Public dental care and the Teeth First trial

A history of decay

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Brotherhood of St Laurence
Working for an Australia free of poverty

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The photographs in this report are not of TF trial participants but represent the types of dental conditions they suffered. Photos are courtesy of the website Dental-Health-Index.com and are used with permission.

Abbreviations

BSL	Brotherhood of St Laurence
EPC	Enhanced Primary Care
CDHP[1]	Commonwealth Dental Health Program, mid 1990s
CDHP[2]	Commonwealth Dental Health Program, proposed in 2008
NACOH	National Advisory Committee on Oral Health
NHHRC	National Health and Hospitals Reform Commission
NSAOH	National Survey of Adult Oral Health
OECD	Organisation for Economic Co-operation and Development
PSP	Personal Support Programme
TF	Teeth First

Note

The term ‘dental chair’ is widely used in government documents. It is generally understood as signifying the provision of a dental chair, equipment and consumables with a dentist and assistant to provide clinical services.

Summary

Dentistry holds a tenuous position in the world of medicine and health policy. Traditionally seen as separate from 'medicine', the teeth have been excised from the rest of the body and treated as less important. This separation is reflected in government policy. Despite the Australian Constitution's inclusion of dental as well as medical services as a Commonwealth responsibility, dental treatment is excluded from Medicare.

Political bickering over dental care has continued for decades. In the mid 1990s, the Labor government introduced the Commonwealth Dental Health Program, which the Liberal government promptly dismantled. The Liberal government introduced a scheme for those suffering chronic and complex illness, the Enhanced Primary Care (EPC) dental program, which the current Labor government seeks to dismantle. Australia now finds itself in a kind of stalemate or 'dental limbo'. The closure of the EPC dental program was twice blocked in the Australian Senate, preventing the rollout of the *new* Commonwealth Dental Health Program. Adding complexity, the National Health and Hospitals Reform Commission (NHHRC) recommended the establishment of 'Denticare'. While still separate from Medicare, an increased levy would fund this universal dental scheme in which care is to be provided both through the public system and, for those able to afford health insurance, the private sector. In the interim, the Commonwealth EPC and state prioritisation of some marginalised groups in Victoria provides timely dental care to the few deemed eligible. This leaves many low-income Victorians waiting for years for subsidised dental treatment.

Research by the University of New South Wales's Social Policy Research Centre indicates that almost 60 per cent of welfare participants could not access dental treatment or an annual check-up for children (Saunders 2007). A National Survey of Adult Oral Health published in 2007 indicated that almost one-fifth of those eligible for public dental care had not visited a dentist for at least five years. The consequences may be seen in the one-quarter of all Australians and 57 per cent of Indigenous Australians with untreated tooth decay. Further consequences are that one-fifth of Australians have moderate gum disease, more than one-tenth have inadequate dentition and one in twenty have no natural teeth remaining (AIHW 2007).

The Brotherhood of St Laurence's Teeth First treatment trial held in Frankston and the Mornington Peninsula sought to secure timely dental treatment for people who are highly disadvantaged and to examine the implications of dental policy for low-income groups. In this area, the standard waiting period for general treatment was up to 41 months (Rosebud) and the wait for dentures up to 29 months (Cranbourne) in June 2009. An evaluation of the impact of Teeth First using pre- and post-treatment surveys and interviews was undertaken, placing the trial in the context of current Australian dental policy and social research. As only one private dentist responded to the invitation to participate, but withdrew due to the patients' complex needs, public sector dentists at community health centres agreed to work with the Brotherhood by seeing a small number of clients who were participating in the trial. Frustrated with the low resourcing and long waiting lists in the public sector, as a one-off, they allowed BSL clients to bypass the waiting list and receive immediate treatment.

Caseworkers in the Personal Support Programme identified long-term unemployed clients who had dental conditions which posed a barrier to employment; and 35 of these clients participated in the trial. Of the 28 surveyed, the most common conditions were rotting or dying teeth, untreated cavities and chipped or broken teeth, with many participants requiring dentures. Some 86 per cent said their dental condition affected their ability to go about their daily activities with 75 per cent

saying this had been a problem for two years or more. The majority said they had not sought treatment because they could not afford it, while 40 per cent said they were on a waiting list, which in mid 2009 ranged from 30 to 41 months for general treatment and 14 to 29 months for dentures at Peninsula-based community health centres.

Approximately 80 per cent of participants cited lack of regular dental check-ups or treatment as a cause of their dental problems. This lack of care had a range of medical, psychological and economic consequences and impacted the broader health system.

Pain or discomfort was experienced by approximately 90 per cent, difficulty eating by 80 per cent and sickness as a result of dental problems by 60 per cent. Just under half took regular pain medication. In desperation from the pain, one young man with a history of homelessness undertook self-dentistry with a hammer and chisel.

Embarrassment due to unsightly teeth and/or missing teeth was suffered by around 90 per cent while poor self-image was common. This impacted their social interactions: one young woman described how she talked with her hand in front of her mouth, and other participants were afraid to smile or laugh. Around 70 per cent felt down in spirits.

Just under half believed their employment prospects were reduced due to the impact of dental problems on their physical appearance, 7 per cent had to leave their work due to sickness and 21 per cent said they were too ill from their dental problems to undertake training or look for work. For 32 per cent of the participants, this had been an issue for two or more years.

Untreated dental problems frequently resulted in infection and, beyond the medical implications, this added to strain on the health system, having broader economic consequences. Two-thirds of participants had visited the doctor and eight had visited the hospital in the last two years because of dental-related health problems, some visiting multiple times.

By mid January 2010, 10 participants had completed their dental treatment with a further five likely to complete. While courses of treatment were not always smooth, participants were glad that their dental health had been addressed, most saying it reduced or eliminated their physical discomfort and improved their spirits and self-image. One participant found work, two believed they would obtain work in the next three months and one was soon to commence further training.

However, the multiple forms of disadvantage experienced by participants impeded their treatment. Lack of private transport and poor public transport in the region reduced attendance at appointments, as did mental health and other health complaints. Financial disadvantage also hindered treatment, for example, the disconnection of clients' phones prevented contact. Lack of housing and client transience were further barriers to the completion of treatment, as were legal issues and prison sentences. Given that these issues impeded clients' treatment when there was no waiting period, it is no surprise that they exacerbate the problem of accessing treatment when there is a waiting period of several years. This further highlights the need for timely dental care for disadvantaged Australians, with added supports to ensure that poor dental health ceases to be one of the barriers to their social and economic inclusion.

The differing dental policies of community health centres resulted in variations in waiting times, treatment periods and the treatment itself. While timely and effective treatment was available for some marginalised groups through the Victorian Demand Management Framework and the Commonwealth EPC dental program, most Teeth First participants were not assessed as eligible

despite their extreme disadvantage. More than one community health centre said they had the facilities to treat more patients but sadly lacked the dentists to do the work. While an industry-wide shortage of dentists is an issue, the lower remuneration and poor work conditions of public dentists and ancillary staff are compounding factors.

While Teeth First was a one-off trial it served to highlight the state of the public dental system and the impact on low-income Australians. Coming up to two years since the announcement of the new Commonwealth Dental Health Program, we remain in dental limbo. As politicians continue to deliberate on policy reform, many low-income Australians rely on pain medication and antibiotics due to their rotting gums. Some have not enjoyed good food for years because they cannot chew or have no teeth. Aside from the consequences for their physical health, this has a profound impact on their self-esteem and the way they socialise and interact with others. And while other forms of disadvantage compound the problem, poor dental health acts as a significant barrier to participation in study and work.

Failure to provide adequate dental services shows a lack of regard for the dignity of low-income Australians. Beyond social justice considerations, it is bad economic management to have 650,000 Australians (Parliament of Australia 2007, p.99) on waiting lists that are years long, adding strain to other health services and increasing health costs as well as impacting the economy through sick days and welfare benefits.

Access to timely dental care is a critical aspect in achieving the social and economic inclusion of disadvantaged Australians and this in turn is important for national productivity.

Recommendations

There are not enough public dental chairs to provide adequate services to people who cannot afford to pay for dental treatment. Based on the state of dental services available to low-income Australians, the costs of not providing timely treatment, and the Teeth First trial, the following eight recommendations are made.

Dental health policy

1. Fully incorporate dental care within Medicare, recognising dental care as being both an important part of health care and the responsibility of the Commonwealth Government under the Australian Constitution.

2. Develop and communicate a consistent, transparent and easily understood policy for public dental clinics operating in community health centres. This policy should include guidelines on the prioritisation of particular client groups, waiting periods, referral to private dentists and use of vouchers, and the time required before dentures may be fitted.

Building capacity within the public sector

3. Offer dental scholarships with similar conditions to those of the Commonwealth Bonded Medical Places Scheme, in which university tuition costs are funded on the proviso that graduates commit to a period of public service in rural and regional areas, with the extent of that service being equivalent to the length of their degree.

4. Introduce, for all dentistry graduates, a compulsory public dental internship scheme that is adequately resourced to include supervision time and remuneration to practitioners with extra responsibilities.

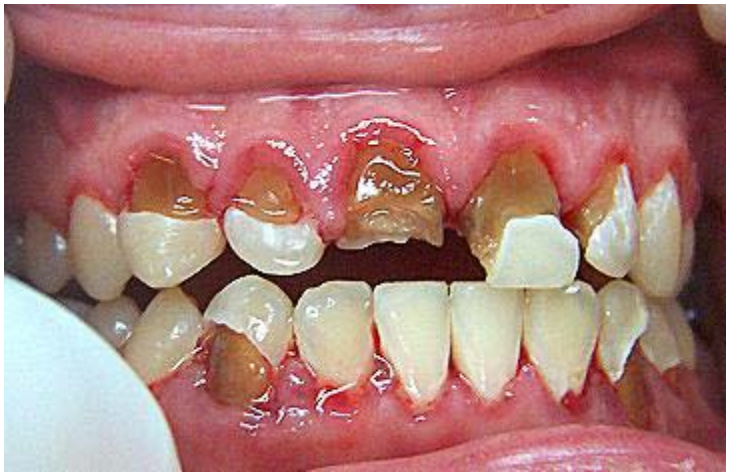
5. Increase remuneration for public sector dentists and ancillary staff to achieve parity with the private sector and maximise public dental service provision.

Addressing dental needs among disadvantaged groups

6. Raise awareness of the public dental services available and encourage community service agencies and Job Services Australia providers to refer clients whose dental health may constitute a barrier to their employment.

7. Introduce supports at community health centres to assist highly disadvantaged clients, facing multiple barriers, to complete their treatment. Given community dentists work within larger community health centres, a more holistic approach to health and wellbeing could include inter-centre referral, with dentists referring clients to, for example, doctors, mental health professionals and even housing workers. Other practical supports could also be implemented such as a mobile phone text reminder system, a community bus service or centre-based childcare to cover appointments.

8. Launch a government-funded national dental health campaign, comparable to anti-smoking or car safety campaigns. One component of the campaign should be its incorporation in parenting programs to increase dental literacy and improve dental outcomes for children.



Person with rotting teeth, photo courtesy of Dental-Health-Index.com

1 Introduction

Dental policy and access to public services is problematic, and with often very painful implications for disadvantaged Australians. The Brotherhood of St Laurence has long been aware of these issues through both its service provision and its broader research and advocacy.

Most recently, in 2008–2009, a generous donation from the Sidney Myer Fund was used to conduct the Teeth First (TF) trial in Frankston and on the Mornington Peninsula, where the waiting time for public dental care has been up to 47 months over the last several years and up to 41 months in June 2009 (See Figure 4.1). A practical response to the oral health needs of disadvantaged people, the TF trial sought to promote social inclusion. The aim of the trial was to improve oral health and reduce the waiting time for dental treatment among disadvantaged people, and in turn enhance their personal wellbeing and social and economic participation. Caseworkers from the Personal Support Programme (PSP) for the long-term unemployed, referred clients who had poor dental health to participate in the trial. By special arrangement with several community health centres, the treatment of TF participants was fast-tracked. Some participants were also referred to private dentists, BSL covering the costs of public co-payments and private treatment at market rates.

The purpose of this report is to evaluate the effectiveness of the TF trial. Evaluation objectives and outcomes were to:

- place the TF trial within the context of current policy and research
- document the demographic profile of participants to better understand the personal circumstances of those with unmet dental needs
- gather evidence to demonstrate the broader positive impact of timely dental treatment, for example, economic and social outcomes
- examine the economic ‘cost’ of lack of timely and effective access to dental treatment
- make informed policy recommendations on how to increase access to dental care and reduce waiting time in disadvantaged communities.

Method

BSL ethics approval was obtained to conduct a mixed method evaluation. A targeted literature review was conducted to examine public dental policy, access and affordability of treatment, the impact on disadvantaged Australians and the broader social and economic consequences (see chapters 2 and 3). Case studies have been developed based on interviews with three participants identified by PSP caseworkers. These interviews loosely applied the Biographic-Narrative Interpretive Method to elicit 'the story' of participants' teeth, or their dental health (Wengraf 2007, p.6). Participants were offered the chance to review their story and pseudonyms have been used to maintain confidentiality. Case studies are located at the end of chapters 2, 3 and 4. In addition, two BSL staff involved in the coordination of the TF trial were interviewed. Their insights have been used to enrich and deepen the different thematic sections of this report.

Finally, pre-treatment (N = 28), post-treatment (N = 9) and feedback (N = 9) surveys were conducted by BSL staff with TF participants in person or by telephone to collect demographic, health-related and outcomes data. The analysis was conducted using SPSS statistical analysis software and findings are reported in Chapter 5. See appendices for copies of the surveys.

2 Policy

The place of dental care

Australians consider dental care to be extremely important. In a survey measuring views about deprivation, respondents were asked to identify basic items and key services which no one should have to go without. Access to dental treatment when required was rated as the eighth most important, regarded as being *essential by 99 per cent of respondents* (Saunders 2007).

Preventative dental care and timely treatment are essential for overall health and wellbeing. Poor oral health has broad ranging implications for physical and psychological health as well as social and economic engagement (NACOH 2004). At a societal level, dental disorders impact upon the health system and carry a heavy economic cost. Dental caries is the second most costly diet-related disease, with an economic impact comparable to that of heart disease and diabetes, according to a 2001 report by the Australian Health Ministers' Advisory Council (Steering Committee for National Planning for Oral Health 2001).

Considering the importance of dental care for individual, social and economic health, the wholly inadequate level of government service provision is most unfortunate. This is not a politically contentious statement given that the policy failings have been acknowledged across the political spectrum (Beazley & Gillard 2005; Siewert 2009). In 2005 under the Liberal government, then federal health minister Tony Abbot described the public dental system as 'a nightmare', with public patients facing 'a horrible predicament' (Pearlman & Ryle 2005). In 2007, the parliamentary briefing book showed that 650,000 people were on waiting lists and estimated a shortfall of 1500 practitioners by 2010. The book states that the majority of dental expenditure is being paid by individuals and that 'private dental care is becoming increasingly expensive and out of reach for many' (Parliament of Australia 2007, p.99).

Two factors help to explain the apparent contradiction in which, on one hand, dentistry is valued as important but, on the other, is so poorly serviced: the traditional place of dentistry within the hierarchy of the discipline of medicine, and its treatment in the Australian Constitution. In the past, there has been a lack of attention to dentistry policy, and boundaries between dentistry and medicine have been preserved. This may well go back to the days when dentistry was performed by lowly barbers, and medicine by gentlemen doctors. Public expenditure on dental health is low relative to many other basic medical services because it is treated as being separate to the health sector 'outside the realm of doctors and medicine' (Lewis 2007, p.1). Moreover, dental care is seen as being less serious because conditions are of a non-fatal nature. Consequently, public policy decisions have treated oral health as an optional extra rather than an essential component of universal health care (Lewis 2007). However, the traditionally inferior place of dentistry within public health care has significant consequences for disadvantaged groups according to Director of the Australian Research Centre for Population Oral Health, Professor John Spencer:

> Income related inequality in health care is not acceptable for other contiguous body parts like eyes, ears, sinuses or throats. Access to health care of these body parts is assisted by universal health insurance. Yet inequalities in dental care seem to have been accepted within the health care system. They should not be (Spencer & Hartford 2007).

Federal versus state responsibility for the provision of dental care has historically been contested. In the Australian Constitution, Part V 'The Powers of Parliament', it is asserted that:

> 51. The Parliament shall, subject to the constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to: -
>
> (xxiiiA.) The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and **dental services** (Commonwealth of Australia Constitution Act, 1901, emphasis added).

Dental health was perceived as being a Commonwealth responsibility in the mid 1990s when the Keating Labor government established the Commonwealth Dental Health Program (CDHP[1]). This was subsequently dismantled by the Coalition government in 1996, with then Prime Minister John Howard maintaining that dental health was traditionally the responsibility of the states (ABC 2001). Refuting this position, Labor continued to assert that dental care is a Commonwealth responsibility under the Australian Constitution (Beazley & Gillard 2005) and shortly after its return to government, the Rudd Labor government moved to re-establish a Commonwealth dental program, and the National Health and Hospitals Reform Commission recommended the establishment of a national 'Denticare' scheme (NHHRC 2009).

Our national dental policy: an overview

Before discussing current dental policy, we will review a summary of our national dental history to provide a context for the 'dental nightmare' and demonstrate its longevity as a health issue impacting disadvantaged Australians.

1975–1997

The Australian School Dental Program commenced in 1975 but had ceased by the 1980s. Prior to 1994, Commonwealth dental care was provided through the Department of Veterans' Affairs. The 1986 Ministerial Review of Dental Services in Victoria highlighted the widespread problem of dental disease and its greater prevalence among lower socioeconomic groups, stating:

> While dental disease is a widespread phenomenon it is more prevalent for some groups, and in particular those from low socio-economic backgrounds. Not only is the risk of disease heightened for some groups, but access is restricted. Barriers such as cost, distance or lack of information currently exist both within the private and the public dental market (Health Department Victoria 1986, p.31).

While the review led to some reform in Victoria, it was not until 1992 that national attention was directed to dental health, a background paper prepared for the National Health Strategy (NHS) finding that 'the dental services catering for low-income people are inadequate in that the coverage is relatively low and waiting times can be very long' (National Health Strategy 1992, p.13). The NHS proposed a range of options to address these issues, including a proposal for emergency and general dental care which was incorporated into CDHP[1].

The CDHP[1] operated from 1994 till 1996 via the Emergency Dental and the General Dental schemes. Offered to recipients of health concession cards, CDHP[1] aimed to reduce geographic and financial barriers to timely and appropriate dental care among low-income groups. Further objectives were to move from emergency to general dental care, extraction to restoration and treatment to prevention. The evaluation of CDHP[1] reports the following benefits for program recipients: fewer extractions and more fillings, less frequent toothaches, more frequent dental visits, shorter waiting times for check-ups and greater satisfaction with dental care at both public

and private dentists (AIHW 1997, pp.1–2). The program had less success in moving low-income groups from emergency and problem-orientated treatment toward more general and preventative care (that is to say, concession card holders were more likely to visit the dentist for a problem, to experience toothaches and to have extractions). However, the program only received full funding for the 1995–96 financial year before being dismantled in December 1996, which was around the time it had started to operate at full capacity (BSL 1998, p.2)

The Coalition ceased the CDHP[1] soon after its election in 1996, deeming dental care to be a state rather than a Commonwealth responsibility. The Brotherhood formed a coalition with other community organisations, coordinating the 'Bite-Back' campaign, to have the CDHP[1] reinstated, while in the New South Wales Parliament, former Labor MP Ron Dyer lamented:

> The Commonwealth Dental Health Program was one of the finest initiatives of the Keating Government. It sought to bring to all Australians what most of us take for granted – quality and timely dental care. Its abolition will seriously affect the lives of thousands. The coalition Government has, in its wisdom, decided to make dental care in Australia a privilege. It has decided to turn its back on country towns which, without Federal assistance, cannot support a dentist on their own. It has decided to turn its back on war veterans, aged pensioners and homeless children, who will now have to go without. The coalition Government has decided to leave the poorest and most vulnerable members of our society to suffer pain and discomfort, and to suffer in silence. The abolition of the Commonwealth Dental Health Program is the cruelest cut in a vicious and nasty budget. The Liberal Government stands condemned for its penny-pinching lack of regard for its fellow Australians (Parliament of New South Wales 1996).

It was in this same period that the Coalition introduced the Private Health Insurance Rebate, this reflecting a preference for the private provision of health services, with public dental care for low-income earners deemed to be the responsibility of states.

In the 12 months after the cessation of CDHP[1], dental waiting lists grew by 20 per cent nationally. Research conducted by the Australian Institute of Health and Welfare showed that between 1996 and 1999, the oral health of low-income earners declined (in Ziguras 2001, p.2). BSL research examining the effects of abolishing the CDHP[1] on low-income Victorians found that they were in pain, and had poor general health and low self-esteem. The impact on their dignity and wellbeing was encapsulated by one participant who exclaimed:

> I've been eating on one side of my mouth for so long because the other side is all rotten. What happens when this side goes? Give up eating! At least it'll save money (BSL 1998, p.1).

The BSL research found that public dental services were unable to meet community needs and that this increased public spending on Medicare as people on low incomes: 'seek pain relief from their local doctors instead of gaining access to the dental treatment they require at that time' (BSL 1998, p.8). In a submission to the Senate Inquiry into Public Dental Services that same year, BSL recommendations included:

- the establishment of a national dental program targeted at vulnerable groups
- the expansion of public services for example through an intern scheme
- the provision of some services for low-income clients
- investigation into the expansion of Medicare for non-cosmetic dental services (BSL 1998, p.8).

The Senate Inquiry report, while not advising the reinstatement of CDHP[1], recommended the Australian Government work with the states to develop oral health programs, introduce a vocational training program, expand the role of dental hygienists, and to develop a national oral health policy and targeted pilot programs to meet the needs of specific disadvantaged groups (Senate Community Affairs References Committee 1998b). While the Coalition supported some of these recommendations, it reiterated:

> Not withstanding the Committee's finding that some low-income earners currently have difficulty accessing public dental services, the Government's position continues to be that the provision of public dental services is a State responsibility and that the States must resolve the structural, management and financial problems in their dental services (Australian Government 1999, p.1).

In 1996–1997 Australia's total health services expenditure was $44.5 billion, of which only six per cent was spent on dental services. Only 15 per cent of the expenditure on dental services was incurred by government, with the majority funded privately and spent on out-of-pocket expenses and on dental insurance (AIHW 2000). According to a 2001 Australian Health Policy Institute report exploring the options for public dental care, the subsidy for public dental care was $176.7 million with an additional indirect subsidy of $23.2 million through the dental expenses taxation rebate. At the same time, between $316 million and $345 million was paid via the private dental insurance rebate, these funds benefiting those able to afford private health insurance. Professor John Spencer comments:

> This pattern is highly unjust and unfair. Higher income adults using private dental insurance and dental care may receive nearly five times the subsidy received by an aged pensioner seeking public dental care. Public dental care is not reaching many of the poorest and most in need Australian adults (Spencer 2001, p.iv).

In 2001, a forum auspiced by the BSL and the Australian Council of Social Services led to the formation of the National Dental Health Alliance, comprising approximately 20 members (Ziguras 2001). The Alliance organised the 'Stop the Rot!' campaign and over 70 agencies Australia-wide signed an open letter to the major political parties calling for the development and implementation of a National Strategy for Oral Health that:

- Addresses the current crisis in the provision of dental services for Australians living on low incomes and other disadvantaged groups by providing appropriate, affordable services in a range of settings;
- Develops community-based preventative programs, including comprehensive and ongoing oral health promotion;
- Addresses current and future labour force issues;
- Is evidence based and independently evaluated (National Dental Health Alliance 2001).

The Alliance made a submission to the 2003 Senate Select Committee on Medicare which was cited in the resulting report. The Committee highlighted the poor oral health of low-income Australians and their limited access to dental treatment, this noted as being ironic at a time when non-disadvantaged persons received subsidised dental care through the private health insurance rebate. Rejecting the assertion that dental services were the responsibility of the states, the committee concluded that the responsibility was *shared* with the Commonwealth who should take 'an active leadership role'. However, the inclusion of dental services in Medicare was rejected on the basis of the 'enormous budget implications' and this being inconsistent with 'the shared

responsibility of the states'. Instead the Committee recommended the restoration of CDHP[1] (Commonwealth of Australia 2003, pp.131–2).

2004–2007

In 2004 an oral health plan endorsed by the Australian Health Ministers was released by the National Advisory Committee on Oral Health (NACOH). It acknowledged that:

> profound disparities exist across socio-economic groups in Australia with respect to oral and general health. In particular, the incidence of caries and periodontal disease increases as socio-economic status decreases. These two most common oral diseases lead to poor social and health outcomes in vulnerable populations. Both are amenable to prevention using safe and effective methods (NACOH 2004, p.27).

Despite the recommendation of the Senate committee the previous year, CDHP[1] was not restored. Instead, the Enhanced Primary Care (EPC) dental program was introduced as one component of the Allied Health and Dental Care Initiative. The EPC dental program (also known as the Medicare chronic disease dental scheme) covered only those persons with chronic, long-term health conditions being treated by multidisciplinary teams of healthcare professionals. The restrictive eligibility requirements led to a low take-up with 16,000 services and $1.8 million in benefits paid during the first three years (Parliament of Australia 2008b, p.8).

While the uptake of the EPC dental program increased significantly after its expansion in 2007, the newly elected Labor government announced that it was to be closed to new patients in March 2008 and wound down, with funding redirected to new programs.

2008

In the 2008–09 Budget, the Rudd Labor government announced a range of new initiatives. These included a nationally consistent framework for public dental services, including performance indicators (Commonwealth of Australia 2008, p.189). Some $11 million was dedicated to increasing Indigenous access to dental care by piloting a mobile dental service, and $49.5 million was committed to James Cook University's proposal to build the Cairns School of Tropical Dentistry. Notably, $490.7 million in funding was provided over five years for a Teen Dental Plan which commenced in July 2008 and has been continued in 2010. Participants aged 12–17 who receive Youth Allowance, Abstudy or live in a family that receives Family Tax Benefit A are eligible to receive a $150 voucher by Medicare to fund a preventative dental check. The program's 2008–09 target was to provide 1 million vouchers annually and send program information to 9000 dentists (Department of Health and Ageing 2008a, p.88; Parliament of Australia 2008c). Teenagers can visit public or private dentists, with costs either bulk-billed by the practitioner or claimed by the patient through Medicare. Note that some community dentists in the TF trial believed this program to be poorly targeted and inefficiently used by private dentists, and that the resources would be better spent on the public sector (see Chapter 4, Access to timely treatment).

Also announced was a new Commonwealth Dental Health Program (CDHP[2]), providing funding of $290 million over three years for consultations and treatments, with priority being given to Aboriginal and Torres Strait Islander people, preschool children and those with chronic disease. The Department of Health and Ageing (DHA) estimate this would provide 1 million additional consultations and treatments. The funding was intended to supplement rather than replace existing state and territory dental expenditure and could be used to enhance public services or purchase private services where these are not accessible (Commonwealth of Australia 2008, p.189; Roxon 2008).

However, at the time of publication, CDHP^2 is yet to commence because this is dependent on the cessation of EPC dental program whose expenditure equates to nearly half the funds promised for CDHP^2 (Department of Health and Ageing 2008c; Department of Health and Ageing 2009; Lewis 2007; Parliament of Australia 2008a). The closure of the EPC dental program has been twice blocked in the Senate because the Liberal party, who established the EPC dental program, the Greens and Family First support its continuation. Greens Senator Rachel Siewert argues that, since the expansion of the EPC dental program, it has helped thousands of low-income Australians and the government cannot guarantee that CDHP^2 will offer the chronically ill on low-incomes the same level of dental care. She said: 'if the Government is serious about helping low-income earners with serious dental problems, they would maintain both of these programs' (Siewert 2008). Negotiations on improving access to dental treatment look set to continue coming up to two years after CDHP^2 was announced. At the time of publication, the DHA website stated that it is still the government's 'intention' to close the EPC dental program (Department of Health and Ageing 2010).

National health reform: 2009 and beyond

In February 2008 the National Health and Hospitals Reform Commission (NHHRC) was established to provide advice on the framework for the next Australian Health Care Agreements (AHCAs) and performance benchmarks in a range of health service areas, as well as to develop a long-term health reform plan. With respect to dental care, the Commission's first report acknowledges that:

> Key gaps in access exist today, for example, support for mental health care and dental care…In the case of dental care, there is clearly inequitable access, with some people relying on public dental programs of varying coverage (NHHRC 2008b, p.15).

With respect to the item, 'improving oral health and access to dental care', the NHHRC interim report's key messages included acknowledgement of:

- the impact of oral health on overall health and wellbeing
- the greater cost and productivity losses of not providing early intervention including 50,000 avoidable hospital admissions in 2004–05
- poor access to care and waiting times with 650,000 adults on waiting lists and an average wait of over two years
- the significant out-of-pocket costs of dental care, with low-income households spending around 8.2 per cent of their income on dental services (NHHRC 2008a, p.259).

The NHHRC's reform response was the proposal of the scheme, 'Denticare Australia' whose objective is to provide: 'universal access to preventative and restorative dental care, *regardless of people's ability to pay*' (NHHRC 2009, p.26, emphasis added). This universal basic dental scheme is to be a mixed public and private-cover approach funded by an increase in the Medicare levy of 0.75 per cent of taxable income and combining expenditure on current Commonwealth programs. People can direct these funds to a private insurer—if they can afford health insurance—and this would cover 85 per cent of treatment costs (Parliament of Australia 2009, p.4). Alternatively they can use public services. NHHRC states that the increased levy will amount to less than people already pay on dental services, while low-income earners will pay considerably less. Also proposed are a one-year internship program for dental students to increase numbers of dentists in the public system, expansion of preschool and school dental programs, and additional funding for oral health promotion (NHHRC 2009).

The reception of the 'Denticare' proposal has been varied. Professor John Spencer of the University of Adelaide is in favour of the scheme, believing that increased universal access will mean people visit the dentist more often rather than waiting until emergencies arise (Sexton 2009). However, the 'Denticare' proposal has received a considerable amount of criticism around cost, supply issues, the need to provide *targeted* dental care that prioritises disadvantaged Australians and the incorporation of *universal* dental services within Medicare as a public good.

Cost

Opposition health spokesman Peter Dutton has rejected 'Denticare' because of the tax increase required. The Australian Dental Association's president, Neil Hewson, believes the scheme would be 'fiscally irresponsible' and would effectively double the cost of dentistry to $11 billion, with around half of all Australians paying more. He objects to the universal provision of dental care, favouring the provision of more-targeted public services for low-income Australians with the private sector lifting the level of service to public patients through a voucher system (Metherall 2009; Sexton 2009).

Supply issues: the shortage of dentists

'Supply' issues represent a significant problem within dentistry, and it was estimated that by 2010 there would be a shortfall of 1500 dentists to maintain service at 2004 levels (NACOH 2004, p.v). The situation in rural Australia is even more severe. In 2006 in the Central West of New South Wales, Professor Charles Burton said: 'The situation in the Central West of NSW is approaching the levels in some developing countries – just 17.3 dentists per 100,000. The OECD average is 56 dentists per 100,000 people' (Charles Sturt University 2006). A further issue, discussed later in this report, is the distribution of dentists across public and private sectors, and discrepancies in remuneration. Queensland Dental Association president, Greg Moore, argues that 'Denticare' will not resolve issues around access to treatment and the 'problems of misdistribution of the dental workforce' (ABC News 2009). While internship programs would increase the number of graduate dentists (at least temporarily) in the public system, the BSL's experience via TF is that private dentists often have full patient loads.

Targeted provision of dental care

President of the Australian Dental Association, Neil Hewson says 'Denticare' provides only basic dental services and therefore will not deliver proper care to the disadvantaged in a country where 35 per cent of the community have not been able to access appropriate dental treatment. In favour of a scheme that targets and provides care to the disadvantaged, he says those currently able to access dental care will continue to do so under 'Denticare'—but less efficiently—while 'those who could not access care previously will be given second class citizen care' (ADA 2009).

The Public Health Association of Australia also called for better targeting of disadvantaged Australians. Priority groups identified included Indigenous Australians and low-income earners including pregnant women and those suffering multiple forms of disadvantage, such as disability, mental illness, chronic illness, having special needs, or living in residential care services. The Association believes that in the absence of a targeted scheme, 'more advantaged groups would be likely to be the immediate beneficiaries, thus increasing inequalities' (PHAA 2009, p.4).

A further indication of this risk is that under 'Denticare', public centres would offer a more limited range of treatments than private clinics, but may be the only services catering for people with particular illness and disabilities (Parliament of Australia 2009, p.3).

Dental care as a public good

Opponents of 'Denticare' state that introducing an entirely new scheme would be far less efficient and equitable than simply incorporating dentistry into Medicare. President of the Association for the Promotion of Oral Health, Hans Zoellner, believes that 'Denticare' would create a two-tier system directing federal funds to private health insurers and paying for private health insurance, leaving those unable to afford private health insurance on public waiting lists:

> The most simple solution is to simply put dentistry in Medicare. Medicare is a system that works. It's been shown to work for dentistry for people with chronic diseases over this past year and it will work for the whole community (ABC News 2009).

John Menadue of the Centre for Policy Development says that both 'Denticare' and another NHHRC proposal, 'Medicare Select' (in which Australians would be enrolled in a government health plan with the option to move to a selected plan that also offers extra services, these managed by private insurers), would undermine Medicare. Both proposals would hand public funds over to the for-profit private sector, which does not control costs. He argues that 'Denticare' is economically inefficient, with administration costs incurred by both the government and the private health insurance sector, which has profit margins of about 15 per cent: 'This is three times the administrative cost of Medicare. The most sensible course to fund dental services would be to extend Medicare…' Beyond the problem of inefficiency, Menadue adds that this is not an appropriate use of public funds:

> If people want to buy a Mercedes Benz or private health insurance, that is their right, but why should the community subsidise them to jump to the top of the queue, undermine the public universal system and push up costs (Menadue 2009, p.3).

As the above overview demonstrates, Australia's national dental policy in 2010 is in a state of flux. Given that the provision of dental services is a public good, decisive action is needed to ensure both universal and timely access to dental care for all Australians, through an efficient system in which scarce health resources are distributed equitably. On this basis, it makes sense to include dental services within Medicare.

State dental care: the case of Victoria

With the cessation of CDHP1, states and territories varied their dental programs to compensate. For example, in 1997, Victoria continued to subsidise services for low-income groups but introduced a co-payment or nominal fee (BSL 1998, p.2) for services provided in community health centres, hospitals and mobile vans (DHS 2008). In an effort to boost the level of service, from 2000 to 2007 the Bracks government allocated an additional $158.2 million to oral health, aimed at reducing waiting times, increasing the number of dentists and centres, improving preschooler access and primary school recall times, and health promotion. The Victorian Government has also fluoridated water supplies in a number of rural towns (DHS 2007b, pp. iii, vii). In the 2008–09 Victorian Budget, $13 million was dedicated to new dental centres at Mildura and Wodonga, and new dental chairs at Melton and Morewell (Victorian Department of Treasury and Finance 2008 p.21). In the 2009–10 Budget, $21 million over four years was committed to new dental chairs in Bendigo and Wodonga and to the reduction of waiting lists in Melbourne and regional Victoria. This funding is also intended to support the training of dental

students, the Budget document stating that this will enable an extra 20,000 public dental patients to be treated in 2009–10 at university centres (Victorian Department of Treasury and Finance 2009, p.17).

Service provision

All Victorians can access emergency dental treatment at the Royal Dental Hospital of Melbourne and, if eligible, via a community health centre. In addition, the VicHealth website indicates the existence of around 17 dental vans visiting rural and regional communities (DHS 2007a, pp. 46–51). Emergency services assess patient needs and provide a waiting time. However, access to non-emergency public dental care is subject to co-payment, age and other eligibility requirements, which are as follows:

- children up to age 12 have priority access to public dental care; 13–17 year olds must be eligible for a Health Care Card, or dependents of Health Care Card holders. No co-payment is required for children who are the dependents of Pensioner Concession or Health Care Card holders.
- adult public dental services are provided to persons eligible for Pensioner Concession or Health Care Cards (DHS 2007a, p. 34).

In addition, a number of priority groups have been identified under the state's Demand Management Framework. These include:

- people with an immediate risk to their safety, or the safety of others
- homeless people, and those at risk of homelessness
- refugees
- Indigenous people
- people with complex care needs that require a priority service to ensure a coordinated team approach (DHS 2009b).

As of June 2009, the co-payment was $23 per visit for adults to a maximum of $92 for a completed course of care. Families without a concession card pay $28 for preschoolers and children aged 5–13 for a completed course of care, with a $112 cap on payments per family. It costs up to $115 for acrylic dentures. Fee exemptions apply for children in residential care, clients of mental health and disability services, patients treated by undergraduate students and participants in special government initiatives. In addition, persons assessed by staff to be experiencing financial hardship are exempt (DHS 2010). DHS do not specify how this is assessed, which is problematic given only recipients of welfare payments and very low-income earners qualify for the service. For instance, to qualify for a low-income Health Care Card and thus the dental service, singles must not earn more than $452 per week, which amounts to $23,504 annually (Centrelink 2010).

The waiting list for public treatment can be lengthy: the Victorian 2009–10 benchmark was 22 months or almost two years (DHS 2009a, p.7). However, based on 2009 figures, 23 centres exceeded the benchmark. In metropolitan Melbourne, the longest waiting time was 41 months at Rosebud, and 52 months at Ballarat in rural Victoria. The wait for dentures was also lengthy. Both St Albans in metropolitan Melbourne and Wangaratta in rural Victoria had waiting times of 41 months (VOHA 2010).

Case study 1: Joshua

Growing up in a sole-parent family on the outskirts of Frankston, Joshua lived with his mother and sister.

> *There was never really a focus on being healthy and things like that in my family so I never looked after my teeth growing up…and my teeth were always hurting.*

Health was not a focus because Joshua and his sister sometimes went days without any food in the house, let alone having a toothbrush or toothpaste. Describing his mother as more of a flatmate, she became angry if he asked if there was anything for dinner.

> *We basically fended for ourselves as kids growing up…You'd hassle her to buy some milk or something like that and she'd be: 'Yeah, yeah' and the next morning she'd go straight out. You wouldn't see her for a couple of days, she'd keep doing it and after four days she'd finally buy a loaf of bread maybe and some milk and that was basically it.*

When he was 15, his mother told him she was moving to a one-bedroom flat so he would have to find somewhere else to live. Joshua didn't have anyone to turn to. Asking his mother where he was supposed to go, she said that was not her problem. The next morning, without any money or any place to stay, Joshua set out at the usual time—but instead of going to school he walked an hour to the nearest station and began taking odd jobs as a painter. For the first few weeks he walked back to his now shut-up home and climbed in his bedroom window, using candles after the power was cut off.

> *Then I slept—a guy I knew who'd be home—I slept near his car in his carport, things like that, and stayed at friends' houses for the next year or so…I didn't brush my teeth for a few years to be honest. There's nowhere to keep those things, I suppose I could have been a little bit more prepared but really I was just trying to live.*

Over the next five years Joshua went through a cruel cycle: taking jobs he hated—labouring and in factories—then losing the job and his accommodation. By his early twenties even this work had ceased. Hating his life, he became a recluse and stopped going out at all. Around this time, the teeth he chipped as a teenager began to rot. One of the teeth was so sharp it was constantly cutting his lip. He was unable to chew properly, drink cold water or, at times, talk or inhale without experiencing sharp pain, this keeping him awake at night.

> *So I got a small sledge hammer and wrapped a tea towel around it and got a chisel and tried to knock it all out…I don't know what the hell I thought I was doing, but it just hurt so much I thought I'd try and knock the whole thing out. I didn't really think: 'OK, there's roots that go way up' and all kinds of stuff like that. I just thought: 'Hey, it'll be out of that area and then it won't be a problem'…I chipped most of the visible part off and I got quite a bit off but it was tough to do. When you're doing it you go [motions as though striking a tooth]: 'No, I know I've gotta do it harder than that'…You've gotta keep going and it's hurting but it's not hard enough to really break it through.*

At 23, Joshua visited the dentist for the first time since a dental van had visited his primary school. Sent for X-rays, Joshua decided not to return to the centre because it would have cost him another $20 and they had already told him the wait for treatment was two years.

> *They said: 'Yes they need to be taken out…We need to give you antibiotics and you put up with it, or you get it taken out and it takes up to a couple of years waiting list; or you get it done privately which costs a couple of thousand dollars'. [Thinking about the two-year wait, he decided] 'Maybe I'll get a job by then, hopefully I can get a job and just pay for 'em', which I never ended up doing;*

which is what I feel a lot of people do: don't end up getting around to doing it because it costs a lot of money. There were about four years where I didn't have a job at all. I'd just be on the street and things like that. So that was just one of many problems that I had to get around fixing…the dentist costs so much…and I didn't even have money for food let alone getting my teeth fixed.

Still in pain, Joshua did save enough money to have his front teeth removed by a private dentist but unable to afford the restoration work, he spent the next two years without front teeth. This had a profound effect on his life.

I'm a pretty self-conscious kind of person anyway. Wherever I go I always feel awkward. So, I mean, your teeth being such a focal part of your face, when you open your mouth, even in the way you talk. If you don't feel comfortable about your teeth and how your mouth looks, you move your mouth a lot different and you'll really hide your personality and the way you express what you're trying to say. So I guess it made me even more closed in and reserved…It made me feel just as awkward having to speak a lot to people I hadn't seen in a long time, people I hadn't seen since high school, running into these people in the street…You have to explain to people why you've got missing teeth. You just look a certain way when you've got missing teeth in the front there. Yeah, it means I'd wanna speak less, I suppose, and definitely not want to smile at all

When you're looking for jobs and things like that it was difficult. You've gotta be presentable even going for a job in a factory or any job. You've gotta look smart, I suppose, I couldn't even do that. It came to the point where I just knew I looked terrible.

Joshua participated in the Personal Support Programme for the long-term unemployed at Frankston BSL for two years. Before completing TF he obtained office work. His experience of starting the new job gives much insight into the barriers that the long-term unemployed face in gaining employment, and the pivotal role of dental health.

It was overwhelming, I've never had to wear nice clothes. I've always had a shaved head or long hair. I've never had to wear a shirt or anything like that you know…It was really difficult for me to go to reception because for the first few months or so while I was there, I didn't have the teeth in…And as a guy who probably already didn't have such great self-esteem, to feel like I've gotta look extra smart and be extra nice to make up for feeling like I look really out of place…just looking like me and feeling like me, not being able to smile, even, or, if I did, I was always wondering if they could see it. There were times where maybe I may have laughed and I may have let it be obvious that I've got teeth missing…So having to greet people and smile and things like that without showing my teeth was difficult especially when I already felt like people were looking at me like, 'What the hell's he doing at reception?' You look out of place, you know.

Now with his dental treatment complete, Joshua talks about the difference it has made to his life.

The main thing is that I feel comfortable in appearance. I mean, I still don't feel comfortable because I'm still me but I feel a little less ugly.

Just being able to talk freely and comfortably and not feel like people are looking at me in a negative way. I honestly don't think about my teeth…That's probably the best thing—that it's not on my mind whereas it always was…I don't even think about my teeth now.

Asked what he would like to say to government about dental health, Joshua said he wished that public dental was more accessible for people who do not have private health insurance or the money to visit the dentist. Had he not participated in PSP, he feels, he may never have had his teeth fixed and always have felt bad about himself.

It's an important thing and it's something that affects you physically and, you know, socially, mentally…It can mean a lot to get your teeth fixed, it's a lot of stress on somebody.

3 Consequences of poor public dental provision

There is considerable evidence to suggest that both limited access to dentists and lack of affordability are issues in relation to dental care. These deficiencies result in negative health outcomes, as well as having broader social and economic consequences.

Access to dental care

The National Survey of Oral Health 2004–06 found that 60 per cent of adults had visited the dentist in the 12 months prior to being surveyed, 56 per cent saying this was for a check-up (AIHW 2007). However, there is considerable evidence to suggest that the broader Australian population has difficulty accessing dental care. Peter Saunders, a research chair in the Social Policy Research Centre (SPRC) at the University of New South Wales, reports that in a survey reflecting the general population, around one-fifth of respondents said they could not access dental treatment when needed and one-quarter could not get an annual treatment for their child or children (Saunders 2007). Research conducted by the Australian Council of Social Services (ACOSS) suggests the figure is much higher, with 40 per cent of Australians unable to access dental care when they needed it (ACOSS 2006, p.1).

The situation is significantly worse for disadvantaged Australians. A SPRC survey examining material deprivation and social exclusion found that among welfare participants, almost 60 per cent could not access dental treatment or annual check-ups for children (Saunders 2007). An epidemiological study conducted in Adelaide found that participants in the highest income quartile were considerably more likely to have visited the dentist in the past 12 months for any reason, and were twice as likely to have received a check-up, than those in the lowest income quartile (Spencer & Hartford 2007). National Survey of Adult Oral Health (NSAOH) data indicates that many disadvantaged Australians have not visited a dentist for at least five years. Almost one-fifth of those eligible for public dental care had not seen a dentist in at least five years. Factors which made it more likely that a person had not visited the dentist in some time include being Indigenous, living outside of a capital city, having low levels of schooling, not having dental insurance, visiting the dentist only when there is a problem and being classified edentulous (having few or no teeth). These factors were amplified among older generations: 40 per cent of Indigenous persons 31 per cent of people outside capital cities over the age of 75 had not seen a dentist for at least five years.

Table 3.1 Percentage of people whose last dental visit was at least five years ago, arranged by generation for different population groups

Characteristics	Generation (decade of birth)				
	All ages	1970–90	1950–69	1930–49	Pre-1930
		15–34	35–54	55–74	>75
All people (%)	***12***	***11***	***9***	***13***	***23***
Indigenous	15	10	14	22	40
Non-capital city	15	11	11	17	31
Year 9 or less	20	10	18	20	29
Eligible for public dental care	18	13	14	18	28
No dental insurance	17	16	13	19	28
Visit for a dental problem	18	22	16	16	25
Edentulous	45	0	46	46	44

Source: *Australia's dental generations: the National Survey of Adult Oral Health 2004–06* (AIHW 2007, selected figures from Table 6.2, p.165)

A likely reason for the infrequency of dental visits among disadvantaged groups is that in 2007 there were 650,000 people waiting for public dental services (Parliament of Australia 2007, p.99). An ACOSS report cited the average waiting time for public dental treatment in 2002 as being 27 months, adding that of those on the waiting list, only 11 per cent were treated each year (ACOSS 2006, pp. 11–12).

The impact of affordability on care

ACOSS reports that of those Australian adults who are not eligible for public dental care, 23 per cent (which amounts to 2.3 million people) reported that they delayed or avoided treatment due to the cost (ACOSS 2006, p.1). The NSAOH data puts this figure at 30 per cent of the Australian population but the percentage delaying and avoiding treatment due to cost was substantially higher among the following groups:

- those *eligible* for public dental care (35%)
- Indigenous Australians (38%)
- those without dental insurance (40%)
- those who normally only visit when they experience a dental problem (45%).

The survey also found that more than one in five Australians reported that cost prevented them from receiving recommended dental treatment, and a similar proportion said they would have difficulty paying a $100 dental bill (AIHW 2007).

Not surprisingly, research indicates differences in treatment patterns across income groups. This relates in part to the greater likelihood of low-income earners visiting the dentist for a specific problem rather than a check-up which could act as a preventative measure. For instance, low-income earners are less likely to have their teeth scaled or cleaned and more likely to have had an extraction. Moreover, because the variation in care occurs over a lifetime, lack of preventative measures—such as check-ups and fillings—can have a cumulative effect and lead to poor outcomes such as infections and extractions (Spencer & Hartford 2007).

The consequences for oral health

Poor access and lack of affordability result in poor dental health outcomes. The National Survey of Adult Oral Health found that:

> Within the Australian adult population, oral diseases were pervasive. They caused a substantial amount of pain and other impacts on quality of life…The frequency of oral disease and related symptoms were inequitably distributed, being greater in groups that were already disadvantaged (AIHW 2007, p.xvii).

One-quarter of Australians reported that they had untreated decay and this figure more than doubled among Indigenous Australians (57%). One-fifth of Australians had moderate gum disease (periodontitis) and around one-quarter had visibly worn enamel. Slightly more than one-tenth had inadequate natural dentition (fewer than 21 teeth) and one in twenty had lost all their natural teeth. Indigenous Australians, persons living outside capital cities, the uninsured and those eligible for public dental care were more likely to suffer from these conditions (AIHW 2007).

Health and wellbeing

Professor John Spencer argues that measures of oral health need to extend beyond clinical outcomes to consider broader health and social impacts as well as the greater impact on the disadvantaged:

> These new measures of oral health carry particular importance because they reflect what we understand oral health to be: the opportunity to eat, speak and socialise without discomfort or embarrassment, and without active disease in the mouth which affects overall well-being (UK Department of Health, 1994). The social gradients in these measures of oral health are also strong and clear. Poorer Australians have poorer oral health, leaving them with a range of consequences for their everyday lives (Spencer 2004, p.1).

Inability to access dental treatment in a timely manner has significant impact on individual health and wellbeing, including:

- prolonged pain and suffering
- increased damage to teeth and gums
- the spread of infection to other parts of the body resulting in other acute medical conditions requiring treatment in hospital emergency departments or by general practitioners
- dependence on pain medication and the implications of their side effects
- poor diet due to inability to eat fresh fruit or vegetables resulting in other medical conditions (e.g. vitamin deficiencies, digestive problems, obesity)
- other major health problems such as cardiovascular disease, stroke, diabetes, low-weight preterm babies
- dental-induced speech problems (e.g. difficulty pronouncing words)
- diminished self-esteem due to physical appearance (e.g. broken and or missing teeth).

A report by the Australian Health Ministers' Advisory Council found that pain from teeth, gums or dentures is reported by approximately 40 per cent of the Australian population, and half of those with teeth and two-thirds of those without teeth, experienced discomfort while eating. One-quarter reported feeling self-conscious as a result of oral health conditions (AHMAC 2001, pp.5–6). Australia's National Oral Health Care Plan 2004–2013 notes some of these broader health impacts:

> Pain, infection and tooth loss are the most common consequences of oral disease, but it can lead to destruction of soft tissues in the mouth and, in rare cases, death. Oral disorders cause difficulties with chewing, swallowing and speech, and can disrupt sleep and productivity. They can affect the way a person looks and sounds, the face they present to the world (US Department of Health and Human Services 2000), with a significant impact on self-esteem, psychological and social wellbeing, employment, interpersonal relations, and quality of life. Tooth loss is directly associated with deteriorating diet and compromised nutrition (NACOH 2004, p.5).

Employability and stigma

As noted in the NACOH report, poor oral health has a negative impact on employment participation. Delayed treatment only compounds this problem and has implications for individuals' economic and social participation. Poor dental health:

- reduces ability to take part in training or study
- prevents attendance at job interviews and/or participation in regular work
- reduces marketability as a job seeker due to appearance and social stigma
- produces economic and social exclusion
- increases government expenditure as a result of greater health problems and the need for income and other welfare support
- has a large-scale impact, social disadvantage having consequences for the broader community.

A 1998 survey by the American Academy of Cosmetic Dentistry found that three-quarters of respondents believed that an unattractive smile can be detrimental to a person's chances of career success. Half perceived unattractive teeth as a sign of poor personal hygiene (in Glasser & Jones undated). Similarly, Jesuit Social Services identify missing teeth as a barrier to employment. While this was stated within the context of a submission on barriers for people with criminal records, the fact of missing teeth is listed as a 'presentation issue', which is arguably applicable to this discussion (Jesuit Social Services 2005).

In her submission to the Senate inquiry into public dental services, Dr Cole, Director of the Royal Dental Hospital of Melbourne, states:

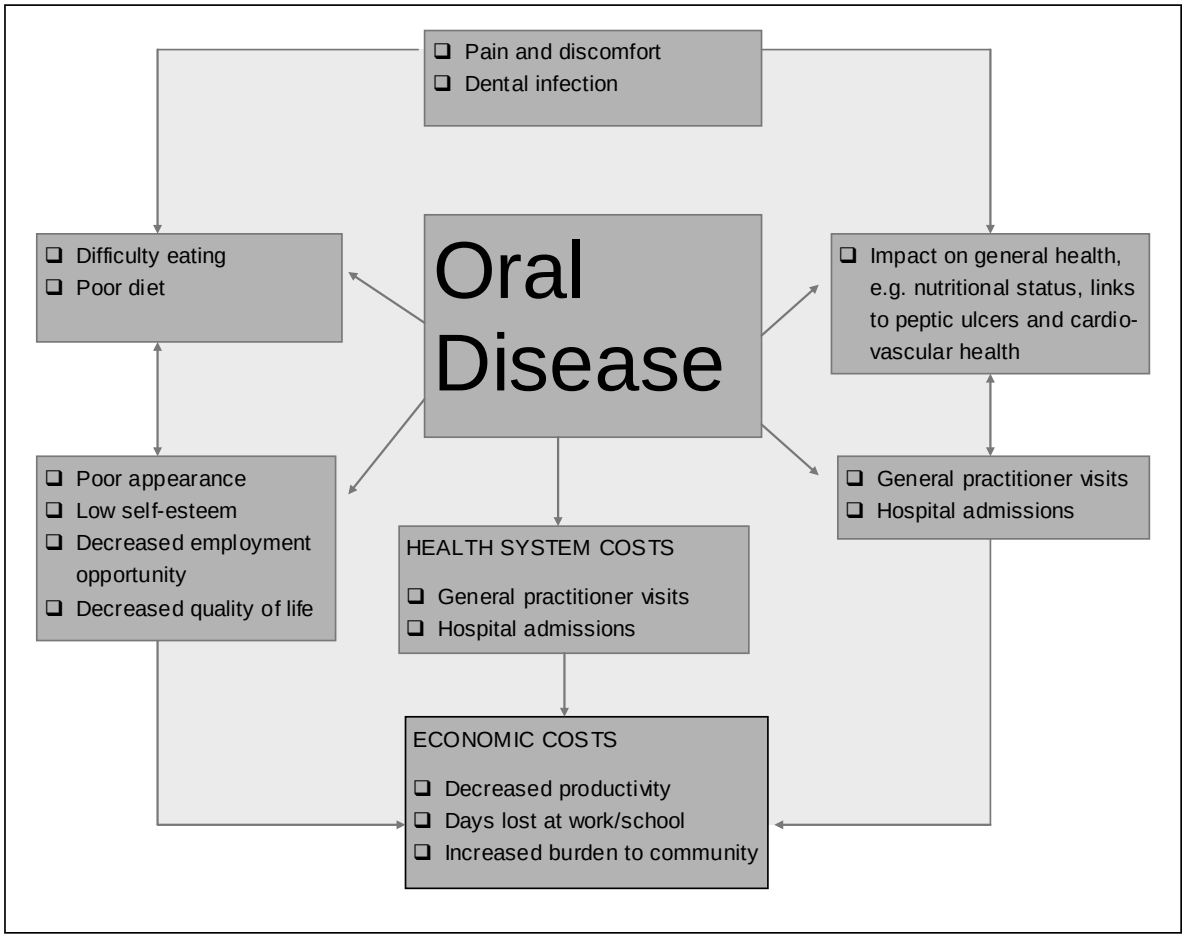
> …It horrifies me that many people, especially decision makers, have no realisation of the dental consequences for the financially disadvantaged. These people with their broken down mouths have their job prospects diminished, are more likely to have problems dealing with landlords, bank managers, the police, doctors, lawyers and many other people they come into contact with in their daily lives. The value judgments that all these people make on a daily basis…come into effect to help these people stay in the poverty trap (Senate Community Affairs Reference Committee 1998a, p.4).

As a further indication of the impact of this stigma, former Democrats Senator Brian Greig, in a speech on drug addition and the Disability Discrimination Act, highlighted the difficulty that people with poor dental health face in finding accommodation. He suggested that even caravan parks reject people with poor dental health on the assumption that they are junkies (Australian Democrats 2003).

Broader social and economic consequences

At a macroscopic level, poor oral health has a negative impact on society and the economy, for example, through increased strain on public services and decreased economic productivity. This is recognised in Australia's National Oral Health Plan, which summarises this broader impact diagrammatically (see Figure 3.1).

Figure 3.1 The impact of oral disease, diagram reproduced from NACOH (2004, p.5)



Negative impact on health services

Expenditure on dental services during 2001–02 was estimated to be $3.7 billion, or 5.5 per cent of total health expenditure. It is reported that much of this expenditure was on repair and rehabilitation of conditions that could have been prevented by personal and public health measures. Inappropriate use of medical services must also be accounted for: during 1998–2000, an estimated half a million visits to medical practitioners were for dental problems, this costing Medicare over $10 million (NACOH 2004, p.8). These service fees are in addition to costs incurred through the Pharmaceutical Benefits Scheme, such as when general practitioners prescribe antibiotics to manage infections caused by untreated dental problems.

Ambulatory Care Sensitive Conditions (ACSC) are conditions in which hospitalisation is considered avoidable with intervention and management. The Commonwealth Department of Health and Ageing states that there are 500,000 preventable hospital admissions each year and 50,000 of these are for dental conditions (Department of Health and Ageing 2008b).

In Victoria, the biggest cause of ACSCs for persons aged under 18, and the second largest for all age groups, were related to dental care. In the 2004–05 fiscal year, 80 per cent of ACSCs involved caries or related conditions, with three-quarters of patients treated by tooth removal which could have been prevented with earlier treatment. Access to fluoridated water and the proportion of households living in poverty were found to be significant predictors of ACSCs (DHS 2007a, pp.12–13).

Productivity

Aside from the impact on individuals, poor oral health results in missed school and work days and, ultimately, on productivity (Department of Human Services 1999). In 1996, around one in six workers reported taking time off for a dental problem (Yanga-Mabunga 1998, unpublished).

The strong link between socioeconomic status and health (NACOH 2004, p.6) means that poor oral health has a greater impact on employment outcomes for already disadvantaged Australians. For example, there is a considerable body of research that links physical health and employment participation. One US study of Californian welfare recipients found that 42 per cent said that health problems had prevented them from looking for work, doing training or fulfilling other work-related responsibilities or commitments in the last 12 months (Speiglman et al. 1999, p.35). In a Michigan study of current and former welfare participants, 70 per cent reported limitations in physical functioning (Corcoran et al. 2003). In Australia, an evaluation of the PSP for the long-term unemployed undertaken by the Brotherhood of St Laurence, Melbourne Citymission and Hanover Welfare Services found that of 13 barriers holding people back from work, physical health issues were second only to mental health problems (Perkins 2007, p.29), and that 20 per cent of PSP clients reported ongoing medical or dental conditions as barriers they faced.

A study in San Francisco examined the oral health and Oral-Health-Related Quality of Life (OHRQoL) of 377 welfare recipients in an employment services program who received dental treatment. Participants who completed their dental treatment were twice as likely to achieve a favourable or neutral employment outcome than an unfavourable outcome, this being defined as losing their welfare benefits due to non-compliance or fraud. The researchers' concluding observation was that:

> The oral health and OHRQoL have not been previously assessed in a welfare population, nor has a Dental Program ever been offered as a welfare intervention. The improved OHRQoL and employment outcomes found for the participants who completed their dental treatment indicate that, for some welfare recipients, oral disease poses as significant a barrier to employment and self-sufficiency as do problems with general or mental health. Thus, oral health treatment can contribute to the goals of the Federal Personal Responsibility and Work Opportunity Reconciliation Act by eliminating barriers to employment and improving OHRQoL (Hyde et al. 2006, p.83).

While long-term unemployed persons often face multiple barriers to employment, inability to obtain dental care seems likely to reduce their chances of becoming more work ready.

Some recognition of the impact of poor dental health on employment participation may be seen in Job Services Australia's new Employment Pathways Fund, which allocates job seekers up to $1100 (for the most disadvantaged) to be used on goods and services that will assist them to obtain employment. Included are dental services along with mental health care, books, tools, driving lessons and a wide range of other items (DEEWR 2008). This is a worthy initiative. However, an even worthier one would be to provide accessible public dental treatment to all Australians so that oral disease never becomes a factor in employment participation.

This hypothetical example indicates the ramifications of poor dental health for productivity: if an unemployed Australian is forced to wait three years for dental treatment in the public system, and this limits their capacity to secure work, the costs of Newstart Allowance and rent assistance equate to $14,763 (per single person without children) per year, or $44,289 for three years, excluding administration and Health Care Card costs. Beyond these costs are those of lost revenue via income tax (Australian Government 2010). On this basis there is a strong economic imperative for providing timely dental treatment.

Case study 2: Stephanie

When Stephanie was only six she had an accident while riding her bike, flying over the handle bars and hitting her front teeth on the road. A few years later her teeth started turning black. Fortunately, at that time, she was able to access good dental care: root canals were performed on the dying teeth, which were also bleached back to white.

At 18 Stephanie became pregnant and this had a significant impact on her health. After having the baby, she suffered severe postnatal depression and felt completely drained. Saying that she never took drugs, smoked or drank much, she recalled how one day to her horror, her two front teeth simply fell out.

> *I went about six months without my front teeth just because I didn't know what to do or where to go to start to do it all. I knew my teeth were all stuffed, though, I had to chew on one side because this side would hurt and then this side would start hurtin'. It was just a big mess in there.*

Stephanie's other health issues meant that her missing teeth were not a priority. Already feeling bad about herself due to the postnatal depression, having no front teeth had an impact on how she interacted with others. When meeting new people, she covered her mouth with her hand: 'I don't really want to have anyone see because it's just horrible'.

Stephanie separated from her partner, who took custody of their son, so she was required by Centrelink to look for work. Commencing the Personal Support Programme at Frankston, she was referred to Teeth First by her caseworker. Learning that the dentist could only save five of her teeth, she replied: 'Well, you may as well just take them all out, there's no use in saving any'. Having resolved to 'get it over and done with' even her dentist was surprised by her level of pain tolerance. Normally his patients needed two weeks between extractions to recover. Stephanie however, 'jumped straight into it' to have eight teeth removed each week across four weeks.

After several months waiting while her gums healed, and a couple of dental assessments, Stephanie learned she required surgery to fix a protruding jaw bone before plates could be fitted and dentures made. After her first surgery, additional consultations with a specialist were required to determine whether further surgery would be required. Stephanie's resolve was important. She recalls how she travelled around the Peninsula visiting different dentists and specialists on almost a weekly basis for some months. Because she was required to act as a witness in a court case, the delays also meant she had to give evidence before a jury without her teeth.

From the time she lost her front teeth, Stephanie had difficulty eating. Explaining that chewing helped the brain feel satisfied, she said she often feels hungry, having lived for months on a diet of sloppy food such as oats and mashed potato. Quite aside from the nutritional impact of having no teeth, there is a social impact of being unable to share food with friends, and—with sudden enthusiasm—Stephanie said: 'Nachos, I can't wait to eat nachos'.

It took around a year to get her dentures and they have been difficult to get used to. Stephanie says she wears them about half the time because they make her gag and she cannot yet eat with them. She does wear them to go out and says they have improved her spirits and self-image, her friends commenting how good they look. And, while still busy caring for her three-year-old son, she is planning—with help from her job services provider—to undertake some further study.

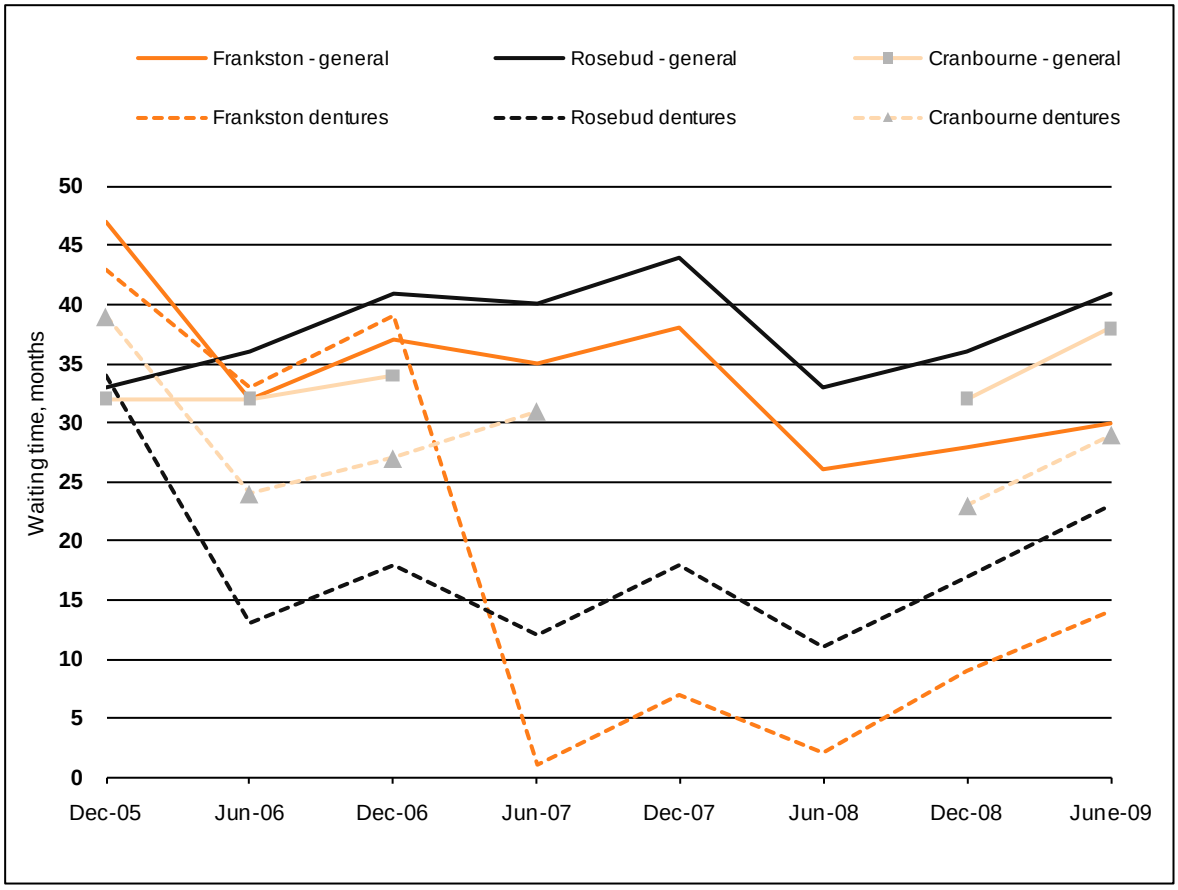
4 Teeth First treatment trial

Prelude: dental care on the Mornington Peninsula

Broad-spectrum dental disease prevention is available on the Mornington Peninsula through its water—which was fluoridated in 1978 (Department of Human Services 2007b). According to a 2007 Victorian Government report, 101,244 people in the Frankston and Peninsula region were eligible to receive public dental care (i.e. children and disadvantaged adults); there were 17 dental chairs and a population of 5,956 per chair (Department of Human Services 2007a, p.52). While the number of chairs per capita in the region is favourable compared to some metropolitan areas, it must be remembered that, geographically, this is a large region with limited public transport.

The waiting time for general care at a public dentist is above the 22-month benchmark set by the health department, whose website lists the waiting times for three public community health centres located in the Frankston BSL catchment area. The waiting period as at June 2009 for general care was 30 months at Frankston, 41 months at Rosebud and 38 months at Cranbourne. The waiting period for dentures was 14, 23 and 29 months respectively. This means that people are literally waiting years to have their dental problems attended to.

Figure 4.1 Public dental waiting times for Frankston, Rosebud and Cranbourne: 2005–2009



Note: Data presented as available. No data available for *Cranbourne – general* for June 2007 through to June 2008 and no data for *Cranbourne – dentures* from December 2007 through to June 2008.

Source: (DHS 2009c; VOHA 2010)

Treatment trial

For more than a decade, the Brotherhood has been active in advocacy and research around the provision of dental services for low-income Australians. This knowledge base has been enhanced by Community Services staff who observed that access to public dental services is limited and many clients experience poor oral health. This was perceived to impact clients' broader health and wellbeing; self-esteem and confidence in social situations; ability to seek and maintain employment; and, ultimately, their social and economic inclusion.

Teeth First was a practical response to the oral health needs of disadvantaged people that sought to promote social inclusion. The broad objective of the TF trial was to secure timely access to dental treatment for the long-term unemployed, and in turn enhance their personal wellbeing and social and economic participation. A further objective was to highlight the issue of poor public dental provision and to advocate on behalf of disadvantaged Australians.

Funded by a generous donation of $40,000 from the Sidney Myer Fund, TF formally operated from December 2007 to July 2009 but, for reasons discussed later in this report, some treatment was ongoing in February 2010. Participants were highly disadvantaged and were identified from within Frankston's Personal Support Program (PSP), a government-funded employment services program that BSL operated until July 2009. The PSP catered for people facing multiple barriers to employment, by providing intensive personal support over a two-year period. At the end of the PSP, clients were moved into employment-focused programs. In an evaluation of the PSP, clients' disadvantage was evident in their very low levels of education and literacy and their elevated risk of social isolation. The majority of clients were on Newstart Allowance and half had experienced homelessness in the past five years (Perkins 2007, p.23).

Coordination

The TF Coordinator was a consultant, with a background in both communications and community development, engaged by the BSL Community Relations and Communications Department. Local oversight was the responsibility of the PSP Senior Case Manager in Frankston. PSP social workers supported the project by identifying trial participants and conducting pre-treatment surveys. With the cessation of PSP in July 2009, much of this support role was undertaken by the Consultant with additional follow-up occurring as part of this evaluation.

The TF trial was initially intended to refer participants to private dentists, with BSL paying for their treatment. Letters were sent with Victorian Dental Association endorsement to recruit private dentists. However, only one private dentist participated but did not continue to offer support due to the complex needs of the participants. With a demand for dental services from participants but without a supply of dentists, the TF Coordinator liaised with community dentists on the Mornington Peninsula. These dentists work in the same centres whose long waiting times are illustrated in Figure 4.1 (above). Frustrated with the situation in the public sector and recognising that participants represent a highly disadvantaged group, they agreed to circumvent the waiting lists and fast-track trial participants' treatment so the impact of timely dental treatment could be evaluated. In some cases, participants' needs made it necessary to refer cases to private dentists and specialists. BSL covered the cost of both public co-payments and private dental fees at market rates in the case of referrals.

Participation

Some 50 PSP clients were identified by caseworkers as having unmet dental needs and were referred into the program. Fifteen of these referrals did not lead to participation because clients either graduated from PSP or left prior to completion. Issues for this group included transience and homelessness, mental and alcohol related illness and prison.

Some 35 people participated in the trial, this defined as attending an initial assessment with a community dentist. Of these participants, around three-quarters returned to the dentist on a subsequent occasion to commence their treatment (N = 26).

At the time of publication, 10 participants had completed their course of treatment (29 per cent) and, together with the anticipated completion in the next several months of five people's ongoing treatment, the future completion rate is anticipated to be 43 per cent.

In total, 20 participants commenced the trial but did not complete and are unlikely to do so. Of these, five may be classified as 'transfers' who met one of the Victorian Demand Management criteria (for example, pregnancy or having a chronic health condition) and were able to access timely public treatment. The remaining 16 ceased their participation after various intervals when, despite numerous attempts by the TF Coordinator, and as part of this evaluation, communication was lost. Frequently, landlines were disconnected and mobiles either continuously switched off or disconnected. Emergency contacts were equally unreachable. However, based on previous contact, reasons for non-completion are likely to have included: injury or personal illness (including admission to a psychiatric ward); threat of physical violence from neighbours; court cases; caring for several young children; going to prison; moving interstate; transience; or homelessness. Commonly, multiple issues act as barriers to completion of treatment.

The TF Coordinator commented that it takes a dental crisis and immediate access to dental treatment for participants to act, otherwise—very often—new crises take precedence over oral care. For this reason, she believes timely dental access is more critical for the severely disadvantaged than for average Australians.

Pre-treatment surveys

Caseworkers assisted 28 participants to complete a pre-treatment survey between January and December 2008.

Participant profile

Based on survey respondents, the trial participant profile is as follows. Participants were aged 22–48 and the median age was 36. Some 54 per cent of the participants were female and 46 per cent male. Just over half reported their family status as single with no children, 37 per cent were single parents, 11 per cent lived in a couple relationship and, of these, 7 per cent lived with their children. Participants lived in varied forms of accommodation and the most common included: staying with family or friends and paying rent or board (36 per cent); a private rental property (32 per cent); and public housing (18 per cent). One participant lived in a hostel or rooming house and one selected the accommodation category of 'car/tent/park/street or squat'. One-quarter of the participants had moved two to four times, and 22 per cent had moved five times or more, in the last two years alone.

While 4 per cent of participants indicated their main source of income was part-time work, the remainder received a government benefit with 82 per cent receiving the Newstart Allowance, 7 per cent the Disability Support Pension and 4 per cent the Single Parent Payment.

Some 30 per cent of participants had completed Year 10 or 11. Just over half the participants indicated that their highest level of education was less than Year 10. Some 15 per cent held a certificate or diploma or had completed some other tertiary (non-university) training, and 4 per cent held a trade or apprenticeship qualification. A small group of participants (11 per cent) were studying or completing training part-time, this specified as trade certificates, Certificate III in Business Administration or Child Services.

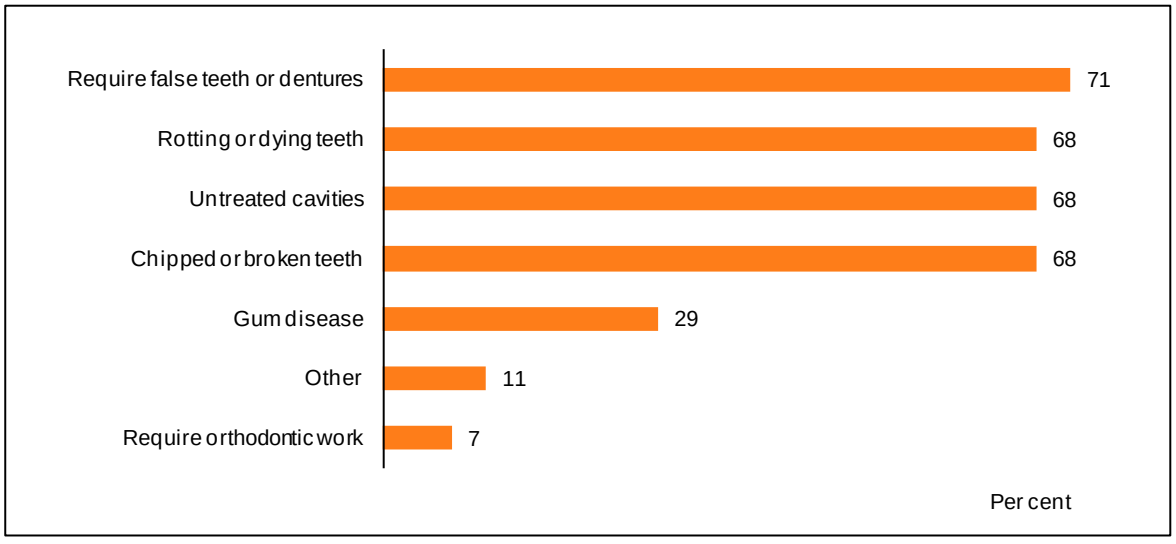
Some 42 per cent of participants said they were not currently looking for work. Written responses and feedback from the PSP Senior Case Manager indicated this was often a consequence of health problems. Of those participants seeking work, one-quarter had been looking for one to two years and around 30 per cent for two years or more. The remaining 4 per cent had been looking for three to six months. Of those participants who indicated they were looking for work, the average respondent rated the likelihood that they would find work at 3 out of 10, or quite unlikely. In fact, 82 per cent rated their chances at 5 out of 10 or less.

Some 23 participants or their caseworkers commented on the likelihood of their finding work, many listing several issues. Health issues were a barrier for 16 participants with psychological illness, drug and alcohol problems and dental issues the most common. Poor self-esteem and presentation issues were also cited. Family commitments were an issue for a minority. Only three participants were optimistic about finding employment in the medium term, this attributed to study and improved self-esteem.

Dental problems

Of the TF participants, around 70 per cent suffered from chipped or broken teeth; untreated cavities; rotting or dying teeth; and/or required dentures (N = 20). Some 29 per cent had gum disease, 11 per cent reported other problems—these often relating to the need for surgery or the removal of wisdom teeth—while 7 per cent required orthodontic work.

Figure 4.2 Untreated dental problems



Some 86 per cent said their dental condition affected their ability to go about their daily activities and three-quarters of those surveyed said they had suffered these dental problems for two or more years.

Access to timely treatment

When asked why they had not sought treatment, 11 per cent of participants said they worried the treatment would be painful. The chronic nature of the dental problems as seen in Figure 4.2 (above) suggests these concerns are legitimate. In addition, many participants suffered from multiple health issues, these including anxiety and depression, conditions which would make the prospect of dental treatment more daunting.

However, difficulty in accessing treatment was a far greater issue: 40 per cent said they had been put on a waiting list for treatment and 86 per cent said they could not afford treatment. Conversations with participants indicated that on some occasions they had sought private treatment. However, others had waited years. For example, Steve (not his real name) contacted his community dentist and was put on a waiting list. Two years later, he contacted the centre to ask when he might receive treatment and staff told him, 'It can take a while'. Now, 10 years later, he says he never heard back from them!

Respondents were asked what the waiting time was for the public dental treatment they required. Some 22 people responded: 18 per cent reported a waiting time of less than one month and 5 per cent less than six months. However, the majority reported much longer waiting times (77 per cent): just under one-fifth said the wait was one to two years and 59 per cent, two years or more. Twelve of the participants were already on the waiting list and, of these, two had waited one to two years and nine participants had waited two years or more without receiving treatment.

In relation to waiting times for emergency treatment, the evaluation indicated differences in how community health centres operated. For example, some centres had a 'sit and wait' policy (where emergency patients were waiting two to three hours to receive a voucher for a private dentist) while others centres did not.

BSL staff reported that community health centres are overloaded and, because they work with the most disadvantaged Australians, are often required to take on the role of social workers. The fact that these patients arrive in pain, to be confronted by long waiting periods, takes its toll on staff, who are also frequently subject to verbal abuse from frustrated clients.

In reducing waiting times and increasing access, community health centre managers said that they had the facilities to treat more patients: the problem was a shortage of dentists. They attributed this shortage to the major differences in the remuneration of public and private dentists. Supporting this, the General Secretary of an Adelaide-based public service association reported that in 2006, the starting salary for graduate dentists entering the public sector was $53,000 compared with $80,000 in the private sector (Bildstien et al. 2007). Similarly, a 2006 New South Wales-based Legislative Council inquiry into dental services recommended strengthening the public dental workforce through increased remuneration (Parliament of NSW 2006, p.3).

Similarly, community health centre managers said that nurses and hygienists were paid less in the public sector and thus often moved to the private sector. Dental hygienists and therapists can perform basic procedures. Given this would reduce the strain on public dentists and reduce waiting periods, the retention and remuneration of hygienists and therapists should also be considered.

Community health centre managers believed that a further factor affecting access to dental treatment for low-income Australians was program targeting and the inefficiency of the private sector. The new Teen Dental Program was perceived to benefit many non-disadvantaged Australians, who were given vouchers for private dentists. However, vouchers were used on basic 'scale and clean' type treatments

with teens returning to public dentists for more complex treatments. Community health centre staff believed that this money would have been better put to use in the public sector.

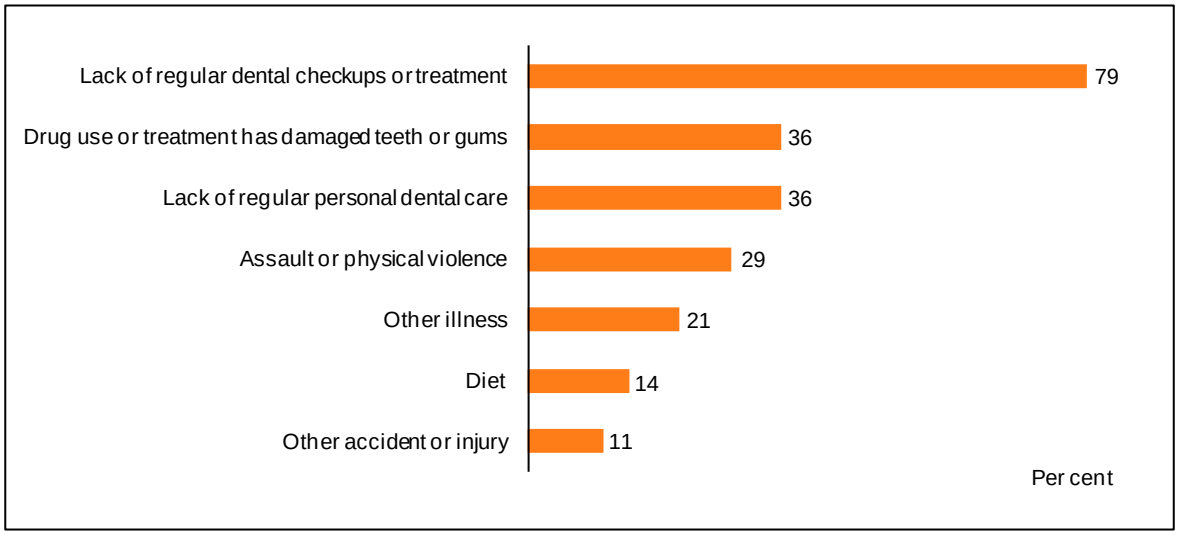
Cause of dental problems

TF trial participants were asked if they could identify any causes for their dental problems, and the results are shown in Figure 4.3 (below). Some 79 per cent attributed their problems to a lack of regular dental check-ups or treatment. Over one-third identified drug use or treatment for drug problems—the PSP Senior Case Manager similarly highlighted the impact of particular treatments and drugs (such as methadone) on teeth.

Over one-third identified lack of regular personal dental care as an issue. A separate question asked how often participants brushed their teeth or cleaned their dentures. Of those that had teeth or dentures, 44 per cent brushed two or more times per day, 26 per cent once, and 30 per cent less than once a day. BSL staff and participants observed that education about oral hygiene had been lacking when they were children and severe disadvantage meant that dental care and tooth brushing was not prioritised or taught by parents.

Assault or physical violence caused the dental problems of 29 per cent of TF trial participants. Illness was a cause for 21 per cent. Diet (14 per cent) and other accidents, such as car accidents, or injuries (11 per cent) were causes for smaller proportions of participants. Poor nutrition was perceived as a significant issue by BSL staff who observed that participants had grown up in an era of convenience foods and also held the view that fast foods were less costly than fruit and vegetables, this impacting their oral health.

Figure 4.3 Causes of dental problems as identified by TF trial participants



Participants were also asked when they had last visited the dentist or dental hospital. For 61 per cent, this had been occurred than two years previously and for a further 18 per cent it had been more than one year.

Only 8 per cent said the purpose of their last visit was for a check-up. Instead, almost 80 per cent had had teeth extracted and 28 per cent had had cavities treated. Obtaining or maintaining false teeth (8 per cent) and having chipped teeth capped (4 per cent) were less common reasons for their most recent visits.

Impact of untreated dental problems

The untreated dental problems of participants had a medical, psychological social and economic impact on their lives.

Medical impact

Just under 90 per cent of participants suffered physical pain or discomfort from their dental problems. Approximately 80 per cent experienced difficulty eating or had a restricted diet; just under 60 per cent were sick, for example, with infections, as a result of their dental problems. Just under half said they needed to take regular pain medication. BSL staff also observed that participants were purchasing black market prescription medicines to deal with the pain. A further health issue was that, in desperation, one participant undertook his own 'dental treatment' using a hammer and chisel.

Psychological impact

Almost 90 per cent of participants suffered embarrassment or poor self-image as a result of their dental problems and around 70 per cent said this left them feeling down in spirits.

Social impact

Approximately 40 per cent of participants said they had lost friends or had difficulty socialising due to the stigma of their dental problems. As the case studies show, Joshua felt awkward meeting old schoolfriends and did not want to talk, smile or laugh. Stephanie talked with her hand in front of her mouth and Matthew (see case study 3, below) said his dental issues made it difficult to meet girls.

Economic participation

Just under half the participants believed their employment prospects were reduced due to the impact of dental problems on their physical appearance. BSL staff observed that some participants with marginal attachment to the labour market had missed work days—as casual employees this meant they lost income, while ongoing absences resulted in job losses. Of those surveyed, some 7 per cent had to stop work or leave their employment due to dental-related sickness and around 20 per cent said they were too ill to undertake further education or training, or look for work. For around one-third of those unable to work or look for work, this had been an issue for two years or more.

Table 4.1 The impact of dental problems on overall wellbeing and participation

Impact of dental problems	Per cent
Medical	
Physical pain or discomfort	86
Difficulty eating or restricted diet	79
Sickness caused by dental problems	57
Need to take regular pain medication for dental problems	46
Psychological	
Embarrassment or poor self-image	89
Feeling down in spirits	68
Social	
Loss of friends or difficulty socialising due to stigma	39
Economic	
Reduced employment prospects due to my physical appearance	46
Cannot undertake further education or training because sick	21
Unable to look for work because sick	18
Had to stop work or leave my employment due to sickness	7

Note: Only 1 respondent said their dental problems had very little or no impact.

Impact on the broader health system

There was also evidence that inability to access timely dental treatment had an impact on the broader health system. Two-thirds of respondents said that they had visited their doctor during the last two years because of health problems caused by their dental problems (N = 11). Four participants said this had occurred once or twice, two visited seven or eight times, two visited 10 to 12 times, and another three visited almost on a monthly basis. Eight participants had visited the hospital because of problems caused by their untreated dental conditions in the last two years. Six had visited once or twice, one had visited six times, and one reported visiting on a weekly basis.

Giving context to this situation is the observation by BSL staff that access to medical care is already limited on the Mornington Peninsula. They observed that the vast majority of doctors do not bulk-bill and have full patient lists, and that it takes many hours to receive treatment at the Frankston Hospital's Emergency Department. Thus, in an area where access to general medical care is limited, untreated dental conditions are adding strain to an already overloaded system.

Post-treatment surveys

Nine of the 10 people who finished their treatment completed a post-treatment survey. Of these, around half reported receiving caps or fillings, the majority had teeth removed and seven said they received dentures. One participant required additional surgery on her jaw. The length of treatment ranged from one month (for dentures to be fitted) through to approximately 18 months (two participants requiring the removal of many teeth and the fitting of dentures). The median treatment period was 9.5 months. It must be noted that several factors acted to lengthen the treatment period, including: centre policy on how long gums require to heal before dentures may be fitted; complications; appointment scheduling; participant attendance; and many issues associated with clients' extreme disadvantage.

Impact of treatment

All those who completed their treatment reported a positive impact on their lives. Eight reported that dental treatment had improved their self-image and the majority said it improved their spirits. Two participants commented that they no longer feel embarrassed when they smile, one saying: 'I smile a lot now. I laugh and don't cover my mouth with my hand'. In another case, the 10-year-old child of a female participant remarked in amazement that she had never seen her mother with teeth before.

Five said the treatment had reduced or eliminated their physical discomfort, three saying that sickness caused by their dental problems was gone. One woman said that her treatment had 'put her health back in balance'. Once her teeth were removed, her 'health came back slowly', 'the aches and pains eased' and she was optimistic that she would be able to lose some weight.

Two participants reported that they no longer needed pain medication. One of these had taken black market morphine to manage his pain for years but was able to stop after receiving treatment through the trial.

The multiple forms of disadvantage experienced by participants, including other illness as well as childcare responsibilities, continued to impede participation in employment. Nonetheless, one participant found work and two participants were seeking employment, and believed it was likely that they would be working in three months. One was going to undertake further study and four believed that dental work improved their physical appearance, increasing their job prospects.

Participants who completed the trial reported difficulties adjusting to their new dentures, which, for some, caused pain and made it difficult to talk. Several said wore their dentures only at specific times, such as when they went out, and removed them to eat. Others were still unable to broaden their diet despite having dentures to wear because they had not yet grown accustomed to them. Regardless of these difficulties, participants were happy the work had been done.

Participant perceptions of the trial

Participants were asked to provide feedback on the trial itself. The average participant was satisfied with the time it took to obtain an appointment for an initial dental assessment (median = 8/10, or 'extremely satisfied'). Also high was satisfaction with the dentist's diagnosis (9/10), the treatment received (8/10) and the extent to which it fixed their dental problems (10/10). Many participants expressed their gratitude to the Brotherhood of St Laurence for arranging the treatment: one saying it only took two weeks to get an appointment, compared to spending two years on a public waiting list.

However, some participants had a less positive experience of the trial. One participant was dissatisfied saying the dentist left three teeth in that would continue to rot and require removal within 10 years. Telephone contact with one participant indicated that his dentist had failed to fully extract teeth leaving jagged bits of tooth in the gum that later had to be removed by another dentist. For several months he was too frightened to continue with his treatment but, at the time of publication, he had returned to the dentist and his treatment was ongoing.

Matthew, whose experience is detailed in case study 3 (below), believed his dentist made very little progress in his visits and, therefore, eventually moved to another centre. He also felt exasperated that his extractions and dentures took almost 16 months of dental visits while his brother's (assessed as a higher priority through Victoria's Demand Management Framework) took only nine weeks.

One female participant reported that administrative staff at the community health centre had been 'horrible'. She reported that they asked at every visit how she was going to pay, even though her participation in the TF trial and payment by BSL should have been known to them. In addition, she says they cancelled appointments and tried to schedule appointments to take place in three months' time, rather than one week's time, as requested by the dentist.

Note, however, that when the TF Coordinator followed up to ascertain why some participants had not completed their treatment, their claim that appointments had been cancelled was contradicted by the centre's records, these stating that it was the participant who cancelled the appointment or simply did not attend on the day.

Case study 3: Matthew

Matthew is 25 but his dental problems began in his late teens.

> *I can tell you the story if you like, mate, that's not a problem. In between the ages of 16 and 19, I took a lot of drugs, I had a break-up with a girlfriend, went a bit off the rails and went to Queensland. I got into a bit of a fight with the town bully in outback Queensland and next thing I knew, three of his friends were punching into me. I swallowed one tooth and cracked another one, so that's basically where the problems with me teeth started.*

Returning to home to the Mornington Peninsula, Matthew visited the dentist to have the cracked tooth removed. However, his problems did not end there: lack of care and drugs had made his teeth brittle and they continued to deteriorate. He lost a couple more teeth in fights or, as he said, they simply fell out during meal times. Matthew recalls, 'it was a bit distressing and it affected my work a little bit'. The physical nature of Matthew's production line work, which involved lifting, became a struggle: 'If I'm going hard for a couple of days, the next day I'll be buggered sort of thing'. He later learned that he had contracted hepatitis C.

Experiencing frequent pain from his remaining teeth, his occasional visits to the dentist were not simple check-ups but involved getting 'stuff ripped out'. Toothaches and pain from frequent infections meant Matthew needed to take antibiotics, and drinking to numb the pain resulted in the loss of his learner's licence. Sick days from the pain in addition to his other health issues made it difficult to retain work.

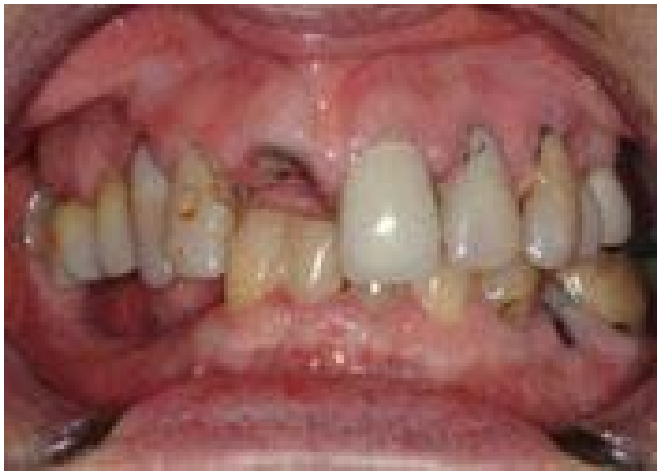
Missing teeth has been difficult in other ways. While his mates 'know what he is about' and do not give him a hard time, missing teeth makes it difficult to meet girls: 'Smiling at someone or anything like that. You don't want to smile'.

A few years back, Matthew spent some time in jail and had trouble finding work again afterwards. He joined the BSL Personal Support Programme but found keeping appointments difficult due to the Mornington Peninsula's poor public transport. Then, just after his referral into the TF trial, one of his brothers was tragically killed and Matthew travelled interstate to care for his nephew.

On his return, he started his dental treatment, saying he needed a 'hell of a lot' of teeth out—in fact he needed all but four taken out. This meant visiting the dentist every week or two. Matthew said that the local community health centre achieved very little each visit. Travelling to a different public dentist resulted in faster progress but, without a licence, this put strain on his parents who had to drive him to and from his frequent appointments. A further exasperation was that another of his brothers was assessed—under the Victorian Demand Management Framework—as having higher priority needs, and it took only 6 to 8 weeks for him to have his teeth removed and dentures fitted at the same centre. By comparison, Matthew started treatment in October 2008 and did not get his teeth until January 2010!

Now, for the first time in six months, Matthew has teeth. His dentures are causing some pain but he is going for a further adjustment. They are also causing speech problems but, on the whole, he is optimistic. He believes having teeth will increase his employment prospects, and he expects to find some work in the next month or two. As soon as he has a job he will regain his licence.

> *Once all that happens, I'm gonna be great, you know what I mean?*



Person with missing and rotting teeth, photo courtesy of Dental-Health-Index.com

5 Discussion

There is cross-party agreement on the poor state of Australia's dental health but considerably less agreement on what to do about it, as indicated in the policy chapter of this report. Over the last two decades, successive Australian governments have introduced dental programs which were later dismantled by their successors. This progression was halted mid 2008 when the Labor government sought to abolish the EPC scheme and introduce CDHP[2], this move blocked twice in the Senate on the basis that the EPC scheme services the most disadvantaged Australians and fulfils an important need. This obstruction has resulted in a stalemate or a kind of dental limbo. It seems the issue of dental care lacks the medical and political importance required to cause a double dissolution and bring about an early election.

The status of teeth is a critical factor in this debacle. Historically, teeth have been excised from the rest of the body, pushed firmly 'outside the realm of doctors and medicine' (Lewis 2007, p.1). Moreover, while the provision of dental care is specified in our Constitution, it is not included under Medicare, which covers primary health care for *every other* part of the body. While the previous Liberal government argued dental care was a state responsibility, the current Labour government sees it as a Commonwealth one, even though it has not sought to include it within Medicare. A further policy complication is the NHHRC's proposal for a 'Denticare' separate to Medicare, in which a tax increase would create a two-tier system, providing basic dental care through the public system or, for those able to afford health insurance, privately. However, there is a risk, given the shortage of dentists and lack of parity between public and private sectors, that the government will be funding the private sector with little improvement to the public sector or the oral health of the disadvantaged Australians reliant upon it.

The TF trial sought to provide more timely treatment to a small group of highly disadvantaged BSL clients on the Mornington Peninsula where the waiting period for general treatment can be as long as 41 months. The patient profile of participants bears witness to their disadvantage. Despite an average age of only 36, most required multiple extractions and dentures. This was a consequence of lack of access to dentists for check-ups, lack of personal dental care and inadequacy of diet—these issues apparently having been present since they were children. Others such as Joseph (not his real name) spent years homeless and struggling to eat. Drug use (and resulting treatments such as methadone), assault and illness were further factors. Of the participants, half had not completed Year 10 schooling, the majority relied on government benefits and a substantial proportion were

unable to look for work due to a range of health conditions including their untreated dental problems. The vast majority lived in pain, with a considerable proportion taking painkillers. They experienced difficulty eating, suffered infections related to their untreated dental problems and had low self-esteem.

Successes

The trial experienced a number of successes. Some 35 participants received a dental assessment, and 26 of them commenced treatment. Based on the June 2009 waiting times for Peninsula community health centres, these highly disadvantaged participants would otherwise have waited between 30 and 41 months to receive dental care. Even though many participants did not complete their treatment, it was at least a step toward improving their oral health.

Ten participants completed their treatment and a further five are likely to complete. The course of treatment was not always smooth and several clients are still acclimatising to their new dentures. Nonetheless these participants are glad their dental health has been addressed. Two reported they no longer required pain medication, while another reported considerable improvement to her health.

Beyond the impact on individuals, there are broader social and economic implications of untreated dental problems. Two-thirds of the participants had visited the doctor in the last two years and eight visited the hospital, some multiple times, due to dental complications such as infections. All trial participants would have been entitled to a Health Care Card and, thus, heavily subsidised antibiotics through the Pharmaceutical Benefits Scheme. Untreated dental problems are costly to the broader health system and increase the strain on its already overburdened services. The TF trial, through securing timely dental treatment for participants, has reduced this burden.

Given the PSP's focus on addressing personal barriers to employment before transferring clients to job search programs, high post-trial employment rates were not to be anticipated, participants facing multiple obstacles such as drug-related and mental illness and homelessness. Nonetheless, one participant is now working, another two are optimistic about finding employment and a third will soon commence training. The case studies of Joshua and Matthew reinforced the impact of untreated dental issues on employment—in terms of ability to maintain employment, marketability and self-esteem. Given the ongoing costs of government benefits and employment services, it makes economic sense to ensure that poor dental health is not an impediment to participation in the workforce.

However, the greatest success of the trial was the improvement to the spirits and self-esteem of those who completed their treatment. Trial participants reported feeling able to smile again or, in the case of Stephanie, laugh without covering her mouth in shame. This success is about returning dignity to people's lives.

Challenges

The trial experienced many challenges in meeting its objectives. Evidence of this may be seen in the time it took for participants to complete their treatment, spanning from 1 to 18 months. While the wide range in duration relates in part to the treatment that was required, there were many other factors.

Impediments to treatment

The multiple forms of disadvantage experienced by participants impeded their treatment. Impediments to attendance at appointments included:

- lack of transport
    - few participants owned cars and many were reliant on the minimal public transport available on the Mornington Peninsula
- poor health, including
    - mental illness and drug and alcohol-related problems which reduced people's ability to go out
    - hepatitis, which meant that some patients could only attend certain clinics
    - conditions such as anxiety, which meant that general rather than local anaesthetic was required
- financial disadvantage and loss of communication, resulting in the cessation of treatment
    - participants' landlines were disconnected and mobile phones were permanently switched off, probably due to lack of credit
    - a further indication of the disadvantage of the group was that the same communication difficulties were experienced with several of their emergency contacts
- transience and homelessness, which meant that participants moved frequently, half moving two or more times in two years
    - participants moved from private rentals, spending periods of time with family and friends
    - caseworkers lost contact with one homeless man early in the trial and feared he had died
    - Stephanie (case study 2) moved frequently, often staying with friends, and communication was lost. The eventual completion of her treatment was made possible only through the contact maintained with her mother
- legal issues—several participants were busy with court cases and a few went to prison before their treatment could be completed
    - in another case, a woman became involved in a dispute with neighbours and was afraid to leave the house.

Issues associated with disadvantage intervened in the lives of participants, these crises impeding their continued dental treatment even when there was no waiting list and no fee.

When participants did not attend appointments, this reduced the productivity of the public dental centres and sometimes resulted in non-attendance fees payable by BSL. The PSP Senior Case Manager believed that if the trial had had the resources to drive participants to their appointments, this may have improved attendance.

Unlike many private dental clinics, public sector dentists do not have the capacity to make reminder calls to participants and, given the difficulty experienced in contacting trial participants by phone, reminder calls would probably not help. When asked whether attendance rates were

lower among TF trial participants than in the general community, one centre agreed they were while another said they were about the same.

Treatment and variation

Due to the extremely poor oral health of many participants, most of their teeth had to be removed—lack of regular dental check-ups is a likely cause, as supported by other research (Spencer & Hartford 2007). Extractions occurred over the course of several weeks and, even, months. The number of teeth removed per visit depended on the dentist and the participants' tolerance for pain. Once extractions were complete, some centres required patients to wait six weeks to reduce gum swelling while others fitted dentures almost immediately.

While, in two cases, complications requiring surgery contributed to delays, the differing waiting times and policies of centres were also contributing factors. The TF Coordinator observed that the public waiting times were not always accurately portrayed, one participant waiting several months longer for dentures than the advertised waiting period. While some centres issued private vouchers to expedite treatment, others did not. In general, she observed that community health centres vary considerably in their policy and operation, lacking a consistent approach.

Denture quality was identified as an issue in the trial. The standard government-subsidised, acrylic dentures were inadequate for several participants. Discussions with a veteran denture maker indicated that standard dentures are inferior in quality and durability, this impacting on the wellbeing of wearers.

Timely provision of public dental care

In the experience of the TF Coordinator, participants who were eligible for priority public treatment (under the Victorian Demand Management Framework) or through vouchers for private treatment (through the Commonwealth EPC dental program) received more timely and effective dental treatment than that available through the TF trial. BSL staff and participants reported favourably on these government schemes, which were seen to fulfil an important service to the most disadvantaged Australians. However, for unknown reasons, the majority of TF participants were assessed as not eligible for these schemes and would have been subject to standard waiting periods if not for the trial.

One of the challenges for BSL staff throughout this trial was making sense of Australia's dental policy. That some participants' teeth were treated through a Commonwealth and others through a state policy hardly seemed likely to produce a coordinated and effective approach. The irony of the situation is increased given Commonwealth responsibility for dental services under the Constitution and the provision of free primary health care for all other parts of the body. Trial participants suffered the consequences of this policy failure, living in pain, unable to chew, suffering low self-esteem, dependent on pain medication and, in one desperate circumstance, driven to self-dentistry using a hammer and chisel. The government's failure to include dental services within Medicare and fulfil its responsibility to the most disadvantaged Australians was a challenge and, indeed, the impetus for the TF trial.

Supply of public dentists

While the dental profession faces a shortage of practitioners, this is most severe in the public sector. Measures to increase the number of dentists—such as through internship and scholarship programs—should be considered. However, despite public demand causing waiting lists of

several years, community dentists reported to the TF Coordinator that they had rooms and equipment available to treat more patients but lacked dentists to perform the work. One factor in the personnel shortfall is that public dentists and other staff receive substantially lower remuneration than private providers. Another factor is that the former group treat the most marginalised citizens, already in pain and angry about long queues—the resulting work environment, therefore, is unlikely to make up for the lower salaries in the public dental system. It is hardly any wonder that greater numbers of dentists and ancillary staff should choose the conditions and rewards of working in the private sector.

A further challenge for the TF trial was that despite endorsement by the Australian Dental Association, only one dentist agreed to join the trial but later withdrew due to the complex needs of the participants. Later treatments performed by private dentists occurred on the same basis as that provided to members of the public, and at market rates. Granted, the industry-wide shortage of dentists has increased patient loads—however, a greater sense of corporate social responsibility from the private dental sector would have been welcome.

Role of BSL

The trial was not embedded in the BSL strategic plan but, instead, an additional project. Imposed upon already busy staff, it took some time to establish which staff member was responsible for its oversight in Frankston. While referred to in this report as the 'TF Coordinator', this consultant from the Community Relations and Communications Department was originally to have a strategic development role but assumed the coordination role out of necessity. The delivery of the trial was also impacted by BSL's decision not to re-tender for the Job Services Australia contract and thus to cease delivery of the PSP program in July 2009. From the beginning of 2009, PSP caseworkers resigned and moved to other employment. This increased the workload of the remaining staff on whom the trial relied. The lengthy nature of participant treatment, which continued well beyond the end of PSP, was a further complication and, if not for the work of the TF Coordinator, the trial would have closed. Had PSP continued, the follow-up and completion of post-treatment surveys would have occurred as part of the casework process, making these tasks more successful and less laborious.

TF was a one-off trial in which BSL was able to bypass waiting lists to secure treatment for highly disadvantaged participants. Replication and delivery of existing dental programs was not an aim, and would be to the detriment of public waiting lists. While there are many potential causes, it must be noted that the waiting times at the participating dental centres had all increased by June 2009.

However, BSL has a role to play in considering the dental health of clients and in developing referral mechanisms within its Community Services Department. The trial demonstrates the susceptibility of disadvantaged participants to poor oral health and the impact it has on overall wellbeing and social and economic inclusion.

In addition, BSL has long advocated the reform of Australia's woefully inadequate public dental services. While this role seems likely to continue for some time, it is hoped that government action will one day render this advocacy obsolete.

Conclusion

While Teeth First was a one-off trial, it served to highlight the state of the public dental system and the impact on low-income Australians. Coming up to two years since the announcement of the new Commonwealth Dental Health Program, we remain in dental limbo. As politicians continue to deliberate on policy reform, many low-income Australians rely on pain medication and antibiotics due to their rotting gums. Some have not enjoyed good food for years because they cannot chew or have no teeth. Aside from the consequences for their physical health, this has a profound impact on their self-esteem and the way they socialise and interact with others. And while other forms of disadvantage compound the problem, poor dental health acts as a significant barrier to participation in study and work.

Failure to provide adequate dental services shows a lack of regard for the dignity of low-income Australians. Beyond social justice considerations, it is bad economic management to have 650,000 Australians (Parliament of Australia 2007, p.99) on waiting lists that are years long, adding strain to other health services and costing the economy billions of dollars in sick days and welfare benefits.

Access to timely dental care is a critical aspect in achieving the social and economic inclusion of disadvantaged Australians and this in turn is important for national productivity.

6 Recommendations

There are not enough public dental chairs to provide adequate services to people who cannot afford to pay for dental treatment. Based on the state of dental services available to low-income Australians, the costs of not providing timely treatment, and the findings of the Teeth First trial, the following eight recommendations are made.

Dental health policy

1. Fully incorporate dental care within Medicare, recognising dental care as being both an important part of health care and the responsibility of the Commonwealth Government under the Australian Constitution.

2. Develop and communicate a consistent, transparent and easily understood policy for public dental clinics operating in community health centres. This policy should include guidelines on the prioritisation of particular client groups, waiting periods, referral to private dentists and use of vouchers, and the time required before dentures may be fitted.

Building capacity within the public sector

3. Offer dental scholarships with similar conditions to those of the Commonwealth Bonded Medical Places Scheme, in which university tuition costs are funded on the proviso that graduates commit to a period of public service in rural and regional areas, with the extent of that service being equivalent to the length of their degree.

4. Introduce, for all dentistry graduates, a compulsory public dental internship scheme that is adequately resourced to include supervision time and remuneration to practitioners with extra responsibilities.

5. Increase remuneration for public sector dentists and ancillary staff to achieve parity with the private sector and maximise public dental service provision.

Addressing dental needs among disadvantage groups

6. Raise awareness of the public dental services available and encourage community service agencies and Job Services Australia providers to refer clients whose dental health may constitute a barrier to their employment.

7. Introduce supports at community health centres to assist highly disadvantaged clients, facing multiple barriers, to complete their treatment. Given community dentists work within larger community health centres, a more holistic approach to health and wellbeing could include inter-centre referral, with dentists referring clients to, for example, doctors, mental health professionals and even housing workers. Other practical supports could also be implemented such as a mobile phone text reminder system, a community bus service or centre-based childcare to cover appointments.

8. Launch a government-funded national dental health campaign, comparable to anti-smoking or car safety campaigns. One component of the campaign should be its incorporation in parenting programs to increase dental literacy and improve dental outcomes for children.

7 Appendices

Appendix A: Pre-treatment survey

Appendix B: Post-treatment survey

Appendix C: Participant feedback survey

Appendix A: Pre-treatment survey

Instructions: Caseworker to complete this survey with the participant after the public dental assessment but PRIOR TO private dental treatment.

PARTICIPANT'S NAME:

CONTACT NUMBERS **a) Home:** **b) Mobile:**

EMAIL:

ADDRESS:

SERVICE PROVIDER **DATE: _____/_____/2008**

☐ BSL, Frankston. Caseworker: _____

1. DO YOU CURRENTLY HAVE UNTREATED DENTAL PROBLEMS? *(tick all that apply)*

☐ 1. Chipped / broken teeth

☐ 2. Untreated cavities

☐ 3. Rotting / dying teeth

☐ 4. Gum disease

☐ 5. Require false tooth / dentures

☐ 6. Require orthodontic work, e.g. braces / retainer

☐ 7. Other, please describe*:* _____

2. IF YOUR DENTAL CONDITION AFFECTS YOUR ABILITY TO GO ABOUT YOUR NORMAL DAILY ACTIVITIES, HOW LONG HAS THIS BEEN A PROBLEM? ***(tick only one)***

☐ 0. Dental conditions do not affect daily activities

☐ 1. Less than one month

☐ 2. One – five months

☐ 3. Six months – less than one year

☐ 4. One – two years

☐ 5. Two years or more

3. WHY HAVEN'T YOU SOUGHT TREATMENT? *(tick all that apply)*

☐ 1. Can't afford private treatment

☐ 2. Have been put on the waiting list

☐ 3. Don't have the time

☐ 4. Because it will be painful

☐ 5. Other, please describe:

4. IF YOU HAVE SOUGHT DENTAL TREATMENT AT A <u>GOVERNMENT / COMMUNITY HEALTH SERVICE</u>, WHAT IS THE WAITING TIME FOR THE TREATMENT THAT YOU REQUIRE? ***(tick only one)***

- ☐ 1. Less than one month
- ☐ 2. One – five months
- ☐ 3. Six months – less than one year
- ☐ 4. One – two years
- ☐ 5. Two years or more

5. HOW LONG HAVE YOU BEEN ON THE WAITING LIST TO DATE? ***(tick only one)***

- ☐ 0. Not applicable
- ☐ 1. Less than 1 month
- ☐ 2. One – five months
- ☐ 3. Six months – less than one year
- ☐ 4. One – two years
- ☐ 5. Two years or more

6. CAN YOU IDENTIFY ANY CAUSES FOR YOUR DENTAL PROBLEMS? *(tick all that apply)*

- ☐ Lack of regular dental check–ups / treatment
- ☐ Lack of regular personal dental care e.g. brushing / flossing / other
- ☐ Diet, e.g. excessive sweet or acidic food or drink
- ☐ Assault / physical violence
- ☐ Other accident / injury, e.g. car accident
- ☐ Other illness, please specify: _____
- ☐ Drug use or treatment has damaged teeth / gums

7. HOW OFTEN DO YOU BRUSH YOUR TEETH / CLEAN YOUR DENTURES? ***(tick only one)***

☐ 1. Two or more times per day ☐ 2. Once a day ☐ 3. Less than once a day

8. WHEN DID YOU LAST VISIT THE DENTIST OR DENTAL HOSPITAL? ***(tick all that apply)***

☐ 1. Less than one year ago ☐ 2. One – two years ago ☐ 3. More than two years ago

9. WHAT WAS THE PURPOSE OF YOUR LAST VISIT? *(tick all that apply)*

- ☐ 1. Check–up
- ☐ 2. Chipped teeth capped
- ☐ 3. Cavities treated / filled
- ☐ 4. Teeth removed
- ☐ 5. False tooth / dentures
- ☐ 6. Orthodontic work done e.g. braces / retainer
- ☐ 7. Other, please specify:

10. WHAT HAS BEEN THE IMPACT OF YOUR DENTAL PROBLEMS?

- ☐ 0. Very little impact / no impact
- ☐ 1.Physical pain or discomfort
- ☐ 2. Sickness caused by dental problems, e.g. infection
- ☐ 3. Need to take regular pain medication for dental problems
- ☐ 4. Difficulty eating / restricted diet e.g. only soft food
- ☐ 5. Embarrassment / poor self-image
- ☐ 6. Feeling down in spirits
- ☐ 7. Loss of friends / difficulty socialising due to stigma
- ☐ 8. Had to stop work / leave my employment due to sickness
- ☐ 9. Unable to look for work because sick
- ☐ 10. Reduced employment prospects due to my physical appearance
- ☐ 11. Cannot undertake further education / training because sick
- ☐ 12. Other, please specify:

11. IF YOU HAVE BEEN UNABLE WORK / LOOK FOR WORK AS A RESULT OF YOUR DENTAL CONDITION, HOW LONG HAS THIS BEEN A PROBLEM? ***(tick only one)***

- ☐ 0. Dental condition has not prevented me working / looking for work
- ☐ 1. Less than one month
- ☐ 2. One – five months
- ☐ 3. Six months – less than one year
- ☐ 4. One – two years
- ☐ 5. Two years or more

12. DURING THE <u>LAST TWO YEARS</u>, HOW FREQUENTLY HAVE YOU VISITED A MEDICAL CLINIC OR HOSPITAL BECAUSE OF HEALTH PROBLEMS CAUSED BY YOUR UNTREATED DENTAL CONDITION? e.g. infection, pain, etc.

	Number of visits or '0' if none
A) MEDICAL CLINIC e.g. local GP/doctor	
B) HOSPITAL e.g. Emergency department	

PARTICIPANT INFORMATION

13. AGE:_____ **14. SEX** ☐ 1. Male ☐ 2. Female

15. FAMILY STATUS ***(tick only one)***

☐ 1. Single person, no kids	☐ 3. Couple, no kids
☐ 2. Single parent / pregnant	☐ 4. Couple, with kids

16. HOW MANY CHILDREN DO YOU HAVE IN YOUR CARE? _____

17. WHICH BEST DESCRIBES YOUR CURRENT ACCOMODATION? ***(tick only one)***

☐ 1. Own / purchasing home	☐ 7. Transitional housing or supported accommodation through a welfare agency
☐ 2. Private rental property	☐ 8. Staying with family / friends rent free
☐ 3. Public housing	☐ 9. Staying with family / friends paying rent or board
☐ 4. Community housing	☐ 10. Motel / hotel
☐ 5. Hostel / rooming house	☐ 11. Caravan park
☐ 6. Crisis housing – Emergency accommodation / refuge	☐ 12. Car / tent / park / street / squat

18. HOW MANY TIMES HAVE YOU MOVED / CHANGED ACCOMODATION DURING LAST TWO YEARS?_____

19. WHAT IS <u>YOUR</u> MAIN SOURCE OF INCOME? ***Individual income (tick only one)***

☐ 1. Full–time work	☐ 6. Single Parent Payment
☐ 2. Part–time work	☐ 7. Sickness Allowance
☐ 3. Casual work	☐ 8. Aged Pension
☐ 4. Newstart Allowance	☐ 9. Other, please describe:_____
☐ 5. Disability Support Pension	

20. WHAT IS THE HIGHEST LEVEL OF EDUCATION THAT YOU COMPLETED ***(tick only one)***

School	***TAFE / vocational training***	***University***
☐ 1. Less than year 10	☐ 4. Trade / apprenticeship qualification	☐ 6. Undergraduate
☐ 2. Year 10 or 11	☐ 5. Certificate / Diploma / other tertiary course	☐ 7. Graduate Certificate / Diploma
☐ 3. Completed year 12		☐ 8. Post graduate

21. ARE YOU CURRENTLY STUDYING OR TRAINING? ***(tick only one)***

☐ 0. No ☐ 1. Yes – part time ☐ 2. Yes – full time

22. WHAT TYPE OF STUDY / TRAINING IS IT? *Please specify:*

23. HAVE YOU PARTICIPATED IN ANY EMPLOYMENT ASSISTANCE OR TRAINING PROGRAMS IN THE LAST YEAR? *(tick all that apply)*

☐ 0. No	☐ 3. Job Network	☐ 6. Other, please describe:
☐ 1. PSP	☐ 4. Work for the Dole	
☐ 2. JPET	☐ 5. Vocational Training, e.g. TAFE	

24. HOW LONG HAVE YOU BEEN LOOKING FOR WORK? ***(tick only one)***

☐ 0. Not looking for work	☐ 3. Seven months – less than one year
☐ 1. Less than 3 months	☐ 4. One year – less than two years
☐ 2. Three – six months	☐ 5. Two years or more

25. ON A SCALE OF 1-10, HOW LIKELY IS IT THAT YOU WILL FIND WORK IN THE NEXT THREE MONTHS? ***(Please circle)***

1	2	3	4	5	6	7	8	9	10
Very unlikely				*Neutral*					*Very Likely*

26. WHY IS THIS?

_____

_____

_____

_____

SO THAT WE CAN SEE HOW THINGS WENT, WE WOULD LIKE TO MEET WITH YOU THREE MONTHS AFTER YOUR TREATMENT.

PLEASE PROVIDE INFORMATION FOR TWO OTHER CONTACTS, WHO WOULD NOW WHERE YOU ARE IF YOU MOVE.

OTHER CONTACTS *e.g. people who would know where you are if you move*

1)
FIRST NAME:
LAST NAME:
CONTACT NUMBERS: Home:
Mobile:
EMAIL:
ADDRESS:
RELATIONSHIP: ***e.g. mother, friend etc.***

2)
FIRST NAME:
LAST NAME:
CONTACT NUMBERS: Home:
Mobile:

EMAIL:
ADDRESS:
RELATIONSHIP: ***e.g. mother, friend etc.***

End of pre-treatment survey

Appendix B: Post-treatment survey

Instructions: Caseworker to complete this survey with the participant 3 MONTHS AFTER treatment.

PARTICIPANT'S NAME:

DATE: _____/_____/2009

1. WHAT DENTAL TREATMENT DID YOU OBTAIN AS PART OF THIS TRIAL? *(tick all that apply)*

- ☐ 1. Check–up
- ☐ 2. Chipped teeth capped
- ☐ 3. Cavities treated / filled
- ☐ 4. Teeth removed
- ☐ 5. False tooth / dentures
- ☐ 6. Orthodontic work done *e.g. braces / retainer*
- ☐ 7. Other: (please specify)_____

2. HOW OFTEN DO YOU BRUSH YOUR TEETH / CLEAN YOUR DENTURES? ***(tick only one)***

☐ 1. Two or more times per day ☐ 2. Once a day ☐ 3. Less than once a day

3. WHAT HAS BEEN THE IMPACT OF YOUR DENTAL TREATMENT? ***(tick all that apply)***

- ☐ 0. Very little impact / no impact
- ☐ 1. Reduced / eliminated my physical pain or discomfort
- ☐ 2. Sickness caused by my dental problems has gone e.g. infection
- ☐ 3. No longer need regular pain medication for dental problems
- ☐ 4. Able to eat more easily / less restricted diet
- ☐ 5. Improved my self-image
- ☐ 6. Improved my spirits
- ☐ 7. Reconnected with friends / I am socialising more
- ☐ 8. Returned to my previous employment
- ☐ 9. Looking for work
- ☐ 10. Increased employment prospects as a consequence of improved physical appearance
- ☐ 11. Undertaking or about to commence further education / training
- ☐ 12. Other, Please specify:_____

4. OTHER COMMENTS ABOUT THE IMPACT OF RECEIVING TREATMENT ON YOUR LIFE

_____

_____

_____

PARTICIPANT INFORMATION *(items of interest that may have changed)*

6. WHICH BEST DESCRIBES YOUR CURRENT ACCOMODATION? *(tick only one)*

- ☐ 1. Own / purchasing home
- ☐ 2. Private rental property
- ☐ 3. Public housing
- ☐ 4. Community housing
- ☐ 5. Hostel / rooming house
- ☐ 6. Crisis housing – Emergency accommodation / refuge
- ☐ 7. Transitional housing or supported accommodation through a welfare agency
- ☐ 8. Staying with family / friends rent free
- ☐ 9. Staying with family / friends paying rent or board
- ☐ 10. Motel / hotel
- ☐ 11. Caravan park
- ☐ 12. Car / tent / park / street / squat

7. HOW MANY TIMES HAVE YOU MOVED / CHANGED ACCOMODATION DURING LAST TWO YEARS?_____

8. WHAT IS YOUR MAIN SOURCE OF INCOME? *Individual income (tick only one)*

- ☐ 1. Full–time work
- ☐ 2. Part–time work
- ☐ 3. Casual work
- ☐ 4. Newstart Allowance
- ☐ 5. Disability Support Pension
- ☐ 6. Single Parent Payment
- ☐ 7. Sickness Allowance
- ☐ 8. Aged Pension
- ☐ 9. Other, please describe:_____

9. ARE YOU CURRENTLY STUDYING OR TRAINING? *(tick only one)*

☐ 0. No ☐ 1. Yes – part time ☐ 2. Yes – full time

10. WHAT TYPE OF STUDY / TRAINING IS IT? *Please specify:*

11. HAVE YOU PARTICIPATED IN ANY EMPLOYMENT ASSISTANCE OR TRAINING PROGRAMS IN THE LAST YEAR? *(tick all that apply)*

☐ 0. No	☐ 3. Job Network	☐ 6. Other, please describe:
☐ 1. PSP	☐ 4. Work for the Dole	
☐ 2. JPET	☐ 5. Vocational Training, e.g. TAFE	

12. HOW LONG HAVE YOU BEEN LOOKING FOR WORK? ***(tick only one)***

☐ 0. Not looking for work	☐ 3. Seven months – less than one year
☐ 1. Less than 3 months	☐ 4. One year – less than two years
☐ 2. Three – six months	☐ 5. Two years or more

13. ON A SCALE OF 1-10, HOW LIKELY IS IT THAT YOU WILL FIND WORK IN THE NEXT THREE MONTHS? ***(Please circle)***

1	2	3	4	5	6	7	8	9	10
Very unlikely				*Neutral*					*Very Likely*

☐ **PLEASE GIVE THE PARTICIPANT THE FEEDBACK SURVEY TO COMPLETE SEPARATELY AND RETURN IN THE POSTAGE PAID ENVELOPE.**

Caseworker's own comments

A) ON THE IMPACT OF DENTAL TREATMENT ON THE PARTICIPANTS

_____

_____

_____

B) ANY OTHER COMMENTS

_____

_____

_____

End of post-treatment survey. Thank you!

Appendix C: Participant feedback survey

Instructions: *Please complete this survey and return using the postage paid envelope provided. This is an anonymous survey so you do not need to include your name.*

AGE:_____

SEX: ☐ 1. Male ☐ 2. Female

HOW SATISFIED ARE YOU WITH…. ***(please rate on a scale of one-10)***

A) YOUR INITIAL ASSESSMENT

1. The time it took to get an appointment for a dental assessment (the list of work needed) at a public dental service?

1	2	3	4	5	6	7	8	9	10
Extremely dissatisfied			*Neither satisfied nor dissatisfied*						*Extremely satisfied*

2. Your assessment or view of the dentist's diagnosis (what he/she said needed to be done)?

1	2	3	4	5	6	7	8	9	10
Extremely dissatisfied			*Neither satisfied nor dissatisfied*						*Extremely satisfied*

B) YOUR DENTAL TREATMENT

3. The dental treatments you received at a private dental clinic?

1	2	3	4	5	6	7	8	9	10
Extremely dissatisfied			*Neither satisfied nor dissatisfied*						*Extremely satisfied*

4. The time it took between joining the trial to receiving your dental treatment?

1	2	3	4	5	6	7	8	9	10
Extremely dissatisfied			*Neither satisfied nor dissatisfied*						*Extremely satisfied*

5. The extent to which the treatment fixed your dental problems?

1	2	3	4	5	6	7	8	9	10
Extremely dissatisfied			*Neither satisfied nor dissatisfied*						*Extremely satisfied*

6. Comments about the Brotherhood of St Laurence.

_____

_____

_____

7. Comments about your initial dental assessment at a Community Health Centre / Public dentist.

_____

_____

_____

8. Comments about the treatment provided by the dentist at the private clinic.

_____

_____

_____

9. Other Comments

_____

_____

_____

Thank you for your participation

Please return using the postage paid envelope provided

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