funding-important

Oral Health Practitioners are fairly evenly distributed across metropolitan, regional, outer regional, remote and very remote locations. In contrast, the rate of dentists per 100,000 of population by remoteness as seen in Box 2 below shows that most dentist are based in major cities. A number of OHPs are employed in public dental services based in regional and remote areas, but are underutilised because of the lack of clarity and consistency in in state and territory government policies that establish that OPHs can provide restorative treatment (i.e. fillings or dental therapy care) to patients who are over the age of 18 or 25 could improve timeliness of access to quality oral health care in Australia.[55] [56]

Box 2

Table 2.2: Registered dental practitioners per 100,000 population, by practitioner type, remoteness area[(a)], 2012

Practitioner type	Major cities	Inner regional	Outer regional	Remote/ Very remote[(b)]	Australia[(c)]
Dentists	72.3	45.6	39.0	22.7	64.7
Oral health therapists	3.3	3.3	3.0	1.3	3.2
Dental hygienists	8.4	3.7	4.0	2.1	7.0
Dental therapists	5.2	6.2	7.7	5.9	5.6
Dental prosthetists	5.4	5.6	3.2	0.4	5.1

(a) Derived from remoteness area of main job where available; otherwise, remoteness area of principal practice is used as a proxy. If remoteness area details are unavailable, remoteness area of residence is used. Records with no information on all 3 locations are coded to 'Not stated'.

(b) Includes *Migratory* areas.

(c) Includes dental practitioners who did not state or adequately describe their location and those who were overseas.

Source: NHWDS: dental practitioners 2012.

Waiting period is a measure of the timeliness of dental care that focuses on prevention and early intervention (Stewart & Ellershaw 2012 p42).[57] [58] The National Dental Telephone Interview Survey in 2008 found that:

> "*Overall 1.0% of cardholders waited less than one month and a further 24.5% waited less than three months to visit a public dental practice. However, 25.0% of those who visited a public practice waited between 1–2 years and 32.1% waited more than 2 years. Those who last visited for a check-up had longer waiting times than those who visited for a problem, although over one-in-two who visited for a problem waited 12 months or more.*"
>
> Stewart & Ellershaw 2012 p 42[59] [60]

[55] For example, a Victorian regulatory precedent established in 2009 that OHPs without additional training could treat patients up to the age of 25 but some states policies inhibit this and has continued to create uncertainty

[56] Australian Institute of Health and Welfare (2014). Dental workforce 2012. National health workforce series no. 7. Cat. no. HWL 53. Canberra: AIHW

[57] Stewart JF & Ellershaw AC (2012). Oral health and use of dental services 2008: Findings from the National Dental Telephone Interview Survey 2008. Dental Statistics and Research Series no. 58. Cat. no. DEN 216. Canberra: Australian Institute of Health and Welfare.

[58] The waiting times data are presented either as the time elapsed from contacting the clinic to the actual dental visit or the number of months patients have waited for general dental care.

We note that in 2010 National Dental Telephone Interview Survey did not collect or analyse waiting periods for dental care.

The first National Partnership Agreement (NPA) on Adult Public Dental Health was introduced in 2012-15. It included increased Australian Government funding to State and Territory governments to achieve targets to reduce adult public dental waiting lists in each state and territory. Limited data about state and territory oral health care waiting lists were publicly available:

- In 2015, NSW reported that 73% of adults waiting for general dental treatment were provided with dental care within the clinically acceptable benchmark time.[61] [62]
- Average time to treatment for general dental care in Victoria slightly increased slightly from April 2014 to June 2015.[63]
- As the NPA commenced in 2012, almost 56% of people on the waiting list in Queensland were reported to have been waiting beyond the desirable period.[64] [65]
- The Australian Capital Territory (ACT) Health Annual Report (2015) noted a significant drop in waiting times from 13.79 months in 2013 to 1.78 months in 2014.[66]

It may be possible to request data from State and Territory governments to further understand how many people are waiting for oral health care in the public system, in what locations and for what reasons. In addition consultations could explore public private models to make best use of the OHP workforce in rural and remote areas.

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[59] Cardholder status is used to determine eligibility for free or subsidised dental care provided by state and territory governments. Cardholders are persons who hold an Australian Government Government concession card (Health Care Card or Pensioner Concession Card) by virtue of their household income

[60] In the survey, cardholders whose last dental visit was at a public clinic within the previous 12 months were asked to report the time elapsed from contacting the clinic to the actual dental visit, defined as the waiting time

[61] The acceptable benchmark times are described in the NSW Policy Directive Priority Oral Health Program and List Management Protocols: http://www0.health.nsw.gov.au/policies/pd/2008/pdf/PD2008_056.pdf

[62] NSW Health (2015). NSW Public Dental Services – Waitlists and Activity. Retrieved from http://www.health.nsw.gov.au/oralhealth/Pages/public-dental-care-waiting.aspx

[63] Victorian Health Services Performance (2014). Average time to treatment for general dental care- Quarterly Data. Retrieved from http://performance.health.vic.gov.au/Home/Report.aspx?ReportKey=18

[64] Lalloo, R., & Kroon, J. (2013). Analysis of public dental service waiting lists in Queensland. Australian journal of primary health.The desirable period in Queensland is described in Lalloo and Kroon's (2013) paper.

[65] The desirable period in Queensland is described in Lalloo and Kroon's (2013) paper.

[66] ACT Health (2015). Annual Report 2013 -2014. Canberra: ACT Government Health Directorate

Section 3 How ADOHTA members meet oral health needs in Australia

Oral health practitioners are the primary preventive oral health providers. Their expertise in the field of dental disease prevention is recognised by their other dental professional and health service provider colleagues. They also provide education and oral health promotion to a wide range of patients and carers.

> Dental therapists have been practising for over 40 years providing examinations, diagnoses and treatment for children, adolescents and young adults in both collaborative and referral models of team care with dentists. They were once only employed in the public sector for the purposes of treating children under 18 years. Starting in Tasmania and South Australia in the 1960s, in Western Australia in the 1970s and much later nationally, dental therapists have been working in private practice providing examinations, diagnoses and treatment for children, adolescents and young adults.
>
> Oral health therapists are dual qualified in dental therapy and dental hygiene, and provide dental hygiene services to people of all ages. Oral health therapists provide dental therapy, dental hygiene and oral health promotion. They have practised in Australia since 2000. Their focus is on preventive oral health, concentrating on techniques that ensure oral tissues and teeth are maintained and remain healthy in order to prevent dental disease, especially common diseases such as dental caries, gingivitis and active periodontitis. In most cases they are restricted to providing restorative treatment to specific age groups.
>
> Dental hygienists carry out dental procedures within their scope of practice for people of all ages. Their scope of practice includes: dental health education, oral hygiene instruction, dietary counselling, examination, diagnosis and treatment planning, examination and recording of conditions of the hard and soft tissues and the recording of periodontal disease, radiography, impressions, study models, fluoride therapy, fissure sealants, polishing restorations, overhang removal, temporary restorations, scaling and prophylaxis, root debridement, rubber dam application, removal of sutures, periodontal dressings, application of desensitising agents and remineralising agents, orthodontic procedures, clinical photography, and tooth bleaching.

Oral Health Practitioners can make a major contribution to addressing the need for oral health care among frail aged people. Some oral health therapists are employed by aged care facilities to provide oral health assessments, oral hygiene care and referrals for residents as well as oral health education and health promotion for the staff and community. There is now community demand for dental and oral health therapists to include adult restorative care. In 2012, most employed dental hygienists worked in private practice (87.3%).[67]

Oral Health Practitioners work in a range of primary care models and settings (e.g. in their own private practices, in general practices, in dental practices, and in public and not-for-profit community services organisations to meet the prevention and primary oral health care needs of the population).[68] They continue to be well placed to meet the preventive oral health needs of the general population and population groups at higher risk of poor access to oral and other health services and at greater risk of poor oral health and its complications.

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[67] Australian Institute of Health and Welfare (2014). Dental workforce 2012. National health workforce series no. 7. Cat. no. HWL 53. Canberra: AIHW.

[68] "In Australia, primary health care is typically a person's first point of contact with the health system for a particular health issue and is most often provided outside the hospital system. A person does not routinely need a referral for primary health care, which includes services provided by GPs, dental practitioners, nurses, Indigenous health workers, pharmacists and other allied health professionals. In some cases, emergency departments within hospitals serve as a person's first point of contact with the health system (AIHW 2015, p 129).

These professions have matured and now work in multidisciplinary team models of health promotion and primary care. In 2010 they were among the generalist dental health professions included in the move to national registration by the Australian Health Professional Registration Agency (through the Dental Board of Australia).

As recently as 30 June 2014, oral health professionals' scopes of practice were revised, removing the word "supervision" (by a dentist) and replacing it with "work in a structured professional relationship with a dentist". Inconsistent interpretation and guidance about the meaning of these words has ensued.

In the case of the provision of Medicare funded services to veterans, only dentists and dental prosthetists are registered with the Department of Human Services (DHS) to provide services through the Medicare Benefits Scheme (MBS). Oral Health Practitioners are able to provide preventive dental services to members of the veteran community if directed by a dentist. Providers of dental services must agree to accept DVA treatment arrangements and fees and meet all of the following criteria:

- be registered with the DBA and comply with approved scope of practice registration standards
- be covered by their employer's indemnity insurance or maintain their own insurance as mandated by the DBA
- be qualified and competent to provide the service.[69]

Barriers exist which prevent dental and oral health therapists and dental hygienists from practising independently within their scope of practice. Their scope of practice standards which allow them to treat patients of all ages have not been updated consistently across all State and Territory policies procedures. A full recognition of the capacity for dental and oral health therapists and dental hygienists to practice independently of a dentist would assist in alleviating demand on current oral healthcare providers. Flexibility would be increased because Medicare provider numbers allow practitioners to treat people in settings not limited to a fixed dental practice.

Services which are provided by dental therapists, dental hygienists and oral health therapists must be billed through a dentist's provider number. The system level efficiencies seen in other allied health professions working in private practice could be achieved in oral health by enabling dental therapists, dental hygienists and oral health therapists to access Medicare provider numbers. Currently, only dentists and dental prosthetists can obtain provider numbers from Medicare. The absence of Medicare provider numbers means that dental therapists, hygienists and oral health therapists are unable to record services and bill patients using their own provider numbers. In addition, some Private Health Insurers (PHI) have rejected patient claims for rebate on services provided by dental and oral health therapists and dental hygienists while using the dentist's provider number, because they are concerned about fraudulent claims. This has resulted in out-of-pocket costs for patients.

The current Medicare financing arrangement has limited data, models of care and increased costs to individuals and Medicare:

- Oral health provider data are limited to dentist only data. Data are not available to Medicare on the extent and nature of oral health services provided in private practice by dental therapists, dental hygienists and oral health therapists, because they are aggregated within dentist data
- ADA items charged to Medicare using dentists provider number for OHP provided services are presented in a matrix at Appendix 3.

[69] http://www.dva.gov.au/providers/dentists-dental-specialists-and-dental-prosthetists

The Australian Government has examined workforce numbers, characteristics and sources of supply and reported on these in the study *Health Workforce 2025 – Oral Health*. The provision of provider numbers for the benefit of workforce data better describe the contribution oral health practitioners make to the delivery of dental services and the cost-benefits of a full utilisation of therapists in service settings. Reliable records will assist planners and policy makers.

The data do not distinguish the number of services which are performed by oral health practitioners and dentists and their distribution. In regional and remote areas, patients are predominantly seen by therapists, as dentist visits are sporadic and often weeks apart. Dental therapist, dental hygienist and oral health therapist services are billed using the dentists' provider number at the dentist's own rates which may incur higher cost to the system and/or limit the affordability of services to patients.

Section 4 ADOHTA's goals, activities, the policy process and decision makers

ADOHTA works on behalf of its members to provide leadership, collaboration and advocacy to deliver practical oral health outcomes for the community and the population as a whole, such as improved accessibility and affordability of preventive dental and oral health care, by

- enhancing the profession
- striving to advocate effectively for evidence based oral health oral health prevention and care
- influencing national oral health policy and program development.

ADOHTA is:

- prepared to work with governments and other peak bodies and stakeholders to support the delivery the governments' reform agendas to deliver more integrated and cost effective services
- committed to supporting governments, on behalf of its members, to make significant, measurable differences to the extent to which individuals, families and communities can more equitably access more affordable oral health services no matter where they live, and without a major funding impost on governments.

The OHP workforce costs less to educate, train and employ than dentists. OHPs and dentists have within their scopes of practice a number of clinical processes (item numbers) in common for which there are Australian Dental Association (ADA) item numbers. The items in common are set out by category at Appendix 2.

Better utilisation of the OHP (dental therapist, oral health therapist and dental hygienist) workforces could save government money, increase access to services and decrease waiting lists. Economies could be achieved by better utilising OHPs as the primary oral health care workforce reduction in health system costs associated with burden of poor oral health and related conditions (e.g. the costs of potentially avoidable hospital admissions for dental conditions).

Major policy achievements in the last 5 years have been 1) the 2010 national registration for all health professionals inclusion of OHPs 2) the Health Workforce Australia oral health practitioner scope of practice review in 2011[70] and 3) the 2014 DBA revised scope of practice registration standard, recognising the autonomous decision making of OHPs, and the collaborative and referral nature of their relationship with a dentist, in line with other allied health professionals and nurses.[71] ADOHTA also provided submissions to the House of Representatives Standing Committee on Health and Ageing inquiry into adult dental services which produced the report entitled Bridging the Dental Gap in 2013.[72] [73]

Siggins Miller undertook a rapid review of the 18 documents provided by ADOHTA from 2007 through to 2015. The documents were letters ADOHTA sent to state and federal, state and territory health ministers (one federal minister and all state ministers and territory chief executives) and their Departments of Health, discussion and briefing papers, one of which was submitted to the

[70] Health Workforce Australia (2011). Scope of Practice Review – Oral Health Practitioners. Adelaide: HWA

[71] Dental Board of Australia (2014). Scope of Practice Standard. Canberra: Dental Board of Australia

[72] House of Representatives Standing Committee on Health and Ageing (2013). Bridging the Dental Gap: Report on the inquiry into adult dental services. Canberra: Commonwealth of Australia

[73] The ADA used an editorial piece in the dentist's newsletter (Bite Magazine) to criticise the Report and its authors on the basis that the data sets used were not the most current, and that the recommendation to review the supervised status of therapists and hygienists was misplaced because they had only 2 years training compared with dentists who had 7 years training

Parliamentary Standing Committee for Health and Ageing's enquiry into Adult Dental Services and the ADOHTA membership, media releases, ADOHTA correspondence with potential policy reform advocates and ADOHTA's responses to enquiries from private health funds regarding provider number issues.

Most of the documents reviewed provided information on the issues relevant to Medicare provider numbers, scope of practice limitations, and the need for independent practitioner status for ADOHTA members. A number of other issues were also raised in the documents, for example:

- Confusion amongst private health fund providers and dental/oral health provider numbers.
- Concern that the historically subjugated and heavily regulated role of Dental Therapists and Dental Hygienists has not benefited the community.
- Workforce gaps and shortages
- Issues with tertiary education providers
- Models of service delivery which have been profession driven with a competitive focus rather than aiming on a supportive model.
- Supportive of the National Health and Hospitals Reform Commission oral health reforms.

All documents were designed with the aim of informing the target audience, advocating for the professions issues and making recommendations for change for which ADOHTA was seeking support. While the messaging and detail provided within the body of the documents was well informed and relevant to ADOHTA's organisational objectives, it was difficult to ascertain the impact they have had on their intended audience and what outcomes to which they have contributed.

In the last 10 years, Australia has implemented strategies based on *Healthy Mouths Healthy Lives, Australia's First National Oral Health Plan 2004-2014* and supported by Health Ministers at federal, state and territory levels.[74]

> *In August 2015, Federal State and Territory Health Ministers considered and endorsed the new National Oral Health Plan 2015-2024, which provides strategic direction and a framework for collaborative action over the next ten years. Translation of the plan into practice requires jurisdictions and sectors to work together, with the Oral Health Monitoring Group reporting on progress of the National Oral Health Plan every two years.*
>
> Council of Australian Governments Health Council 2015[75]

ADOHTA wishes to work with key decision makers and stakeholders to further develop opportunities to provide direct access to OHP services for people of all ages, particularly people with low incomes and poor access to oral health preventive care, as a critical part of the solution to expand access to preventive oral health care, improve oral health promotion and disease prevention, and contribute to reducing the number of avoidable hospital admissions for dental conditions. These improvements include adjustments in the composition, registration and scope of practice (ages and independent practice) of the OHP workforce, to make best use of the all oral health professionals working in primary care roles.

ADOHTA continues to advocate for changes to four drivers of improved affordability and access to primary oral health prevention and care. These are:

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[74] See Appendix 1 for a list of programs implemented by Australian governments from 2005 to 2015

[75] Council of Australian Governments (COAG) Health Council (2015). Communique August 2015. Accessed 10 September 2015 at: http://www.health.gov.au/internet/main/publishing.nsf/Content/F7AFA43E9E64023ECA257EB90018786B/$File/dept007.pdf

1. ultimately, changed education and registration scope of practice to include all age groups
2. to be deemed independent practitioners to fully utilise their scopes of practice no matter where they are working (in line with the current situation for other registered allied health professionals and nurses)
3. access to Medicare provider numbers by registered members
4. consistency in the way dental therapists and oral health therapists are referred to in state and territory drugs and poisons, and radiation legislation.

Key *decision makers* are organisations, groups or government departments which have been identified as being able to influence policy reform and decisions. Key decision makers relevant to obtaining Medicare provider numbers for ADOHTA member professions are Federal Government representatives in Medicare and sections responsible for provider numbers etc, the senior public servants who advise Ministers who in turn advise Cabinet about provider numbers.

Key *stakeholder groups* have been identified as those which ADOHTA can seek to engage and partner with to advocate and promote policy reform in the oral health sector. Key stakeholders are ADOHTA members, employers and employer groups including State and Territory Governments and the community and peak consumer groups. Other potential stakeholders are peak Aboriginal and Torres Strait Islander health and public health advocacy bodies, key academics in population health and wellbeing, key public health associations and the medical and dental associations and colleges.

The analysis of decision maker and stakeholder groups presented at Table 2 below is not intended to limit the groups, organisations or departments which could appropriately be decision makers or stakeholders. The analysis will remain a living piece throughout the consultancy project. Stakeholders and their groupings will be reviewed and refined as the environment changes across the life of the project.

Table 2 Preliminary key decision maker and stakeholder analysis

Key decision makers		
Commonwealth Department of Health	State and Territory Health Departments and: • NSW Centre for Oral Health Strategy • SA Dental Services • Dental Health Services Victoria	Medicare Benefits Schedule (MBS) Review Taskforce
Primary Health Care Advisory Group	Commonwealth Department of Human Services	Signatories to the NPA on public dental services
National Oral Health Plan Monitoring Group (NOHPMG)	The COAG Standing Council on Health through the Australian Health Ministers; Advisory Council tasked the NOHPMG to oversee the review of the plan, the development of the 2015 plan and its implementation	Responsible for the development, implementation, and monitoring of the National Oral Health Plan
Key stakeholders groups		

National Aboriginal Community Controlled Health Organisation	Services for Australian Rural and Remote Allied Health	Royal Flying Doctor Service
Consumer Health Forum of Australia	Australian Health care and Hospitals Association	Australian Institute of Health and Welfare
Dental Hygienists Association of Australia	Dental Board of Australia	Australian Dental Association
Australian Society of Special Care in Dentistry	Australian Dental Prosthetists Association	The Royal Australian College of General Practitioners
Australian Medical Association	National Aged Care Alliance	Aged and Community Services Australia Inc
Australian Research Centre for Population Oral Health (ARCPOH)	Oral Health Professionals Association (OHPA)	Dental Directors of Australia
Australian Council of Social services (ACOSS)	Brotherhood of St Laurence	Australian Dental Council (accredits education providers)
Public Health Association of Australia Inc (PHAA) especially the Oral Health Special Interest Group	Australian Healthcare Reform Alliance	College of Oral Health Academics
Australian Research Centre for Population Oral Health (ARCPOH)	National Rural Health Alliance (NRHI)	Council on the Ageing (COTA)

Appendix 1 Oral health funding programs, providers, and funding sources

This matrix presents funding programs relevant to the provision of preventive oral health services. The national funding programs presented in this matrix are historical apart from the Child Dental Benefits Schedule (which replaced the Medicare Teen Dental Plan from January 2014) and the current National Partnership Agreement (NPA) Adult Public Dental Services (2015-16). The NPAs on public dental services replaced programs for low income adults. Under the NPAs, Commonwealth Government plays a role in the funding dental services and the state and territory governments are responsible for delivering the public dental program for children and eligible adults.

Dental and oral health funding programs	Provider/Auspice	Funder/Period
Australian Government (national)		
Enhanced Primary Care Program (became the Medicare Chronic Disease Dental Scheme) (People with specified chronic disease impact on, or impacted by, their oral health who are being managed by their GP under a GP Management Plan and Team Care Arrangements, or a multidisciplinary care plan for residents of aged care facilities. Dental practitioners may set their own fees and in some cases patients may have out-of-pocket expenses. The care planning requirements are the same as those under the EPC allied health items, and the existing EPC dental items Medicare primary care items provide Medicare rebates for a range of services provided by general practitioners, nurse practitioners, midwives, practice nurses and allied health providers. A range of services are covered by the dental items, including dental assessments, preventive services, restorative services such as fillings, crowns, bridges and implants, extractions and other oral surgery. Capped at $4,250 over two calendar years)	Dentists, dental specialists and dental prosthetists registered with Medicare Australia.	Medicare 2004-2007 closed
Medicare Chronic Disease Dental Scheme (People with GP managed chronic disease whose oral health is or is likely to impact on their general health. Program design details as above for the EPC)	GPs sign up people with chronic diseases for the dental scheme	Medicare 2007-2012 closed
Commonwealth Dental Health Program (not implemented) (Public dental services included dedicated funds for Aboriginal and Torres Strait Islander people).	TBA	Commonwealth 2007
Medicare Teen Dental Plan (Children aged 12-17 receiving Family Tax Benefit A, and other income support payments. Teenagers can receive a preventive dental check)	Most dentists were registered to provide services and dental therapists, dental hygienists and oral health therapists were also able to provide services under the supervision of a dentist	Medicare 2008-2013 Closed Note: covered in the Child Dental Benefit Scheme (see below for details)
Voluntary Dental Graduate Year Program (Provide practice, experience and professional development opportunities, including in underserviced areas, to additional dental graduates. Program will support 50 voluntary dental graduate placements per annum.)	Australian Information technology Engineering Centre is responsible for advertising, participant selection and roll out of the measure.	Australian Government Department of Health 2013-2016

Dental and oral health funding programs	Provider/Auspice	Funder/Period
		current
Oral Health Therapist Graduate Year Program (Provide practice, experience and professional development opportunities, including in underserved areas, to additional oral health graduates to develop a public sector workforce. Enable graduates to provide additional preventive dental care and health advocacy to adults and children in areas of need)	Australian Information technology Engineering Centre (AITEC) is responsible for advertising, participant selection and roll out of the measure.	Australian Government Department of Health 2012/3 - 2015/16 current
Dental Relocation and Infrastructure Support Scheme (Provided to encourage and support dentists to relocate to regional and remote areas. The measure was designed to help improve dental workforce distribution and service deliver capacity in regional and remote communities)	The Rural Health Workforce Australia	Commonwealth 2013-2014 closed
NPA – Treating More Public Dental Patients ($344 million over three years for additional dental services to a target of 400,000 adult public dental patients to reduce public dental waiting lists. The objective is to alleviate pressure on public dental waiting lists with a particular focus on Indigenous patients, patients at high risk of, or from, major oral health problems and those from rural areas. Funding will be targeted at treating additional people with a focus on the following: priority access clients, areas of high demand and high need and areas with long waiting lists)	Funding is provided to Australian states and territories. The states and territories will then provide funding to Hospitals and Health Services, public and private sectors.	Commonwealth 2012-13-2014-15 closed
NPA – Adult Public Dental Services ($155 million over 1 year for additional dental services to a target of 178,000 adult public dental patients to reduce public dental waiting lists)	Australian states and territories	Commonwealth 2015-16 current
Child Dental Benefit Scheme (CDBS) (Aims to provide access to Medicare benefits for basic dental services to 3 million children aged 2-17 years including dental examinations/check-ups, x-rays, cleaning, fissure sealing, fillings, root canals and extractions. A child is eligible if they are eligible for Medicare and is part of a family receiving Family Tax Benefit Part A. The CDBS can be accessed in either the private or public sector. The total benefit is capped at $1,000 per child for two calendar years. Benefits are not available for orthodontic or cosmetic dental work and cannot be paid for any services provided in a hospital)	Public or private dentists	Medicare Since January 2014 current
State and territory governments		
Australian Capital Territory Dental Services		
Child and youth dental services (Service provides children and young people with comprehensive dental assessment, oral health plans based on individuals' needs, general preventive and restorative treatment and emergency treatment. All children who are under 5 who live in the ACT, all children 5 – 14 years old who live or attend school in the ACT and young people living or attending school in the ACT under the age of 18 years who are covered by a current Centrelink Concession	Community-based clinics	ACT Health

Dental and oral health funding programs	Provider/Auspice	Funder/Period
Card can use this service.)		
Adult dental services (Service is available to ACT residents who 18 years and older are the primary holder of a current ACT Centrelink issues Pension Concession or Healthcare card.)	Civic and Philip Health Centres	ACT Health
Emergency dental services (Emergency services are available Monday to Friday to all eligible clients of Community Health's dental health services who require urgent dental treatment. Individuals under 14 who attend a school or reside in the ACT and individuals over 14 years old who hold a Centrelink Concession Card are eligible to receive this service.)	Community-based clinics	ACT Health
Denture services (Community Health provides a range of denture services including denture repairs, denture relines, adjustments and the making of both partial and complete new dentures. All ACT residents aged 18 and over who hold a Centrelink Concession Card, such as a Healthcare Card or Pension Concession Card are eligible to receive treatment)	Community-based clinics	ACT Health
New South Wales Dental Services		
Public Oral Health Services (Public dental services are provided to children and eligible adults. For adults, the eligibility criteria means they must have one or more of the following cards: Commonwealth Seniors Health Card, Health Card or Pensioner Concession Card. delivered in dental clinics based in community health centres, hospitals and schools and include general dentistry such as examinations, fillings and dentures.)	Delivered by each of the Local Health Districts. These services are	NSW Health
NSW Oral Health Fee for Service Scheme (Deliver priority dental treatment to eligible patients in NSW. Engages private dental practitioners to provide priority dental treatment to public patients)	Private practitioners who are registered with this scheme.	NSW Health
Northern Territory Dental Services		
Services for Adults (Adults with a Centrelink Pensioner Concession Card or Health Care Card are eligible for free dental services. Patients are prioritised based on their clinical need and those with the most urgent problems will have priority)	Dentists	Oral Health Services NT
Services for Children and Adolescents (Free dental services are provided from birth to 18 years of age through school-based clinics, community clinics and mobile services)	Primary school-based clinics, community health centres, community dental clinics and mobile vans.	Oral Health Services NT
Healthy Smiles – Training Package (Designed to provide non-oral health professionals with oral health background information, knowledge and early childhood caries as well as prevention and management of oral disease)	..	Oral Health Services NT
Stronger Futures Northern Territory – National Partnership Agreement – Health Implementation – Oral		Commonwealth 2012/13 – 2021/22

Dental and oral health funding programs	Provider/Auspice	Funder/Period
Health Services Programme (Aboriginal children under 16 with a focus on remote communities)		
Queensland Dental Services		
Child and Adolescent Oral Health Services (All Queensland resident children four years of age or older who have not completed Year 10 of secondary school are eligible for publicly funded oral health care.	On-site at schools through fixed or mobile dental clinics, some dental clinics within Hospitals and Health Services.	QLD Health
Adult Dental Services (For adults to be eligible they must be a Queensland resident and where applicable, in receipt of benefits from either a; Pensioner Concession Card issues by the Department of Veteran's Affairs, Pensioner Concession Card issued by Centrelink, Health Care Card, Commonwealth Seniors Health Card or Queensland Seniors Card)	Community-based clinics	QLD Health
South Australia Dental Services		
Dental Care for Children (Dental care is free for all preschool children and most school aged children at all school dental service clinics)	School dental clinics	SA Health
Dental Care for Adults (SA Dental Service community dental clinics provide a range of dental services to eligible adults at clinics throughout South Australia. Adults (or their adult dependents) with a current Pensioner Concession Card (Centrelink or Veterans' Affairs) or a health care card are eligible to receive a range of general and emergency dental care services through a community dental clinic)	Dentists	SA Health
Emergency Dental Care (SA Dental Service provides emergency dental services for eligible adults and children. Patients with urgent needs will receive priority access, while others may be offered a place on the general waiting list)	Local clinics	SA Health
Oral Health Information (SA Dental Service offers oral health promotion resources to South Australian health professionals, community service providers and the community. SA Dental Services implements a range of population health promotion programs and strategies to improve the oral health of South Australians)	Health Promotion team	SA Health
Tasmania Dental Services		
Dental Services for Adults (To be eligible, patients must have a Health Care Card or Pensioner Concession Card. Services that are available include, priority care, general care and denture services.	Local public dental centres	Oral Health Services Tasmania (?)
General Dental Care Program (Provides eligible clients with access to general dental care in their region through a private provider. Clients must be	Private Provider	Centrelink Funded till 30 June 2015.

Dental and oral health funding programs	Provider/Auspice	Funder/Period
18 years of age or older, hold a current Health Care Card or Pensioner Concession Card or be on the general care waiting list.)		
Dental Services for Children and Adolescents (Children under 18 years of age, including pre-schoolers. Patients can receive dental check-ups and any necessary treatment as determined by the check-up)	Dental Therapists and Oral Health Therapists provide the majority of dental care for children and teens.	Medicare
Denture Information (To access adult public dental care and public dental services patients must have either a Health Care Card or Pensioner Concession Card.	Local clinics	Centrelink
Victoria Dental Services		
General Dental Care (Adult) (Patients with Health care and pensioner concession cardholders are eligible for this service. Includes examination, cleaning, fillings, extractions and root canal treatment)	Community dental clinics and The Royal Dental Hospital of Melbourne	Vic Health
General Dental Care (Infants, children and youth) (Eligible patients include: all children aged 0-12 years, children and adolescents between 13 and 17 years if they or their parents hold a current health care or pensioner concession card. Services include: check-ups and advice every 1 to 2 years, dental sealants to prevent decay, cleaning, fillings and extractions)	Community dental clinics and The Royal Dental Hospital of Melbourne	Vic Health
Emergencies (Eligible for health care and pensioner concession cardholders and non-Victorian concession card holders)	Community dental clinics and The Royal Dental Hospital of Melbourne	Vic Health
Dentures (Health care and pensioner concession cardholders)	Community dental clinics and The Royal Dental Hospital of Melbourne	Vic Health
Specialist Care (Includes orthodontics, oral and maxillofacial surgery, endodontics, periodontics, prosthodontics, paediatric dentistry and oral medicine. Available for health care and pensioner concession cardholders and their dentists who have had a written referral made by their dentists)	The Royal Dental Hospital of Melbourne	Vic Health
Special Needs (Care is available to children and adults with special needs. Services include domiciliary (homebound services)).	The Royal Dental Hospital of Melbourne and some community dental clinics	Vic Health
Victorian Emergency Dental Scheme (Patients with these vouchers are eligible for government-subsidised emergency dental treatment at a private dental clinic.)	Private dental clinicians	Vic Health
Victorian General Dental Scheme (Offered to patients on public General waiting lists, particularly when the Community Dental Agencies do not	Private dental clinicians	Vic Health

Dental and oral health funding programs	Provider/Auspice	Funder/Period
have the capacity to provide in-house care, or where additional funding is available.)		
Victorian Denture Scheme (Designed to facilitate greater numbers of patients receiving dentures.)	Private dental clinicians	Vic Health
Western Australia Dental Services		
Adult Dental Service (If an individual holds a Health Care Card or Pensioner Concession Card then they are able to be subsidised for public dental care through Dental Health Services. This includes emergency and general dental care.)	Dental Health Services	WA Health
School Dental Service (All school children are eligible for the School Dental Service from the year they turn five until the end of Year 11 or the attainment of 17 years of age, whichever comes first. This service includes emergency and general dental care).	Dental Health Services	WA Health

Appendix 2 Average dental charges for privately insured services during 2014

The information presented below displays the average dental charges for privately insured services in 2014. The table outlines publically available data on 21 common dental services by the Australian Dental Association (ADA) code and the average charge within each state/territory based on consumers place of residence.

De-identified data was provided by private health insurers to the Department of Health for the following dental services provided to privately insured patients in 2014.

It is important to note that charges within each state/territory will vary depending on location (e.g. major city, inner regional or remote) and that this list of dental services does not contain the full breadth of services claimable by privately insured patients.[76]

ADA Code	NSW/ACT	NT	QLD	SA	TAS	VIC	WA	National Average
Item Category	**DIAGNOSTIC SERVICES**							
011	$57.77	$70.09	$57.55	$55.46	$61.59	$57.51	$59.18	$57.89
012	$54.43	$62.48	$51.57	$51.27	$58.27	$52.27	$54.05	$53.11
013	$48.27	$58.95	$45.06	$47.91	$48.15	$46.24	$48.27	$47.25
014	$64.72	$71.85	$60.21	$59.27	$61.25	$63.84	$61.74	$62.67
022	$40.74	$46.10	$40.25	$43.01	$42.29	$42.30	$43.40	$41.57
071	$62.67	$59.75	$55.52	$60.39	$63.58	$60.14	$61.85	$60.50
Item Category	**PREVENTATIVE SERVICES**							
111	$57.69	$72.67	$56.19	$59.18	$56.07	$54.08	$62.90	$56.96
114	$104.00	$128.47	$102.10	$105.39	$104.33	$104.22	$106.63	$104.22

[76] http://www.privatehealth.gov.au/healthinsurance/whatiscovered/averagedental.htm

ADA Code	NSW/ACT	NT	QLD	SA	TAS	VIC	WA	National Average
121	$34.02	$30.30	$29.82	$31.32	$31.51	$31.94	$33.18	$32.39
161	$51.81	$63.43	$52.40	$44.46	$45.51	$51.13	$56.61	$51.51
Item Category	**ORAL SURGERY**							
311	$166.34	$172.83	$160.26	$141.40	$173.11	$154.89	$153.74	$158.99
Item Category	**RESTORATIVE SERVICES**							
521	$135.94	$147.22	$130.42	$122.37	$146.58	$132.68	$129.64	$132.37
522	$168.33	$179.33	$157.18	$149.87	$175.33	$158.97	$157.01	$160.85
523	$192.68	$209.26	$183.57	$171.06	$197.05	$180.56	$181.73	$184.93
531	$141.78	$157.91	$139.67	$132.50	$154.03	$138.74	$142.34	$140.29
532	$185.15	$196.97	$175.39	$168.79	$191.01	$175.70	$181.74	$179.28
533	$212.72	$238.85	$206.45	$203.77	$217.37	$204.80	$214.82	$209.31
534	$235.75	$288.30	$232.85	$221.90	$245.90	$225.48	$237.37	$232.14
575	$32.77	$33.80	$31.44	$29.85	$32.90	$32.82	$33.66	$32.17
577	$34.06	$34.55	$33.57	$30.31	$33.77	$31.93	$39.42	$33.42
Item Category	**CROWNS**							
615	$1,424.56	$1,584.63	$1466.52	$1,436.11	$1,519.84	$1,480.64	$1,404.10	$1,441.0

Appendix 3 Australian Dental Association items billed to Medicare for services provided by OHPs using dentists provider numbers

	Description	DVA Item	DVA Rebate Amount (Excl. GST)	CDBS Item	CDBS Rebate Amount	Comment
Item Category	**DIAGNOSTIC SERVICES (011 – 081)**					
Item Sub-Category	*Examinations*					
011	Comprehensive oral examination	D011	$53.55	88011	$52.65	
012	Periodic oral examination	D012	$44.50	88012	$43.75	DVA: S012- Specialist item code $44.50
013	Oral examination - Limited	D013	$27.95	88013	$27.50	DVA S013- Specialist item code $27.95
014	Consultation	S014	$64.55	X	X	DVA: Specialist only item
015	Consultation - extended	S015	$105.60	X	X	DVA: Specialist only item
016	**Consultation by referral** - A consultation with a patient referred by a dental or medical practitioner for an opinion or management of a specific dental disorder. The consultation may not necessarily be with a specialist. The referring practitioner should be provided with a report from the consultant, included within the item number.	D016	$104.45	X	X	S016- Specialist item code $153.45
Item Category	**DIAGNOSTIC SERVICES (011 – 081)**					
Item Sub-Category	*Examinations*					

	Description	DVA Item	DVA Rebate Amount (Excl. GST)	CDBS Item	CDBS Rebate Amount	Comment
017	**Consultation by referral - extended (30 minutes or more)** - An extended consultation with a patient referred by a dental or medical practitioner for an opinion or management of a specific dental disorder. The consultation may not necessarily be with a specialist. The referring practitioner should be provided with a report from the consultant, included within the item number.	S017	$209.10	X	X	Specialist only item
018	Written report	D018	$47.85	X	X	S018- Specialist item code $47.85
019	Letter of referral	D019	$11.30	X	X	S019- Specialist item code $11.30
022	Intraoral periapical or bitewing radiograph - first exposure	D022	$37.65	88022	$30.45	DVA Specialist item code:S022 rebate: $37.65
022B	Intraoral periapical or bitewing radiograph -each sub ex	D022	$30.95	88022	$30.45	DVA Specialist item code: S022, rebate: $30.95
025	Intraoral radiograph - occlusal, maxillary, mandibular - per exposure	D025	$62.60	88025	$61.55	DVA Specialist item code: S025, rebate: $62.60
036	Cephalometric radiograph - lateral, antero-posterior, posteroanterior or submentovertex	S036	$151.10	X	X	Some Oral Health Practitioners have completed additional training to provide these services. Specialist item.
Item Category	**DIAGNOSTIC SERVICES (011 – 086)**					
Item Sub-Category	*Radiological Examination and Interpretation*					
037	Panoramic radiograph - per exposure	D037	$95.80	X	X	Some Oral Health Practitioners have

	Description	DVA Item	DVA Rebate Amount (Excl. GST)	CDBS Item	CDBS Rebate Amount	Comment
						completed additional training to provide these services. DVA Specialist item code: S037, rebate: $95.80
Item Sub-Category	*Other Diagnostic Services*					
041	Bacteriological examination	X	X	X	X	
046	Periodontal disease screening test	X	X	X	X	Some Oral Health Practitioners have completed additional training to provide these services
047	Caries activity screening test/Saliva screening test	D047	$41.20	X	X	DVA Specialist item code: S047, rebate: $41.20
048	Caries susceptibility test	X	X	X	X	
061	Pulp vitality test - per visit	X	X	X	X	
071	Diagnostic model - per model	D071	$61.45	X	X	DVA Specialist item code: S071, rebate: $61.45
072	Photographic records - intraoral	D072	$33.05	X	X	DVA Specialist item code: S072, rebate: $33.05
073	Photographic records - extraoral	D073	$33.05	X	X	DVA Specialist item code: S073, rebate: $33.05
Item Category	**DIAGNOSTIC SERVICES (011 – 086)**					
Item Sub-Category	*Radiological examination and interpretation*					
081	Cephalometric analysis – excluding radiographs	S081	$66.05	X	X	Service which **may be**

	Description	DVA Item	DVA Rebate Amount (Excl. GST)	CDBS Item	CDBS Rebate Amount	Comment
						provided by Oral Health Practitioner. Specialist only item
	PREVENTIVE, PROPHYLACTIC AND BLEACHING SERVICES (111 – 171)					
	Dental Prophylaxis and Bleaching					
111	Removal of plaque and/or stain	D111	$54.70	88111	$53.80	DVA Specialist item code: S111, rebate: $54.70
113	Recontouring of pre-existing restoration(s)	D113	$20.70	X	X	DVA Specialist item code: S113, rebate: $20.70
114	Removal of calculus - first visit	D114	$91.20	88114	$89.70	DVA Specialist item code: S114, rebate: $91.20
115	Removal of calculus – subsequent visit	D115	$59.35	88115	$58.35	DVA Specialist item code: S115, rebate: $59.35
116	Enamel micro-abrasion per tooth	X	X	X	X	
118	Bleaching, external - per tooth (in-office)	X	X	X	X	In some states and territories
119	Bleaching, home application – per arch (tray & medicaments items 926/927)	X	X	X	X	
	Remineralising Agents					
121	Topical application of remineralising agent, one treatment	D121	$35.15	88121	$34.55	DVA Specialist item code: S121, rebate: $35.15
Item Category	**PREVENTIVE, PROPHYLACTIC AND BLEACHING SERVICES (111 – 171)**					
Item Sub-Category	*Remineralising Agents*					
122	Topical remineralising agent, home application - per arch	X	X	X	X	

	Description	DVA Item	DVA Rebate Amount (Excl. GST)	CDBS Item	CDBS Rebate Amount	Comment
123	Concentrated remineralising agent, application - single tooth	D123	$27.50	X	X	DVA Specialist item code: S123, rebate: $27.50
	Other Preventative Services					
131	Dietary advice (analysis and advice)	D131	$37.00	X	X	DVA Specialist item code: S131, rebate: $37.00
141	Oral hygiene instruction (Instruction and advice)	D141	$50.30	X	X	
151	Provision of a mouthguard - Indirect	D151	$152.80	X	X	In some states and territories. DVA Specialist item code: S151, rebate: $152.80
161	Fissure sealing - per tooth	D161	$46.85	88161	$46.05	DVA Specialist item code: S161, rebate: $46.85
165	Desensitising procedure - per visit	D165	$27.50	X	X	DVA Specialist item code: S165, rebate: $27.50
171	Odontoplasty (recontouring fissures)	D171	$51.65	X	X	DVA Specialist item code: S171, rebate: $51.65
213	Treatment of acute periodontal infection - per visit	D213	$70.90	88213	$69.70	Service which may be provided by Oral Health Practitioner. DVA Specialist item code: S213, rebate: $70.90
Item Category	**PREVENTIVE, PROPHYLACTIC AND BLEACHING SERVICES (111 – 171)**					
Item Sub-Category	*Other Preventative Services*					
221	Clinical periodontal analysis and recording	D221	$53.85	88221	$52.95	Service which may be provided by Oral Health Practitioner. DVA Specialist item code:

	Description	DVA Item	DVA Rebate Amount (Excl. GST)	CDBS Item	CDBS Rebate Amount	Comment
						S221, rebate: $143.35
222	Root planning and subgingival curettage - per eight teeth or less (LA normally used)	D222	$26.50	X	X	Service which may be provided by Oral Health Practitioner. DVA Specialist item code: S213, rebate: $70.90
225	Non-surgical periodontal treatment where not otherwise specified - per visit			X	X	Service which may be provided by Oral Health Practitioner
281	Course of non-surgical periodontal treatment	D281	$584.25	X	X	Service which may be provided by Oral Health Practitioner. DVA Specialist item code: S281, rebate: $1045.65
282	Continuation of periodontal treatment or maintenance subsequent to item 281	D282	$161.25	X	X	Service which may be provided by Oral Health Practitioner. DVA Specialist item code: S282, rebate: $279.85
Item Category	**ORAL SURGERY (311 -399)**					
Item Sub-Category	*All categories*					
300	Routine Post-op visit	X	X	X	X	
311A	Removal of tooth or tooth parts 1st tooth each quadrant	D311	$133.55	88311	$131.30	DVA Specialist item code: S311 rebate: $165.85
311B	Removal of tooth or tooth parts subsequent teeth extraction in same quadrant			X	X	
316	Removal of additional tooth or parts thereof			88316	$82.75	

	Description	DVA Item	DVA Rebate Amount (Excl. GST)	CDBS Item	CDBS Rebate Amount	Comment
384	Repositioning of displaced tooth/teeth - per tooth	D384	$194.10	88384	$190.85	
387	Splinting of displaced tooth	D387	$392.10	88387	$385.55	
388	Replanting and splinting of tooth	D388	$598.75	X	X	
411	Direct Pulp capping	D411	$35.45	88411	$34.85	DVA Specialist item code: S411 rebate: $47.05
414	Pulpotomy	D414	$77.35	88414	$76.05	DVA Specialist item code: S414 rebate: $89.65
421	Resorbable canal filling - primary tooth	D421	$121.45	88421	$119.40	In some states and territories. DVA Specialist item code: S421 rebate: $194.10
	ORTHODONTICS (811-881)					
	All categories					
	There are no billable services by Oral Health Practitioners, however Oral Health Practitioners have many permissible duties in Orthodontics					
Item Category	**RESTORATIVE SERVICES (511-597)**					
Item Sub-Category	*All categories*					
511	Metallic restoration - 1 surface - direct	D511	$106.00	88511	$104.25	DVA Specialist item code: S511 rebate: $106.00
512	Metallic restoration - 2 surface - direct	D512	$129.95	88512	$127.80	DVA Specialist item code: S512 rebate: $129.95
513	Metallic restoration - 3 surface - direct	D513	155.10	88513	$152.50	DVA Specialist item code: S513 rebate: $155.10
514	Metallic restoration - 4 surface - direct	D514	$176.80	88514	$173.85	DVA Specialist item code: S514 rebate: $176.80
515	Metallic restoration - 5 surface - direct	D515	$201.80	88515	$198.45	DVA Specialist item code:

	Description	DVA Item	DVA Rebate Amount (Excl. GST)	CDBS Item	CDBS Rebate Amount	Comment
						S515 rebate: $201.80
521	Adhesive restoration - 1 surface - anterior tooth - direct	D521	$117.40	88521	$115.45	DVA Specialist item code: S521 rebate: $117.40
522	Adhesive restoration - 2 surface - anterior tooth - direct	D522	$142.55	88522	$140.15	DVA Specialist item code: S522 rebate: $142.55
523	Adhesive restoration - 3 surface - anterior tooth - direct	D523	$168.80	88523	$166.00	DVA Specialist item code: S523 rebate: $168.80
524	Adhesive restoration - 4 surface - anterior tooth - direct	D524	$195.10	88524	$191.85	DVA Specialist item code: S524 rebate: $195.10
525	Adhesive restoration - 5 surface - anterior tooth - direct	D525	$229.30	88525	$225.45	DVA Specialist item code: S525 rebate: $272.55
531	Adhesive restoration - 1 surface - posterior tooth - direct	D531	$125.40	88531	$123.30	DVA Specialist item code: S531 rebate: $125.40
532	Adhesive restoration - 2 surface - posterior tooth - direct	D532	$157.45	88532	$154.80	DVA Specialist item code: S532 rebate: $157.45
Item Category	**RESTORATIVE SERVICES (511-597)**					
Item Sub-Category	*All categories*					
533	Adhesive restoration - 3 surface - posterior tooth - direct	D533	$189.25	88533	$186.10	DVA Specialist item code: S533 rebate: $189.25
534	Adhesive restoration - 4 surface - posterior tooth - direct	D534	$213.25	88534	$209.70	DVA Specialist item code: S534 rebate: $213.25
535	Adhesive restoration - 5 surface - posterior tooth - direct	D535	$246.30	88535	$242.20	DVA Specialist item code: S535 rebate: $319.20
572	Provisional (Intermediate/Temporary) restoration	D572	$49.60	88572	$48.75	DVA Specialist item code: S572 rebate: $49.60
576	Stainless steel crown	D576	$261.40	88576	$257.05	DVA Specialist item code:

	Description	DVA Item	DVA Rebate Amount (Excl. GST)	CDBS Item	CDBS Rebate Amount	Comment
						S576 rebate: $353.60
577	Cusp capping	D577	$30.80	X	X	DVA Specialist item code: S577 rebate: $30.80
578	Restoration of incisal corner - per corner	D578	$30.80	X	X	DVA Specialist item code: S578 rebate: $30.80. In some states and territories
Item Category	**PROSTHODONTICS (611 -779)**					
Item Sub-Category	*Denture Maintenance*					
753	Cleaning and polishing of pre-existing denture	D753	$43.05	X	X	DVA Specialist item code: S753 rebate: $57.30
776	Impression	D776	$46.85	88776	$46.05	DVA Specialist item code: S776 rebate: $46.85
	GENERAL SERVICES (911-972)					
	Emergencies					
911	Palliative care	D911	$69.50	88911	$68.35	DVA Specialist item code: S911 rebate: $92.55
915	After hours emergency call out	D915	$93.40	X	X	DVA Specialist item code: S915 rebate: $93.40
916	Travel to provide care	D916	$67.95	X	X	DVA Specialist item code: S916 rebate: $67.95
926	individually made tray - medicaments (bleaching, fluorides)	D926	$161.25	X	X	In some states and territories. DVA Specialist item code: S926 rebate: $161.25
Item	**GENERAL SERVICES (911-972)**					

	Description	DVA Item	DVA Rebate Amount (Excl. GST)	CDBS Item	CDBS Rebate Amount	Comment
Category						
Item Sub-Category	*Drug Therapy*					
927	Provision of medication/medicament	D927	$27.95	X	X	item code: S927 rebate: $27.95
	Anaesthesia, Sedation and Relaxation Therapy					
941	Local Anaesthesia	X	X	X	X	
944	Relaxation Therapy	X	X	X	X	In some states and territories
	Occlusal Therapy					
964	Registration and mounting of models for occlusal analysis	D964	$76.85	X	X	item code: S964 rebate: $92.35
	Miscellaneous (981-999)					
986	Post-operative care not otherwise included (in normal circumstances)	D986	$71.70	X	X	
990	Treatment not otherwise included	D990	*	x	X	*Fee by negotiation
999	Nonattendance – broken appointment	X	X	X	X	