



Access to Dental Care for Low Income Tasmanians

A Discussion Paper

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1. INTRODUCTION

Access to dental care for Tasmanians living on low incomes is a widely recognized problem. This issue was identified as a major concern for Tasmanian low income earners consulted in the statewide qualitative research conducted by Anglicare (2000) as part of the Just Tasmania research. In 2001 dental health care emerged again through focus group discussions with low income earners undertaken by Anglicare and in client based case studies collected across the agency between June and October. This discussion paper provides a background to the issue and expands on key themes raised in the concerns of the participants in our focus groups and case studies.

The correlation between low income and poor dental health status is well established and this paper provides a Tasmanian context to this. Recent research by Anglicare (Madden, 2002) shows that Tasmanians have the lowest household income per capita in Australia. Adult Tasmanians also have the worst dental health status in the nation. This paper explores these two themes, concluding with an argument for an increase in funding for the public dental service from the Tasmanian government. The poor dental health of Tasmanians living on low incomes is not an issue which affects only a minority of the community. With 40% of Tasmanians dependent on government pensions and benefits as their main source of income, this is a critical issue for the attention of the State Government.

Following the election of a Federal Coalition Government for the next three years, the State can no longer wait in hope for the reinstatement of the Commonwealth Dental Health Programme. This paper argues that this critical issue is clearly the responsibility of the State Government. It shows that Tasmania spends well below the national average on adults eligible to use the public dental service, ie adult pension and concession card holders, and argues for an increase in funding to bring State expenditure up to the national average.

There is a growing recognition of the significant health and social consequences of poor dental health. Often called the 'silent epidemic' because its consequences remain largely invisible, poor oral health, dental caries and periodontal diseases have a significant impact on people's everyday lives. In addition to influencing everyday experiences such as eating, sleeping, speaking and general social roles, poor dental

health impacts negatively on employment, social relations, self-image and esteem. There is growing evidence to suggest that poor dental health is a causal factor for a range of other illnesses including cardiovascular disease, diabetes and pre-term low birth weight babies (Spencer, 2001:5-6).

Tasmania Together Targets

Tasmania Together's Vision, Goals and Benchmarks document recognizes the poor dental health of adult Tasmanians. The key goals and indicators for dental health are based on the premise that good dental health is critical to individual wellbeing and the maintenance of a healthy lifestyle. The specific indicators are intended to address the issues of access to dental services, the lengthy waiting lists and the high rates of extractions and Tasmanians requiring dentures. These indicators and goals provide the context for the following discussion paper and recommendations.

Goal 5 Standard 1: to improve Tasmanians' health through promotion of a comprehensive approach to a healthy lifestyle. Indicator 1.5 The number of fillings and missing or decayed teeth in the population.

Goal 6 Standard 1: Improve the health and wellbeing of the Tasmanian community through the delivery of coordinated services. Indicator 1.1 The number of people on the waiting list for more than six months for full or partial dentures; Indicator 1.2 Level of satisfaction with access to health and community services

2. THE ORAL HEALTH STATUS OF TASMANIAN LOW INCOME EARNERS

Tasmanian adults have the worst dental health in the nation with the highest percentage of edentulous (complete loss of natural teeth) adults per capita. At 15.3% of the adult population, the Tasmanian rate is 5.6% higher than the national average (see Table 1). There is a combination of factors that contribute to this. The correlation between low income and poor oral health is well documented (for example AIHW, DSRU 2001b; Zigarus and Moore, 2001) and this is a particularly significant factor for Tasmania with the highest proportion of concession cardholders of any Australian state (Madden 2002). Almost 40% of Tasmanians are dependent on government pensions and benefits as their main source of income. The problem is further

compounded by the state having the lowest ratio of dentists to population in Australia (Dever, 1997).

Table 1: Percentage of edentulous persons by State



(Source; AIHW DSRU, 2001a)

National research demonstrates that the oral health problems experienced by people living on low incomes are worsening. In a recent analysis of the National Dental Telephone Survey data, the Australian Institute of Health and Welfare Dental Statistics and Research Unit argue that the gap between the 'deprived' and the 'privileged' in Australia in oral health outcomes and the use of dental services is growing. The DSRU found that people who are uninsured and living on a low income have:

- Higher rates of complete tooth loss;
- Problem oriented dental visiting;
- Higher rates of extractions and lower rates of fillings;
- Longer periods since the last visit;
- Greater likelihood of avoiding or delaying care due to cost; and
- More self-reported treatment needs (AIHW DSRU, 2001b).

Tasmanian low income earners are severely affected in all these areas and their situation compares poorly with low income earners in other states. Specifically, the high rates of edentulism (complete tooth loss), high rates of extractions, barriers of

cost and prolonged delays in accessing dental care are key themes discussed in this report.

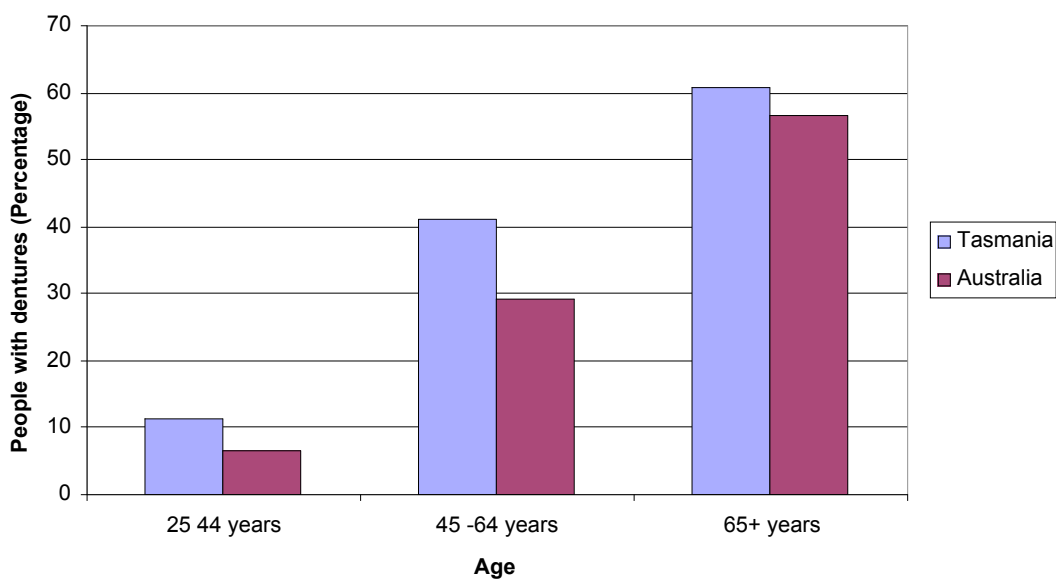
2.1 High rates of tooth extraction

*“You never get an option of keeping a tooth when you are poor, do you?
None of these root canals or that sort of business” (Shelley, aged 21)*

Australia-wide, the rates of oral surgical or extraction services in public dental care are 122% more than those in private dental care. A tooth is extracted every three minutes in public dental services around Australia, every hour of every day; or more than a tooth a minute for each working hour (Spencer, 2001:34).

Tasmania has the highest percentage of persons wearing a denture in the nation. The rate of 23.1% is 4.6% higher than national average of 18.5%. In all the age categories from 25 to 65+ years, Tasmania is significantly above the national average. Of particular concern, Tasmania’s rate of 11.2% in the 25 – 44 year category is almost double the national average. Similarly, 41% of Tasmanians in the 45 – 64 year age category have dentures, which is 12% above the national average (see Table 2).

Table2: Percentage of people wearing a denture by age



(Source: AIHW DRSU 2001a)

The focus groups participants and client case studies referred to in this paper all fall within the 17 – 30 year age group. This group is highly susceptible to poor oral health. They characteristically have 'risky' health behaviours associated with their age group which means they are less inclined to adopt preventative health strategies. For the young people we spoke to these issues are often compounded by unstable housing arrangements and lack of income, as the following explanation by Shelley illustrates.

“Four years ago, which is a long time, and that’s when I had my left eye tooth out, and I was told to book for dentures. I’ve never had a permanent home or anything until recently, so I haven’t got in for my dentures...[T]he dentist didn’t explain it to me. He just said ‘Oh you’ll have to get in for dentures’ and so I just went ‘Oh well, whatever’ and I left it for years. Now my whole face...the top of my teeth are pulling towards this way, making the right eye tooth (that’s missing as well) forcing this over here. It’s causing pain through my nose, it’s really weird, it pulls through my jaw. Now I need braces to pull all that across, then get a denture put in and all sorts of stuff.” (Shelley, aged 21)

The following story highlights the real difference in the treatment options available to people on low incomes. The statistics cited by Spencer (2001) confirm Rebecca’s experience that the dental health options available to those with private health insurance are not offered to people dependent on the public dental system.

Rebecca is a young mother aged 23, with two small children. Her dental treatment resulted in the extraction of ten teeth from her upper jaw. Rebecca said that she was not given the option of having a partial denture made before her teeth were extracted. Having had the teeth removed she was then told she would have to wait for five months before her dentures would be ready. She was not offered any other alternatives, which she assumed was because the dentist doubted her ability to pay. Rebecca believed that the dentist thought it wouldn’t bother her if she was without teeth for a long period because she was a low income earner and concession cardholder. (Client case study, August 2001)

The extremely high percentage of people wearing dentures Tasmania can be explained by a number of factors. First, the lengthy waiting times for general dental care during which dental problems deteriorate from restorative treatments to acute surgical ones. Second, the limited resources and time in the public system strongly influence dentists' treatment options (Spencer, 2001:34). Third, people find it more effective to substitute emergency care for the long wait for basic dental care. People making this choice are 4.5 times more likely to have an extraction. The lack of choice available to low income earners and the lengthy delays for general dental care is a source of profound frustration for both clients and service providers in the public dental health clinics. All of the issues identified here preclude the development of preventative dental care. As one participant in this research remarked in response to the question about regular dental check-ups:

"That's above us. And anyone like us as well".

The following comments from focus group participants illustrate this emphasis on emergency dental care in the Tasmanian public dental system:

"I've been to New Town, we had to pay \$20 and there is a three year waiting list so I did the 'I've got a toothache' and I got in."

"You have to pretend it's an emergency to be seen. They lead you to say it's an emergency if you really need to go and you feel guilty but what do you do?"

"I have early stage gum disease which needs to be treated regularly but you can't get in unless you have an emergency."

"They are not really interested they just looked at the sore tooth but they didn't check any of my other teeth."

"Apparently you are meant to have your teeth checked during pregnancy but what chance has a pregnant woman got when there is a three year waiting list?"

In the long term, the most effective approach to this problem is a comprehensive community oral health promotion strategy, commencing in the primary schools but particularly targeting the 18 – 25 age group which is most at risk. Extending the availability of regular dental checks for this group, combined with increased information about oral health would have the potential to continue the excellent oral health status of Tasmanian children into adulthood. However, in the short term, an adequately resourced initiative for dentists in the public health system is required which is directed at encouraging them to examine other treatment options, making extraction a last resort for all their clients.

3. ISSUES OF ACCESS TO DENTAL CARE FOR LOW INCOME EARNERS

3.1 Cost as a barrier to treatment

The introduction of fees for adult dental care in 1998 has been a major disincentive for people on low incomes to access dental care. The introduction of co-payments nationally saw a dramatic one-third reduction in the demand for non-emergency treatment in public dental care (Dooland 2000; Spencer 2001). National research indicates that more than one quarter of adult Australians avoid or delay visiting a dentist because of cost. This has the most significant impact on those with the lowest incomes.

This research further shows that, nationally, cost prevented 40% of concession cardholders from seeking recommended or wanted dental treatment and this represents an 11% increase from the previous year (AIHW DSRU, 2001a). In Tasmania 44.5% of concession cardholders avoided or delayed treatment due to cost compared to the national average of 37.5%. Cost prevented 38.5% of Tasmanian concession cardholders seeking recommended or wanted dental treatment compared to the national average of 32.3% (AIHW DSRU, 2001a).

The imposition of fees in many cases results in low income earners accessing dental services only for emergency treatment, rather than for preventative or restorative procedures. One of the negative outcomes of this fee schedule or co-payment policy

is the net increase in the total cost of dental care by increasing the number of more expensive emergency treatments (Ziguras and Moore, 2001).

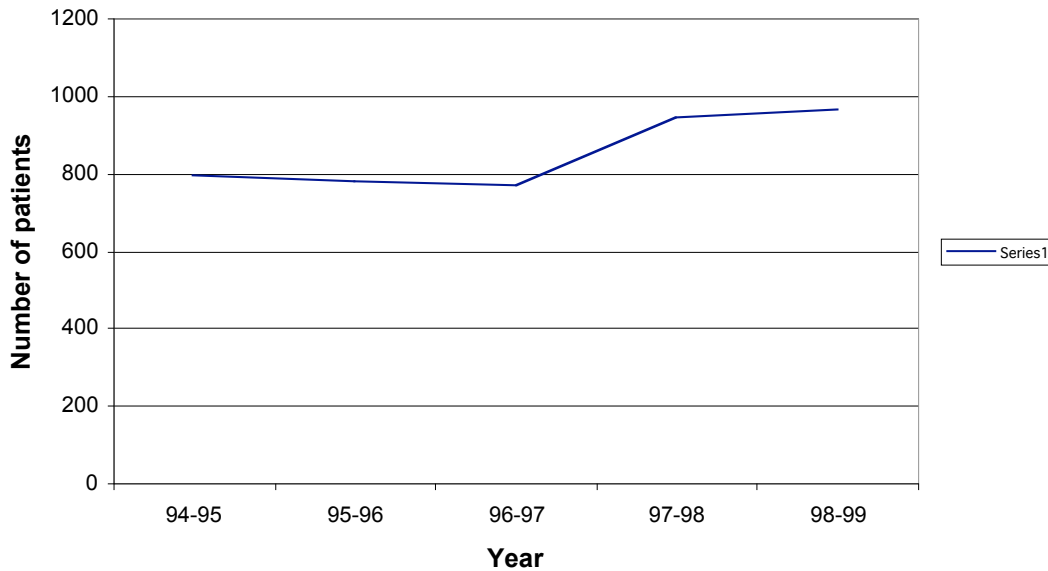
Tasmanian data on the number of public patients in public hospitals for dental procedures from 1994–99 provided by the Department of Health and Human Services, indicates a corresponding pattern over that period. The data provided shows patient numbers in all public hospitals across the State. This data includes two categories of dental procedures: the removal and restoration of teeth and other operations on teeth, gums and alveoli. Table 3 shows a slight decrease in hospital dental procedures from 1994 to 97 and then a significant increase in the period 1997-98 and a further increase in the following year. One explanation for this may be that the loss of the CDHP and the introduction of co-payment charges at public dental clinics resulted in more concession card holders in Tasmania being denied access to general dental care so that the problem deteriorated to the point where a surgical procedure, such as an extraction, was required.

Anglicare researchers have found that participants in the focus group discussions and client case studies identify cost as a major barrier. Departmental policy on dental co-payments does acknowledge the financial impost of treatment by capping fees for a course of treatment at \$100. However they continue to maintain an upfront fee of \$20 per visit. As indicated in previous sections of this submission, the extremely low income of concession cardholders means that the \$20 fee for a dental visit is often beyond their capacity. In a situation where the limited budget has to be so tightly managed, even urgent dental treatment cannot be considered a high priority.

As one focus group participant stated:

“When you are living on the breadline the only thing you can cut back on is the food. I couldn’t afford to go to the dentist.”

Table 3: Public dental patients in Tasmanian public hospitals 1994-99



(Source: DHHS, Hospitals and Ambulance Service 2001)

The case of Jenny, a young mother aged 22 years old, illustrates the effect of both cost and the lengthy waiting list on her dental health:

“I was on the waiting list for two years. My tooth ended up crumbling so I got in as an emergency case a week later and the dentist told me off for leaving it so long. He said there was nothing left to pull out. That was the week before Christmas and they said I needed to have five other teeth done. I could have got in but I didn’t have the twenty dollars. I’d had to lend the \$20 before I went the first time and it was the week before Christmas. I needed time to save up but now I’ve been on the waiting list ever since. I’ve given up on my teeth entirely.” (Focus group participant, July 2001)

Other participants described how they try to manage their pain and discomfort if they don’t have the money to pay the upfront cost for a dental appointment. Jeremy is 28 years old. His tooth was broken two years earlier.

“Just lately it’s just starting to give me headaches, enough to deal with after two or three Panadols. I’ve got to go and get it out but I haven’t got around to it. So what I’ve done is I’ve probably chewed through enough Panadols to have almost been better off to have gone to the dentist, but I haven’t had all the money in one go. Sometimes when we are hard up for cash I’ll find it easier to say, you know, just buy me a cheap packet of Panadols and I’ll get through the week. So we don’t get there [to the dentist].” (Focus group participant October 2001)

The elimination of fees would remove one significant barrier to accessing dental care for low income earners. This would be a powerful strategy to improving access and attitudes to preventative and general dental care. The estimated revenue raised for dental co-payments in 2000-2001 is \$760,000 (Jackson, 2001a). Based on this estimate an additional injection of funds to this amount would increase the dental health options for Tasmanian low income earners.

3.2 Flexibility in payment options

Participants in the focus groups identified the lack of flexibility in the dental clinics’ payment schedule as problematic. They viewed the strict adherence to upfront payment as a distinct barrier to dental care. Although the departmental policy does provide an option of part payment with a negotiated payment plan for low income earners who are unable to pay the fee upfront, this option is not widely known by clients and certainly not promoted by some dental clinic staff. The following comments reflect the general perception of the focus group:

“If you don’t have the \$20 you know they will turn you away at the door.”

“They are very firm, they don’t let you pay it off.”

“Mum has half her teeth rotting and I think it affects her health, but she doesn’t have the money up front.”

“If I had known that [flexible payment options] probably would have had it out instead of it being such a pest. I do have common sense, I know it’s only going to get worse and worse. It’s just a case of when the money comes in of saying having to do other things, so I say ‘we’ll prioritise this, so sling me a packet of Panadols and we’ll be right’.”

Currently only a small proportion (6%) of clients who access the dental service do not make the payments. This can be interpreted to mean that the co-payment is not a problem for those using the service. However the evidence of participants consulted suggests that many of those in need of dental care are simply not seeking it because of the general perception that there will be an upfront charge of \$20.

Although Anglicare would argue that the elimination of fees is the preferable way to encourage low income earners to seek dental health care, the use of flexible payment plans may enhance their ability to access these services. Anglicare has been informed that the Department is currently examining a range of strategies to increase client awareness of the payment option, including telephone information services, pamphlets and posters with fee schedules in dental services waiting rooms. It is important that the information makes clear that payment plans do not involve the withholding of treatment and/or dentures until full payment has been recovered. It is important that this valuable information dissemination is funded from additional revenue rather than through a reduction of funding in other vital service areas. To address widespread literacy issues in the community, the information should be communicated through the use of a range of media, including television.

3.3 Length of Waiting lists

In Tasmania, there were 15,831 people on the waiting lists up to the end of March 2001. This includes those waiting for general dental care (approximately 13,049) and for full and partial dentures (approximately 2,509). These figures represent an increase of approximately 800 from the previous year. The waiting times show regional variations but range between 4 1/2 years (54 months) in the South to 3 _ years (43 months) in the North West (Jackson 2001b).

The Department of Health and Human Services has recently completed an audit of the waiting list which has result in the re-categorisation of the needs of people on the list as well as redefinition the actual numbers. The audit results have not yet been made available, nor any analysis of the current status of waiting lists. The numbers on the waiting lists in December 2001 remained virtually unchanged (personal communication State Manager Oral Health Program 5/2/02). The re-categorisation however has meant that those people waiting for partial dentures are now included in the general dental care and only those requiring full dentures are on the denture waiting list.

However the broader issues inherent in the lengthy and growing waiting lists remain a problem for low income Tasmanians. The length of waiting lists for dental care in combination with the co-payment costs can act as a deterrent for low income earners, who, like Jenny, just give up on their teeth altogether. As Dooland (2000) argues this makes co-payments a 'dangerous tool for controlling waiting lists'.

Nationally, the growth of waiting lists to 'absurd lengths' has dramatically increased the demand for urgent dental services. The complexity of the problem has been described as a system 'trapped in a vicious cycle' in which the predominance of emergency treatments limits the scope and depth of dental services, leading to quicker visits by orally sicker people or "poor dentistry for poor people" (Spencer, 2001:30). There is strong evidence to show that when the waiting lists have grown, there is a corresponding increase in the rate of tooth extractions (Dooland, 2000).

The size and the composition of the waiting lists raise a number of critical issues. While there has been an increase in the number of people on the waiting lists, there is evidence that people do 'drop off' for reasons other than seeking alternative dental care. Changes in eligibility and death are often cited as key reasons, as is seeking alternative treatment although this is a less likely explanation for very low income earners. Residential mobility however is a significant factor which can impact negatively on oral health outcomes of particular low income groups. For example, insecure and short term tenancy is a problem for many low income groups, with young people being particularly susceptible. Transience and homelessness result in this group falling off the waiting list and being lost to the public dental health system, until their dental problems become acute. Research into the reasons why people 'disappear' from waiting lists without treatment would be instructive.

Anglicare's focus group participants discussed the impact of dental waiting lists on their dental health care. These comments reflected a common theme:

"They don't give you any idea about how long it will take and I did ring back but it is so much effort and they are not hurting at the moment so I'm just leaving it." (Focus group participant, August 2001).

Kathy lives in the north of the state. She has experienced continual pain with her teeth. When she tried to make an appointment at the Dental Health Clinic, she was told the first available appointment was fifteen weeks away, but then due to a cancellation was given the next earliest appointment in eleven weeks. Kathy had no choice but to accept that, although she was in constant pain. She was informed that if it became an emergency she would be placed on the emergency list and might be seen within a week. (Client case study, July 2001)

Clearly the response to these complex problems must be multifaceted. There are a variety of ways in which the lists and waiting times for general dental care can be reduced. For example, the Department's current policy of extending the purchaser – provider agreements with private dentists as well as the introduction of legislation to enable dental hygienists and therapists to provide dental care for people over the age of 16 should have a positive impact on the Tasmanian lists. The injection of additional funding has decreased waiting times for basic dental care for concession card holders in both Victoria (Dooland, 2000) and Western Australia (D. Neesham, 3 October 2001: personal communication).

The problem is further compounded in Tasmania by the difficulties in recruiting and sustaining the dental workforce, including dental technicians and prosthetists. Clearly this is a significant factor in reducing waiting time for dentures, but dental workforce issues are beyond the scope of this paper.

3.4 Dental care for people with complex needs

“I know that beggars can’t be choosers but we should be able to get something.”

The issues confronting concession card holders in accessing the public dental health care system are compounded when those people have complex needs such as physical disability, mental illness or drug dependency. Issues of lack of choice, financial hardship and lengthy delays are amplified when these people have deal with the daily effects of their disability or illness.

Marilyn is a young woman living in Ulverstone. She has complex mental health issues and days when medication confusion severely limits her capacity to function. When she experienced severe pain with toothache, the Dental Health Clinic rang her at short notice with an appointment time for treatment. She was advised that she had to attend that appointment and pay the \$20 fee upfront. Marilyn was unable to make the appointment for a number of reasons including that she did not have transport to get to the clinic in Devonport, she did not have the money readily available and her mental health condition made it particularly difficult for her to organize herself in the short time given before the appointment. Her non-attendance was interpreted as a sign that she did not require emergency care and she was placed on the waiting list. (Client case study, June 2001)

Evelyn, a 26 year old mother of three, had previously been an intravenous drug user. As she describes, her treatment program had severe effects on her teeth and she requires high level monitoring and general care to minimize tooth deterioration and loss.

“I was on the methadone program in Queensland and am on it down here but up there they always asked you about your teeth and would make an appointment for you if you had any problems because they say that methadone really chews out your teeth. You could get an appointment within two weeks. Down here they just laughed when I asked if there was any dental program.” (Focus group participant, July 2001)

4. PUBLIC DENTAL EXPENDITURE ON PENSIONER CONCESSION AND HEALTH CARE CARD HOLDERS

Funding for dental health has always been problematic in Australia. Historically, questions of responsibility have muddied the water of funding sources. Dental health generally has not been considered to be the province of government by politicians, neither has the dental profession been keen for government intervention (Lewis 2000). For a variety of reasons, funding for dental health care has fallen between the cracks of the ongoing debate between Commonwealth and state governments and clearly, it is low income and disadvantaged Australians who have been the victims.

Unlike general health care, dental health is viewed as the responsibility of the individual, both in terms of cost and in terms of the degree to which individuals are held responsible for their oral health. Poor oral health is explained by lack of personal care, negligence or poor budgeting. This individualistic focus in combination with the strong emphasis on private enterprise in dental practice has resulted in a situation where 85% of service provision in dental health care for adults is in the private sector. The public sector continues to struggle for funding to serve the dental health needs of people living on low-incomes who cannot afford the private health insurance or the charges set by private dental practitioners. Nowhere is this policy of individualism more powerfully illustrated than in the implementation of the Private Health Insurance Incentive Scheme. According to calculations by Spencer (2001:39), in June 2000 the estimated national dental component of the private health insurance rebate was \$327 million. As he points out, this is considerably more than \$176.7 million estimated expenditure on public dental care for eligible adults across the States and Territories. In effect, this means that the Commonwealth is subsidizing the dental health care of wealthy Australians to the detriment of low income Australians who are solely dependent upon a seriously under-resourced public dental health service.

4.1 The impact of the loss of the Commonwealth Dental Health Program

It is generally agreed that the loss of \$3.4 million to the State with the axing of the Commonwealth Dental Health Program 1994-96 in 1997 has had a severe impact on the State public dental health services. The national evaluation of the Commonwealth Dental Health Program (Brennan et al 1997) shows that in the 24 months following the introduction of the program, eligible card-holders had:

- decreased perceived need for extractions and fillings;
- reported less frequent toothaches;
- more frequent visits to the dentist and
- waited a shorter time for a checkup.

Significantly, the evaluation also found that during the life of the CDHP, eligible card-holders had fewer extractions and more fillings and were more satisfied with the dental care they received. Recent national research comparing access to dental care between 1994-6 and 1999, indicates that extractions for card-holders has increased and fillings decreased and that financial hardship in purchasing dental care increased for card-holders who visited a private practice (Stewart et al 2001).

However, to a certain extent the debate about Commonwealth versus State responsibility for dental health care does distract from the central issue. Historically Tasmania has a poor record of spending on public dental health care. Ten years ago the estimated expenditure on eligible adults in this State was \$13 per capita against a national average of \$44 (National Health Strategy 1992). While current figures (see Table 4) show an improvement, Tasmania still spends well below the national average of \$44.8. At \$28.9 per adult cardholder, this is \$15.9 below the national average expenditure.

Table 4: Public Dental Expenditure on adult card holders 2000/2001¹

	<i>No. Adult Card Holders</i>	<i>T o t a l Expenditure (\$ Million)</i>	<i>Expenditure per Adult card holder</i>
NSW	1,657,000	\$58.2	\$35.1
VIC	1,200,000	\$41.4	\$34.5
QLD	865,000	\$63.5	\$73.4
WA	433,000	\$21.3	\$49.2
SA	425,000	\$21.2	\$49.9
TAS	142,000	\$4.1	\$28.9
NT	40,000	\$4.2	\$105.0
ACT	71,000	\$3.1	\$43.7
AUSTRALIA	4,833,000	\$217	\$44.8

(Source: Dr Martin Dooland, Director Statewide Dental Services, South Australia (October 2001))

The actual Tasmanian expenditure on oral health services is difficult to ascertain because of the provision of some dental services in the public hospital system as well as in the Tasmanian Dental Service. However, the national figures have been adjusted to account for the fact that some States have dental hospitals, which, in addition to providing general and surgical care, includes education and training programmes.

Anglicare argues that the Tasmanian Government should at least increase the funding to an equivalent national level. Allowing for cost shifting, we would argue that the additional injection of \$2 million into the dental health system would bring the Tasmanian expenditure to within a comparable national range. In terms of meeting the *Tasmania Together* targets on dental health, this should be seen as the minimum amount of additional funding.

¹ These figures have been adjusted to ensure comparability between States.

5. CONCLUSION

The issues identified in this report highlight the depth and the complexity of problems confronting public dental services. Many of these reflect the entrenched and structural nature of the provision of public dental care in socio-political environment where resources are increasingly constrained. However these problems are not irresolvable. Models are being developed elsewhere in Australia which address these complex issues, reduce waiting lists, balance emergency treatments with general and restorative dental care and include a preventative component as well (see for example Dooland, 2000).

Oral health has elsewhere been described as the 'Cinderella' of health in Australia – the area least considered (Roberts-Thomson 2001). This neglect is reflected in the small percentage of the Commonwealth health budget allocated to dental health (5%) and the historical reticence of governments, at both state and federal level, to assume responsibility for this critical area of health care. This report has argued that the dental health status of low income earners in Tasmania is in a poor and deteriorating state. It has, in consultation with Anglicare workers, clients and focus group participants seeking to access the public dental system, identified barriers and concerns and concludes with recommendations for the State Government.

The Tasmanian Government can no longer tell Tasmanians to wait for the return of the Commonwealth Dental Health Program. The State Government must act to address this urgent health issue.

6. RECOMMENDATIONS

That \$2 million additional recurrent funding is allocated to the Tasmanian Dental Service to bring Tasmania up to the average national level of per capita expenditure on eligible adults.

That the upfront \$20 fee for the Tasmanian Dental Service for adult concession cardholders be eliminated or reduced. This could be achieved with the addition of \$800,000 recurrent funding based on current estimates and other improvements in the public dental health scheme.

That \$10,000 be allocated for an extension of the planned public information campaign about flexible payment options and fee schedules.

That funding is allocated for independent qualitative research to be conducted in collaboration with the Department, to identify the issues of access to public dental health care for low income earners in two key areas: the impact of lengthy waiting lists on the dental health choices for concession card holders aged between 20 – 40 years; and the issues and concerns for people with complex needs.

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