

**Report of the Workshop on Monitoring of  
Australia's National Oral Health Plan  
Adelaide, 17–18 September 2009**

**Presented to the  
National Oral Health Plan Monitoring Group  
November 2009**



## Contents

Introduction .....	1
Purpose of the Workshop .....	1
Process .....	1
Structure of this report .....	1
Report of Workshop sessions on Action Areas .....	3
Action Area One: Promoting Oral Health Across the Population .....	3
Action Area Two: Children and Adolescents.....	6
Action Area Three: Older People .....	9
Action Area Four: Low Income and Social Disadvantage.....	12
Action Area 5: People with Special Needs .....	15
Action Area Six: Aboriginal and Torres Strait Islander Peoples .....	17
Action Area Seven: Workforce Development .....	20
Missing Action Area: Rural and remote dwellers .....	23
Summary .....	25
Appendix A: Workshop program .....	27
Appendix B: List of Workshop attendees.....	31



## **Introduction**

The National Oral Health Plan (the Plan) 'Healthy Mouths Healthy Lives' was adopted in June 2004 to "improve health and wellbeing across the Australian population by improving oral health status and reducing the burden of oral disease". The middle of 2009 marked the mid-point of the Plan and an opportune time to review its monitoring and to reflect on the Plan itself. To that end a two-day Workshop on Monitoring of the National Oral Health Plan was held in Adelaide in September 2009. The Workshop provided a forum in which progress towards the goals of the Plan was reviewed and issues highlighted by the monitoring process were discussed.

## **Purpose of the Workshop**

As part of a mid-term review process, the Workshop had the following aims:

- to update information on the activities that have been undertaken to date under the auspices of the Plan to implement the National Actions,
- to update information on progress against the key process and outcome performance indicators for the Plan,
- to consider opportunities to strengthen the monitoring process,
- to discuss issues highlighted by the monitoring process and their implications for ongoing operation of the Plan, and
- to consider the need to modify or add to the National Actions.

## **Process**

A Report Card on the monitoring of key performance indicators (KPIs) including data to 2008 was distributed prior to the Workshop. A short presentation on activities to date for each Action Area was led by the jurisdictions, where each jurisdiction presented on one Action Area. These were followed by a short presentation of monitoring data then a facilitated Workshop discussion of their interpretation and suggestions for refinements. Finally, the Workshop canvassed the need for revision of the National Actions under the Plan. (See Workshop Program at Appendix A.)

The Workshop was highly interactive with the purpose of arriving at a consensus on future monitoring needs and any revisions that might be made to the Plan. This is documented in this report of the Workshop for consideration at the November 2009 meeting of the NOHP monitoring group.

The Workshop was attended by forty three people (see Appendix B for list of Attendees) and facilitated by Dr Arthur van Deth, former Chair of the National Advisory Committee on Oral Health, which was responsible for the production of the NOHP in 2002.

## **Structure of this report**

For each Action Area, the National Actions, activities and performance against KPIs presented at the Workshop are summarised, as well as the main areas of concern for each Action Area raised in the facilitated discussion.



## Report of Workshop sessions on Action Areas

### Action Area One: Promoting Oral Health Across the Population

One of the two goals of the National Oral Health Plan is to “Improve oral health status across the Australian population by reducing the incidence, prevalence and effects of oral disease”. Action Area One of the Plan, which focuses on Promoting Oral Health Across the Population, is seen as underpinning and providing the context for action in every other Action Area of the Plan.

The specific outcomes identified relate to improved oral health and reduced inequalities in oral health across the Australian population and to support overall health, wellbeing and quality of life.

Ten National Actions are identified in the Plan.

Action Area	Time-frame
1.1 Consider oral health as being integral to general health in the development of health policy and the health reform agenda.	Short
1.2 Extend fluoridation of public water supplies to communities across Australia with populations of 1000 or more.	Short
1.3 Undertake a National Adult Oral Health Survey and a National Children’s Oral Health Survey, each to be repeated every ten years.	Short
1.4 Undertake a consensus conference on use of discretionary sources of fluoride and other preventive agents, as a first step towards establishing an evidence-based suite of health promotion messages.	Short
1.5 Develop an oral health promotion database / clearing house to provide a central point for the collection and dissemination of Australian oral health policy, practice, research, resources and evidence.	Medium
1.6 Ensure State/Territory Dental Acts, Regulations and Codes of Practice do not impose barriers to the full use of the skills of the whole dental team (general and specialist dentists, dental therapists, dental hygienists, oral health therapists, prosthetists and dental assistants) in the provision of high quality, accessible and affordable dental care for the whole community.	Medium
1.7 Explore with the health insurance industry opportunities to structure rebates for dental treatment that support patterns of preventive dental services that have a firm evidence base.	Medium
1.8 Develop oral health and oral health promotion modules for inclusion in the training of health and community service practitioners and teachers.	Medium
1.9 Ensure that oral health is a consideration in health promotion plans at all levels of government (local, State/Territory and Commonwealth), supported by adequate resourcing, local leadership and designated responsibility for implementation.	Medium
1.10 Establish regular local/regional surveys of adults and children to provide information on oral health and disease, and their determinants.	Medium

## Progress on National Actions

Strong progress has been made on four of the National Actions

Action Area	Description	Progress
1.2	Extend water fluoridation	Extension of water fluoridation in Queensland, regional/rural towns in New South Wales and Victoria. Limited action for smaller and remote towns.
1.3	Undertake national adult and child oral health surveys	National Survey of Adult Oral Health conducted 2004–06 National Child Oral Health Survey planned 2010–2011.
1.4	Undertake a consensus conference on [discretionary] fluorides as a step towards establishing an evidence-based suite of health promotion messages	Workshop on the use of Fluorides in Australia conducted 2006. Further Workshop to be held in November/December 2009.
1.5	Develop an oral health promotion clearing house	National Oral Health Promotion Clearing House established 2008. Funding at risk.

Only some progress has been made in the remaining National Actions.

Action Area	Description	Progress
1.1	Consider oral health in health policy and programs	Integration of oral health into healthy weight strategies. National Health and Hospital Reform Commission.
1.6	Ensure regulations are not barriers to full use of the dental team	Some states have lifted restrictions on the role of dental therapists.
1.7	Explore with the insurance industry alignment of rebates with services with a firm evidence base	Some health insurers have little or no gap for check-ups and prevention. Four insurers have dental centres with little or no gap for preventive services.
1.8	Develop on oral health promotion clearing house	National Oral Health Promotion Clearing House established 2008. Funding at risk.
1.10	Establish regular local/regional oral health surveys	Two states undertaking population surveys for 5–12 year olds.

### The Workshop expressed its concern over:

- The lack of progress on oral health as a consideration in health promotion plans at all levels of government.
- The need to cast a wider view of important oral diseases or disorders. This would specifically include diseases like oral cancers.

## Key Performance Indicators

There are eight KPIs for this Action Area:

- Indicator 1: National Oral Health Surveys undertaken regularly.
- Indicator 2: The proportion of the population with access to optimally fluoridated water supplies.
- Indicator 3: Adoption of a nationally consistent suite of oral health promotion messages.
- Indicator 4: Proportion of 6-year-olds experiencing dental caries.
- Indicator 5: Mean number of deciduous teeth with experience of caries in 6-year-olds.
- Indicator 6: Proportion of 12-year-olds experiencing dental caries.
- Indicator 7: Mean number of permanent teeth with experience of caries in 12-year-olds.
- Indicator 8: Proportion of edentulous adults 45–64 and 65+ years old.

The monitoring of these KPIs is presented in the ‘Key Process and Outcome Performance Indicators – Second Follow-up Report 2002–2008’. Indicators 1–3 have already been discussed against the equivalent National Action. Indicators 4–7 cover child oral health. Child oral health, both the prevalence and extent of deciduous and permanent caries, has deteriorated a little across the early part of the decade. The deterioration is more marked if the 2004 data are compared with the best levels of child oral health achieved in the mid-to-late 1990s. Indicator 8 covers edentulism where the prevalence of edentulism continues to fall. All the oral health outcome measures show variation across the states and territories, but reasonably consistent time trends.

### The Workshop expressed its concern over:

- Securing funding for regular national oral health surveys.
- Ongoing funding for the National Oral Health Promotion Clearinghouse.
- The inclusion of the monitoring of risk factors for major oral diseases e.g. sugar consumption, smoking, alcohol consumption (i.e. common risk factors).
- A slightly expanded array of outcome indicators including 4-year-old and 15-year old caries experience, oral health outcomes among young adults as well as adults’ oral cancers and dental trauma.

## Action Area Two: Children and Adolescents

Good oral health for all infants, children and young people, to support overall health and quality of life and underpins good oral health throughout life, to be achieved through:

- collaborative, multidisciplinary and cross-sectoral approaches to oral health education and promotion;
- regular check-ups and timely, preventively focused oral health care for all children and adolescents;
- connecting oral health into primary health and community care systems.

Five National Actions are identified in the Plan.

Action Area	Time-frame
<b>2.1</b> Include a simple oral health risk assessment and provision of preventative oral health advice in: <ul style="list-style-type: none"> <li>• the routine checks carried out by maternal and child health nurses; and</li> <li>• existing home visiting programs for infants and families identified as being at risk; and</li> <li>• develop such programs where they do not exist.</li> </ul>	Short
<b>2.2</b> Ensure the continuation and/or expansion of school dental services to provide regular and timely check-ups and preventively focused oral health care for children and adolescents	Short
<b>2.3</b> Link with and build on existing health promotion and common risk factor approaches within sport and recreational settings (eg mouthguards, SunSmart, alcohol initiatives, nutrition), to promote oral health.	Medium
<b>2.4</b> Work with governments, industry and the media to limit the promotion and advertising of foodstuffs and beverages that are harmful to the oral health of children.	Medium
<b>2.5</b> Support approaches in child care, preschools, and primary and secondary schools to develop environments (eg through curriculum, canteen, parents etc) that foster and promote oral health.	Long

## Progress on National Actions

Considerable progress has been made in a number of National Actions.

Action Area	Description	Progress
2.1	Include a simple oral health risk assessment and provision of preventative oral health advice in routine well-child checks and home visiting programs for infants and families, and develop such programs where they do not exist.	Development and introduction of programs to identify young children with early signs of dental decay in collaboration with other health professionals. Incorporation of oral health checks and advice into home visiting and other child health check programs Integration of school and community dental programs enabling families to present together
2.3	Link with, and build, on existing health promotion and common risk factor approaches in other sectors.	Implementing smoking cessation programs for dental patients using brief intervention models
2.5	Support approaches in child care, preschools, and primary and secondary schools to develop environments that foster and promote oral health.	Participation in a range of wider health programs aimed at improving children's diets in a range of settings. Programs in which oral and general health promotion work together particularly in preschool environments.

Many states and territories are involved in health promotion integrated with other health and education areas. There remains a challenge to make these changes sustainable and part of normal business. No progress was reported against Action Areas 2.2 and 2.4.

### The Workshop expressed its concern over:

- Child dental care in Australia not currently offering universal, comprehensive, active care across the age range with appropriate accountability.
- A lack of balance between clinical treatment, clinical prevention and health promotion.

## **Key Performance Indicators**

There is one KPI for this Action Area:

Indicator 9: The proportion of children and adolescents receiving timely dental care.

Time since last visit by children aged 5–11 years

Time since last visit by children aged 12–17 years

Rate per 100,000 children requiring general anaesthetics for oral health problems.

The monitoring of this KPI is presented in the 'Key Process and Outcome Performance Indicators – Second Follow-up Report 2002–2008'. The percentage nationally of 5–11 year-olds who visited within the past 12 months declined from 83 % in 2002 to 78.7 % in 2008 while the proportion who visited in the last 2 years declined slightly from 92.9 % to 90.2 %. Amongst 12–17 year-olds, neither the proportion who visited in the past 12 months nor those who visited in the last two years changed.

### **The Workshop expressed its concern over:**

- The lack of identification of Indigenous status in the Child Dental Health Survey.
- The lack of comprehensive national data on Indigenous children, which could be resolved by identifying a nationally representative group of Indigenous children among whom to monitor access.
- The lack of monitoring of risk indicators/factors or early disease markers amongst children.
- The need for data on oral health and dental care among 2–4 year olds.

### Action Area Three: Older People

Good oral health for older people, to help them maintain high levels of general health, quality of life, nutrition and social interaction to be achieved through:

- Multidisciplinary approaches to oral health assessment and support for maintenance of oral hygiene
- Improved access to affordable, timely and preventively focussed oral health care.

Five National Actions were identified in the Plan.

Action Area	Time-frame
3.1 Include an enhanced questionnaire based oral health assessment in existing assessment systems for older adults in the community (eg Home and Community Care, Aged Care Assessment Services) to identify people with, or at risk of, oral disease.	Short
3.2 For older people in the community who are identified as being at risk of oral disease, include support for the maintenance of oral hygiene in care programs aimed at assisting them to remain in their own homes.	Short
3.3 Ensure that oral screening is carried out by an oral health professional on admission to residential aged care facilities (RACF) and on a regular basis.	Short
3.4 Require the development of a simple but practical oral health care plan as part of the overall care plan for every person in a residential aged care facility.	Short
3.5 Ensure that support for residential aged care facilities have the flexibility to implement the oral health component of the overall care plan including maintenance of oral hygiene and timely dental treatment where needed.	Short
3.6 Make affordable portable dental equipment available to public and private oral health providers to enable them to treat older people in their homes and in residential aged care facilities.	Short
3.7 Ensure that oral health is considered in the development of nutrition plans and programs for older people, including access to fluoridated water.	Short
3.8 Establish affordable and appropriate transport arrangements to enable frail older people to attend oral health clinics.	Short
3.9 Require residential aged care facilities of an agreed size to set aside a small dedicated area for the provision of a range of simple primary health services including oral health services.	Medium

## Progress on National Actions

Considerable progress has been made in two National Actions.

Action Area	Description	Progress
3.1	Include an oral health assessment in existing assessment systems for older adults in the community to identify people with, or at risk of, oral disease.	Inclusion of oral health screening included in Enhanced Primary Care,, Aged Care Assessment Teams and Domiciliary Care assessments.
3.4	Require the development of an oral health care plan as part of the overall care plan for every person in a residential aged care facility.	Availability of free annual check-ups and personal care plans for people in residential aged care with training to care workers.

Some progress has been made in the following National Actions:

Action Area	Description	Progress
3.2	Include support for the maintenance of oral hygiene in care programs for 'at risk' older people in the community.	Priority access to public dental care and support for hygiene for individuals identified as 'at risk'. Extension of the Domiciliary Dental Program.
3.3	Ensure that oral screening is carried out by an oral health professional on admission to residential aged care facilities and on a regular basis.	Implementation of a number of programs to support oral health assessment and hygiene practice at residential aged care facilities. Commonwealth-funded development of oral health assessment and care planning tool for medical practitioners in nursing homes.

### The Workshop expressed its concern over:

- The need to focus actions earlier in life to improve oral health in older people
- The need to make better use of the dental team and non-oral health professionals
- The lack of integration of oral and general health care provision and health promotion
- The need to take care to people, for example settings-based health promotion, using portable dental equipment
- The need to promote high fluoride toothpaste/other Fluoride Products
- Embedding an adequate oral health component in undergraduate education for all health workers
- Providing holistic care by dental professionals and others
- Recognising and building on existing capacities of older people in their oral self-care
- With respect to residential aged care
  - Improving education and enforcement through accreditation standards
  - Focusing on the role of the registered nurse in oral health assessment and planning
  - Focusing on quality of life
  - Involving students and interns to provide care
  - The need to develop strategies to deal with psycho-geriatric, access, behavioural, institutional, consent and treatment cost issues

## **Key Performance Indicators**

There are two KPIs for this Action Area:

Indicator 11: The numbers of older people living independently in the community receiving timely dental care.

65+ year olds visited in last 2 years

Dentate 65+ year olds usually visit for a check-up

Indicator 12: Improved oral-health-related quality of life as recorded by indicators such as the Oral Health Impact Profile (OHIP)

Frequency (prevalence) of 1+ OHIP impacts

The monitoring of these KPIs is presented in the 'Key Process and Outcome Performance Indicators – Second Follow-up Report 2002–2008'. The percentage nationally who visited within the last 2 years increased from 60% in 2002 to just over 65% in 2005, where it remained in 2008. The proportion of dentate 65+ year olds who usually visit for a check-up declined from 51.9% to 48.9% between 2002 and 2008. There was no discernible change in the prevalence of one or more OHIP impacts between 2002 and 2005. No updated report on OHIP scores was available after 2005 as this indicator is not routinely collected in the National Dental Telephone Interview Survey.

### **The Workshop expressed its concern over:**

- The need to develop an expanded array of KPIs that include
  - recognising that there are a number of life stages over the age of 65 years (eg the old and the very old)
  - monitoring of progress in the Action Areas for residential aged care.

## Action Area Four: Low Income and Social Disadvantage

Good oral health for Australians who are on low incomes and/or are socially disadvantaged, to support good general health, sustainable living and working conditions, and quality of life to be achieved through:

- improved access to affordable, timely and preventively focussed oral health care.
- a collaborative approach involving the oral health, general health care, employment and education sectors
- targeted programs for high needs groups that include environmental and lifestyle interventions
- greater national consistency in oral health goals and service standards.

Three National Actions are identified in the Plan.

Action Area	Time-frame	
4.1	Using a community development approach, develop and implement targeted health promotion and preventive programs for specific socio-economically disadvantaged groups including people in rural and remote areas, the homeless, people in institutions and correctional facilities, low-income earners and their families, disadvantaged young adults and older people, and disadvantaged people from Aboriginal, Torres Strait Islander and non-English speaking backgrounds.	Short
4.2	Increase funding to public oral health services to enable concession card holders living in the community to have timely access to preventively focused dental care that meets the minimum standard benchmarks for oral health service provision.	Medium
4.3	Pilot a range of programs to explore more efficient models for the provision of timely dental care for concession card holders using the skills of the full oral health care team (general and specialist dentists, dental hygienists, dental therapists, oral health therapists, prosthetists, dental assistants).	Medium

## Progress on National Actions

Limited progress has been made for this Action Area

Action Area	Description	Progress
4.1	Using a community development approach, develop and implement targeted health promotion and preventive programs for specific socio-economically disadvantaged groups.	Implementation of oral health promotion programs for older people from Italian and Greek speaking backgrounds. Implementation of oral health promotion programs for identified community groups. Development of a range of culturally appropriate multimedia tools for Indigenous peoples.
4.2	Increase funding to public oral health services to enable concession card holders living in the community to have timely access to preventively focused dental care.	3.5% increase in real terms of State/Territory funding between 2004/05 and 2007/08. Proposed reintroduction of the Commonwealth Dental Health Program primarily covering concession card holders, with funding of \$290m over 3 years. Implementation has been blocked.
4.3	Pilot a range of programs to explore more efficient models for the provision of timely dental care for concession card holders using the skills of the full oral health care team.	Utilisation of Dental Therapists for the treatment of adults and older teenagers. Increased outsourcing to the private sector as well as developing partnerships with private practitioners working in public clinics on a pro bono basis

The challenges in this Action Area are enormous, including, this being a difficult target group to access, long waiting lists, limited/no access in rural and remote areas, cultural differences and appropriateness of existing dental services, lack of knowledge amongst target group on service availability, how to access services and who is eligible.

### The workshop expressed its concern over:

- The need for an active program for improving access for young adults (especially 25–44 years) as social inequalities emerge early in the lifespan
- The need to flexibly explore models from other sectors that improve outcomes for people who are on low incomes or socially disadvantaged
- The need to encourage voluntary enrolment in disease management programs and use electronic dental records to improve patient management
- A lack of continuity of funding
- Lack of capacity in the public dental care sector
- The lack of developed pro bono schemes
- The need to target gaps and reduce inequalities
- The lack of detailed exploration of the causes of the social gradient in oral health outcomes
- Waiting times for dental services
- Use of antibiotics/analgesia by dental and non-dental professionals for dental problems

## Key Performance Indicators

There are three KPIs for this Action Area:

Indicator 13: Increased proportion of concession card holders receiving access to timely preventively focused dental care.

Cardholders who visited in last 2 years

Dentate cardholders who usually visit for checkup

Dentate card holders visiting in last year not receiving an extraction in last 12 months

Indicator 14: Reduction in prevalence of dental caries, periodontal disease and tooth loss among concession card holders treated in the public sector.

Caries experience by age, for Concession card holders treated in the public sector

Prevalence (%) of periodontal pockets 6+mm by age for concession card holders treated in the public sector

Indicator 15: Reduction of oral health inequalities across population.

Percentage who visited in last 2 years, low and high income quartiles

Percentage who visited in last 2 years, low and high income quartiles,

Percentage who visited in last 2 years, low and high income quartiles

The monitoring of this KPI is presented in the 'Key Process and Outcome Performance Indicators – Second Follow-up Report 2002–2008'. Between 2002 and 2008 there were very small increases in the proportion of all cardholders and dentate cardholders who visited within the last 2 years. There was no change in the proportion of dentate cardholders who usually visit for a check-up or who did not receive an extraction at their last dental visit. Inequalities between the lowest and highest income quartiles remained constant between 2002 and 2008.

Updates on 2001/02 dental health status data for cardholders were available for only two states (Western Australia and South Australia). These data indicated a small reduction in total caries experience between 2001/02 and 2003/04 in cardholders who visited public dental services and minimal change in the proportion of cardholders with periodontal pockets of 6+mm.

### The workshop expressed its concern over:

- The need to improve data on service use and disease experience for low income Australians.
- The broadening of KPIs to reflect the full range of social disadvantage.
- The lack of that measures for oral health impact.
- The monitoring of growth of service availability in underserved areas.

## Action Area 5: People with Special Needs

“Special needs” refers to people with intellectual or physical disability, or medical or psychiatric conditions, that increase their risk of oral health problems or increase the complexity of oral health care.

Good oral health for people with special needs, to support their overall health, independence and quality of life; achieved through:

- collaborative approaches across health, community services and peak bodies for people with special needs;
- supportive oral health care settings that are physically and geographically accessible;
- improved capacity among service providers and oral health practitioners to meet the oral health needs of people with special needs;
- access according to need (including priority access where appropriate), supported by appropriate funding/resourcing arrangements;
- targeted programs for specific and/or high needs groups;
- an oral health promotion and preventive approach.

Three National Actions are identified in the Plan.

Action Area		Time-frame
5.1	Develop and implement mechanisms to identify people with special needs at their first point of contact with health services so that the implications for oral health services can be managed.	Short
5.2	Include appropriate oral health indicators in the intake, assessment and case planning processes for those people with special needs, as well as appropriate referral pathways and mechanisms to ensure continuity of care across service systems	Medium
5.3	Implement targeted “access according to need” policies, including: <ul style="list-style-type: none"> <li>• priority access for identified groups, and</li> <li>• proactive identification and follow-up of young people with special needs to provide continuity of care after School Dental Service involvement</li> </ul>	Long

## Progress on National Actions

Only some progress has been made in two of these National Actions.

Action Area	Description	Progress
5.1	Mechanisms to identify people with special needs.	Special needs professional advocacy groups formed.
5.3	Targeted access according to need policies.	Referral pathways for special needs clinics. Medicare Chronic Disease Dental Services Program.

No progress has been made in National Action 5.2

## The Workshop noted

Key professional groupings have emerged with an interest in special needs, which provide a knowledge base to support policy formulation and program development. Such development should recognise the role of all members of the oral health professions as well as the specific role of special needs programs. Policy that supports referral pathways for people with special needs require a commensurate level of resourcing to provide required services. Future resourcing will be dependent on a strengthened dental undergraduate education in special needs.

## Key Performance Indicators

At present there are no KPIs related to Action Area Five. No existing surveillance activity collects information which would identify special needs and public dental service MISs do not consistently include any flag by which dental services for people with special needs can be monitored. Hence, gaps exist against all the KPIs listed in the Plan:

### Process indicators

- The adequate recoding of oral health indicators at intake and assessment of people with special needs.
- Identification of, and contact with, a dental care provider in the case management of those with special needs.
- Implementation of priority access for people with special needs within public dental services.
- Implementation of programs targeting younger vulnerable people with special needs, including recall according to need.

### Outcome indicators

- Reduction in backlog of dental needs and symptom experience among those with special needs.
- Improved oral health-related quality of life.
- Improved oral-health-related quality of life, as recorded by indicators such as the oral health impact profile (OHIP).

## The Workshop expressed its interest in:

- Including oral health and use of dental services in existing generic population surveys such as the Survey of Disability, Ageing and Carers; and
- Adding appropriately defined identifiers for people with special needs to existing dental surveillance activities and administrative Management Information Systems.

This would allow reporting of:

<b>Process Indicator</b>	
The number of people with chronic disease/complex needs receiving timely dental care.	People with chronic disease who have visited a dentist in last 2 years. People with chronic disease who usually visit dentist for a check-up.
<b>Outcome Indicator</b>	
Improved oral-health related quality of life.	People reporting poor/very poor self-related oral health.
<b>Process Indicator</b>	
The number of people receiving public dental care who require special management.	Proportion of people receiving public dental care who require special management.
<b>Outcome Indicator</b>	
Prevalence and severity of oral diseases among people who require special management.	Caries experience by age. Prevalence of periodontal pockets 6+mm.

## Action Area Six: Aboriginal and Torres Strait Islander Peoples

Good oral health for Aboriginal and Torres Strait Islander (ABTSI) peoples, commensurate with that of the overall Australian population, which supports good health and quality of life; achieved in culturally supportive ways through:

- enhanced understanding of Indigenous health issues in the community;
- collaborative approaches to oral health planning and delivery;
- improved public health measures that address oral health;
- local and timely access, according to need, to affordable, culturally appropriate dental care; and
- improved collection, quality and dissemination of oral health information about Aboriginal and Torres Strait Islander people.

Six National Actions were identified in the Plan.

Action Area	Time-frame	
6.1	Support the proposal to include under Medicare a biennial adult health assessment for Aboriginal and Torres Strait Islander people, which includes an oral examination.	Short
6.2	Provide culturally appropriate and accessible oral health care services through: <ul style="list-style-type: none"> <li>• partnerships between Indigenous –specific and mainstream health services at a regional level;</li> <li>• provision of patient-assisted transport schemes;</li> <li>• increasing the proportion of mainstream dental services that provide culturally appropriate services.</li> </ul>	Short
6.3	Increase oral health promotion activity for Aboriginal and Torres Strait Islander oral health both as stand alone and integral to other health promotion activities (e.g. diabetes, cardiovascular disease, tobacco, nutrition and alcohol control)	Medium
6.4	Foster the integration of oral health within health systems and services, particularly with respect to primary health care, by: <ul style="list-style-type: none"> <li>• Inclusion of oral health into health check guidelines for well people, and recall mechanisms for people with chronic illness</li> <li>• Integrating oral health into relevant Aboriginal and Torres Strait Islander health policy.</li> </ul>	Medium
6.5	Improve the collection and quality of oral health information on Aboriginal and Torres Strait Islander people by: <ul style="list-style-type: none"> <li>• developing an agreed national Indigenous oral health data set;</li> <li>• consolidating existing data on oral health;</li> <li>• regular standardised collection and dissemination of oral health data.</li> </ul>	Medium
6.6	Consistent with the National Aboriginal and Torres Strait Islander Workforce National Strategic Framework, increase the oral health workforce available to improve the oral health of Aboriginal and Torres Strait Islander people by: <ul style="list-style-type: none"> <li>• Increasing the number of Aboriginal and Torres Strait Islander people working across the oral health professions, including provision of scholarships for Aboriginal and Torres Strait Islander students</li> <li>• Clarifying roles and recognising Aboriginal and Torres Strait Islander health workers as a key component of the oral health workforce;</li> <li>• Addressing the role and development needs of the oral health workforce contributing to Aboriginal and Torres Strait Islander health;</li> <li>• Improving training, recruitment and retention measures for oral health staff working in Aboriginal primary health services;</li> <li>• Expanding the role of dental therapists, dental hygienists and oral health therapists.</li> </ul>	Long

## Progress on National Actions

Action Area	Description	Progress
6.1	Support the proposal to include under Medicare a biennial adult health assessment for Aboriginal and Torres Strait Islander people, which includes an oral examination.	Simple oral health check included under the Medicare Indigenous Well Person's Check. The Medicare funded checks for Aboriginal and Torres Strait Islander children 0–14 years includes an oral health check.
6.2	Provide culturally appropriate and accessible oral health care services.	Services delivered by mainstream dental services supported by cultural awareness training for staff. Provision of travel assistance for dental care. Provision of culturally appropriate care by mainstream services to Rural and remote Indigenous persons travelling to cities for care.
6.3	Increase oral health promotion activity for Aboriginal and Torres Strait Islander oral health.	Implementation of a number of Indigenous-specific child oral health programs. Implementation of standards to encourage the availability of nutritious foods
6.4	Foster the integration of oral health within health systems and services, particularly primary health care.	Inclusion of oral health assessment in a number of child general health checks. Linkages for Aboriginal people attending wider health promotion programs for chronic diseases to dental care. Establishment of committees on Aboriginal Oral Health to advise the broader health policy system on oral health policy and programs.
6.5	Improve the collection and quality of oral health information on Aboriginal and Torres Strait Islander people.	All State/Territory dental program data systems for children collect Aboriginality and are able to report on oral health and services delivery to Aboriginal children. Development of adult data collections that can report on Aboriginal oral health and service use. Improved completeness of the recording of Indigenous status in public programs .
6.6	Increase the oral health workforce available to improve the oral health of Aboriginal and Torres Strait Islander people.	Implementation of strategies to increase the number of Aboriginal people working in the provision of oral health services. Implementation of oral health promotion training for Aboriginal Health Workers

Efforts to improve the oral health of Aboriginal and Torres Strait Islander peoples are hampered by lack of workforce. This is compounded by restrictions that impede the development and implementation of flexible service delivery models within existing health services and the difficulties associated with gaining a high priority for oral health in a population with many pressing health problems.

### **The workshop expressed its concern over:**

- The need to improve integration of oral health and primary health care
- The need to raise oral health awareness in the relevant non-dental bureaucracies
- The need for **sustainable** programs, with ongoing funding to ensure confidence about availability of care, not 'pilots'
- The need to provide support for dental worker in services – both dental professional support and public health support
- Need for support for Aboriginal Medical Services in developing dental care.
- Support coordination and collaboration of Aboriginal Medical Services on dental care provision
- High rates oral cancer incidence in the Indigenous population
- The threat to oral health of higher rates of HIV infection
- The need to develop cultural competence and concern for closing the gap integrated into undergraduate education
- The need to develop programs to recruit Indigenous students into dental education

### **Key Performance Indicators**

There are two KPIs for this Action Area:

Indicator 16: The rate of ABTSI children having general anaesthetics for oral health problems.

Indicator 17: Reduction of oral health inequalities between ABTSI people and the rest of the Australian population.

Percentage of ABTSI children with no caries experience relative to their non-ABTSI counterparts

Mean number of teeth with caries experience, ABTSI vs non-ABTSI children

The monitoring of this KPI is presented in the 'Key Process and Outcome Performance Indicators – Second Follow-up Report 2002–2008'. The data provide no evidence of gains under Indicator 16 between 2002 and 2008. It is not possible to make any assessment of gains under Indicator 17 due to unavailability of updated information. Indigenous status of children is not reported by all states in the Child Dental Health Survey. Therefore data on Indigenous children are derived from a limited number of states and territories. Data on Indigenous adults are sparse and there is no indicator to reflect gains in Indigenous adult oral health.

### **The Workshop expressed its concern over:**

- The lack of comprehensive adult oral health data and the need for complete Adult Dental Programs Survey data that identifies Indigenous status.
- The lack of support for oral health data collection and sharing by Aboriginal Medical Services.
- Existence of barriers to collecting representative data for research work.
- The desirability of a sample (not necessarily representative) of Indigenous communities for the purpose of monitoring Indigenous oral health and access to services.
- The need for data on dental visiting among Indigenous adults.

## Action Area Seven: Workforce Development

Action Area Seven of the NOHP focuses on the development of the dental workforce. The actions identified were aimed at producing a sufficient, sustainable and appropriately skilled [dental] workforce to meet identified oral health needs across the Australian population, including consistent national planning, appropriate aggregate number and mix, equitable distribution, involvement of other health professionals in aspects of oral health promotion, disease prevention, and identification and management of oral health concerns, education programs of a high standard and increased numbers and involvement of Aboriginal and Torres Strait Islander [oral] health workers.

Twelve National Actions are identified in the Plan:

Action Area	Time-frame
<p><b>7.1</b> Increase the supply of overseas-trained dentists by:</p> <ul style="list-style-type: none"> <li>• Retaining the existing qualifications that automatically enable registration of overseas-trained dentists;</li> <li>• Streamlining entry for dentists trained in dental schools/faculties formerly accredited by the UK General Dental Council;</li> <li>• Reviewing the range of overseas dental qualifications that allow a dental practitioners to receive exemption from the ADC preliminary examination;</li> <li>• Expanding educational pathways to registration for overseas-trained oral health practitioners;</li> <li>• Improve the provision of information to applicants, employers and State Health Departments with regard to optimising the flexibility of existing immigration arrangements for overseas trained oral health practitioners.</li> </ul>	Short
<p><b>7.2</b> To maintain current levels of access to dental services and achieve workforce self-sufficiency, increase the supply of new Australian-trained oral health practitioners by at least 150 graduates per year by increasing undergraduate student places at Australian Dental Schools</p>	Short
<p><b>7.3</b> To begin to meet the additional oral health service needs identified in Healthy Mouths Healthy Lives, further expand numbers of student oral health practitioners.</p>	Medium
<p><b>7.4</b> Improve recruitment and retention of oral health professionals in public dental services through enhanced professional development, improved career paths and more competitive pay scales.</p>	Medium
<p><b>7.5</b> Improve recruitment and retention of oral health professionals in rural and remote areas through dedicated places for students from rural and remote backgrounds, rural scholarships, enhanced professional development, professional support, rural rotation and rural incentives.</p>	Long
<p><b>7.6</b> Recognise and support the role of a suitably representative Australian Dental Council to ensure a National approach to the maintenance of a high standard of dental services.</p>	Medium
<p><b>7.7</b> Increase the remuneration of oral health academics in tertiary education institutions to levels that are internationally competitive and sufficient to attract and retain skilled practitioners from the private sector.</p>	Medium
<p><b>7.8</b> Develop and implement programs, including dedicated student places and scholarships, to increase recruitment of Aboriginal and Torres Strait Islander oral health students.</p>	Long
<p><b>7.9</b> Fund dental schools and other oral health training programs at a level that better reflects the full cost of training oral health practitioners.</p>	Medium

<b>7.10</b>	Further develop undergraduate and postgraduate educational programs for the oral health workforce to build its capacity to work with: <ul style="list-style-type: none"> <li>• Children aged 0-5</li> <li>• Older people</li> <li>• People with special needs</li> <li>• Cultural diversity.</li> </ul>	Medium
<b>7.11</b>	Build community and health workforce capacity in oral health and oral health promotion by collaboration of the oral health sector with: <ul style="list-style-type: none"> <li>• Policy makers in health, community service and education;</li> <li>• Other human services providers and their associations; and</li> <li>• Teachers</li> </ul>	Long
<b>7.12</b>	Explore the provision, by State/Territory public dental services, of dental care to the general community on a full cost recovery basis to allow oral health providers in the public sector to provide a wider range of services.	Medium

## Progress on National Actions

Reasonable progress has been made in a number of National Actions:

Action Area	Description	Progress
<b>7.1</b>	Increase the supply of overseas-trained dentists.	Establishment of the Public Sector Dental Workforce Scheme (2004) Some progress in streamlining processes for entry of overseas trained dentists.
<b>7.2</b>	Achieve self-sufficiency with new Australian trained oral health practitioners.	Achieved increased number of dental schools, dentist graduates and oral health graduates.
<b>7.3</b>	Meet additional oral health service needs as identified in the plan.	Increase in labour force capacity is greater than population growth, allowing some additional needs to be met.
<b>7.4</b>	Improve recruitment and retention of oral health professionals in public dental services.	Attraction and retention allowance in public dental services.
<b>7.5</b>	Improve recruitment and retention of oral health professionals in rural and remote areas.	Rural scholarship schemes (limited uptake). Rural Placement Program 2007/08. Rural allowances in public dental services.
<b>7.6</b>	Recognise and support the role of the Australian Dental Council (ADC).	ADC membership expanded and its role will change under National Accreditation Authority
<b>7.10</b>	Further develop programs for the oral health workforce with children, older people, people with special needs and cultural diversity.	Limited progress in specific situations.

No progress has been made in some National Actions:

Action Area	Description	Progress
7.7	Increase remuneration of oral health academics.	
7.8	Increase recruitment of Aboriginal and Torres Strait Islander oral health students.	
7.9	Fund dental schools and other training programs at a level that reflects full costs.	Health Workforce Australia will have a responsibility for appropriately funded placements.
7.11	Building community and health workforce capacity in oral health.	PHAA 1996 resolutions give guidance.
7.12	Explore public dental service provision of a wider range of services.	

### The Workshop identified two significant achievements

- Increased numbers of graduates and establishment of the Public Sector Dental Workforce Scheme (PSDWS) However, it was considered that there were substantial challenges in addressing distributional issues (public/private, geographic and specialty), strengthening the PSDWS, introducing a ‘competent authority’ model for allied oral health professionals seeking registration.
- Continued efforts to reduce regulation as an impediment to the full use of the dental team. Further concern was raised with regard to the impact of the Bradley Review of tertiary education on the dental workforce and maintaining the academic workforce.

### Key Performance Indicators

There are a suite of seven KPIs that address Action Area Seven. These relate to recruitment, predominantly of dentists into the dental workforce (dentists migrating from countries covered by automatic registration, successful completions of ADC examinations by OTDs, domestic dentistry and allied oral health course completions) and the monitoring of actual dentist, specialist and allied oral health professionals rate per 100,000 population by state/territory and remoteness area, and finally the reconciliation of projections of demand and supply of dental visits.

### The Workshop expressed its concern over:

- Some technical data issues, for example, Department of Education Science and Training (DEST) codes for BOH graduates. It was anticipated that some technical data issues would be addressed by improved processes and the ability to conduct supplementary research under the National Registration Authority from 2010 onwards
- The need for contemporary data on allied oral health professionals’ practice activity
- The need to prioritise tracking of dentists who successfully complete the ADC examinations in terms of residence and practice in Australia
- The collection of adequate practice activity data for **all** oral health practitioners

## Missing Action Area: Rural and remote dwellers

The National Rural Health Alliance has identified oral health as a priority issue.

Barriers to good oral health and access to dental care for rural and remote residents are not just limited to children, adolescents, older persons, low income, social disadvantage, people with special needs and Indigenous Australians. Rural and remote residency creates issues in oral health and access to dental services for all rural and remote dwellers.

Specifically programs such as the Teen Dental Plan, Medicare Scheme and Denticare assume heavy reliance on private sector contribution. However, private sector dental care provision is very limited in rural and remote areas. The role of the public sector as the main or even sole provider in many of these areas must be recognised.

Specific characteristics of rural and remote areas, particularly non-financial barriers to access, significantly influence implementation and effectiveness. Provision of dental care to rural and remote areas incurs specific cost issues that must be recognised and tackled. In particular, access is influenced by lack of transport. In addition, there are currently significant workforce shortages, with heavy reliance on overseas trained dentists. Policies to increase provision of dental care need a specific focus on the special issues facing rural and remote areas to ensure opportunities are taken.

Content of three existing Action Areas are relevant to this Action Area.

Action Area		Time-frame
1.2	Extend fluoridation of public water supplies to communities across Australia with populations of 1000 or more.	Short
4.1	Using a community development approach, develop and implement targeted health promotion and preventive programs for specific socio-economically disadvantaged groups including people in rural and remote areas, the homeless, people in institutions and correctional facilities, low-income earners and their families, disadvantaged young adults and older people, and disadvantaged people from Aboriginal, Torres Strait Islander and non-English speaking backgrounds.	Short
7.5	Improve recruitment and retention of oral health professionals in rural and remote areas through dedicated places for students from rural and remote background, rural scholarships, enhanced professional development, professional support, rural rotations and rural incentives.	Short

### The Workshop expressed its concern over:

- Rural and remote not being included as an Action Area
- Lack of specific policy development in relation to fluoride availability and foods in rural and remote locations

## Progress on related National Actions

Action Area	Description	Progress
1.2	Extend fluoridation of public water supplies to communities across Australia with populations of 1,000 or more.	Fluoridation has been extended in a number of jurisdictions. However, many rural and remote residents do not have access to fluoridated water.
4.1	Using a community development approach, develop and implement targeted health promotion and preventive programs for specific socio-economically disadvantaged groups.	There have been health promotion and prevention plans, however these have not usually had a specific focus on the particular needs of rural and remote residents.
7.1	Increase the supply of overseas-trained dentists by (a number of specified strategies).	PSDWS gravitating to rural areas. New South Wales International Dental Graduate Program introduced.
7.5	Improve recruitment and retention of oral health professionals in rural and remote areas.	Two regional dental schools have been established.

## Key Performance Indicators

There are no KPIs for this Action Area:

None of the KPIs for the Action Areas that have been identified as relevant to rural and remote dwellers include indicators specifically for this population.

The following information was presented to the Workshop to assist in evaluating the case for inclusion of a specific action area for rural and remote Dwellers

- Rural dentists have different practice activity patterns. Regional/remote dentists;
  - supply more visits, and feel busier,
  - provide less preventive and crown/bridge
  - provide more fillings and extractions.
- Access to dental care and oral health differ by location among children. Rural/remote children;
  - have similar percentages accessing care;
  - receive less private care, and
  - have more caries experience (% dmft>0, DMFT>0) compared to their capital city counterparts.
- Access to dental care and oral health varies by location among adult. Non-capital city adults;
  - have a lower percent accessing dental care,
  - experience higher levels of tooth loss and untreated decay,
  - but similar levels of gum disease compared to their capital city counterparts.

## The Workshop expressed its concern over:

- Need for an indicator on the age of the dental workforce in rural areas.
- Need for the presentation of indicators on oral health and access to dental care for residents of rural and remote areas.

## Summary

The Workshop reviewed all Action Areas and the identified concerns with progress on the implementation of National Actions and Key Performance Indicators as well as concerns over their completeness or quality of the available data.

Progress on the implementation of a number of National Actions related to oral health promotion was a concern. This included oral health promotion as a consideration in health promotion, potentially through the Common Risk Factor approach, the involvement of non-dental health workers in oral health promotion and the continued extension of fluoridation of water supplies, especially in rural and remote Australia. The second overarching concern was for a strong public policy response to the inequalities in access to dental services for many of the people highlighted in the Plan's Action Areas. Security of funding for existing programs addressing target groups was an immediate concern, but additional new financing schemes for improving access to dental services were discussed. Against the backdrop of a constrained supply of the dental work force, there were particular concerns with the appropriate use of the allied dental work force and the occupational, specialty and geographic distributions of the dental work force. There was also support for the addition of an eighth Action Area for Rural Dwellers.

The existing suite of Key Performance Indicators was providing useful data. There was concern expressed over the security of funding for the surveillance activities that inform the KPIs and for funding to support the series of national oral health surveys. The need for collaboration between stakeholders in the collection of surveillance data was seen as essential, but not always sufficiently forthcoming.



**Appendix A: Workshop program**



# Workshop on: “Monitoring of Australia’s National Oral Health Plan”

**17 & 18 September 2009  
National Wine Centre, Adelaide**

## *Day One*

<b>8.45 am</b>	<b><i>Coffee/tea</i></b>
<b>9.00 am</b>	<b>Welcome and housekeeping</b>
<b>9.05 am</b>	<b>Overview of the facilitated Workshop</b>
<b>9.15 am</b>	<b>Background to monitoring of the National Oral Health Plan</b>
<b>9.30 am</b>	<b>Presentation by Veronica Hancock and colleagues (Commonwealth Department of Health and Ageing)</b>
<b>10.00 am</b>	<b>Action Area One: Promoting oral health across the population</b>
	<ul style="list-style-type: none"> <li>• <b>Activities to date. Presented by Martin Dooland (SA)</b></li> <li>• <b>Monitoring data. Presented by John Spencer (ARCPOH)</b></li> <li>• <b>Facilitated Workshop discussion and reporting</b></li> </ul>
<b>11.15 am</b>	<b><i>Morning tea</i></b>
<b>11.30 am</b>	<b>Action Area Two: Children and adolescents</b>
	<ul style="list-style-type: none"> <li>• <b>Activities to date. Presented by Kaye Roberts-Thomson (ARCPOH)</b></li> <li>• <b>Monitoring data. Presented by Kaye Roberts-Thomson (ARCPOH)</b></li> <li>• <b>Facilitated Workshop discussion and reporting</b></li> </ul>
<b>12.45 pm</b>	<b><i>Lunch</i></b>
<b>1.45 pm</b>	<b>Action Area Three: Older people</b>
	<ul style="list-style-type: none"> <li>• <b>Activities to date. Presented by Mary Blackwood (TAS)</b></li> <li>• <b>Monitoring data. Presented by Jane Harford (ARCPOH)</b></li> <li>• <b>Facilitated Workshop discussion and reporting</b></li> </ul>
<b>2.45 pm</b>	<b><i>Afternoon tea</i></b>
<b>3.00 pm</b>	<b>Action Area Four: Low income and social disadvantage</b>
	<ul style="list-style-type: none"> <li>• <b>Activities to date. Presented by Ian Meyers (QLD)</b></li> <li>• <b>Monitoring data. Presented by Anne Ellershaw and David Brennan (ARCPOH)</b></li> <li>• <b>Facilitated Workshop discussion and reporting</b></li> </ul>
<b>4.30 pm</b>	<b>Wrap up of day one</b>
<b>5.00 pm</b>	<b>Close</b>
<b>7.00 pm for 7.30 pm</b>	<b><i>Dinner</i></b>

# Workshop on: “Monitoring of Australia’s National Oral Health Plan”

**17 & 18 September 2009  
National Wine Centre, Adelaide**

## *Day Two*

<b>8.30 am</b>	<b><i>Coffee/tea</i></b>
<b>8.45 am</b>	<b>Action Area Five: People with special needs</b>
	<ul style="list-style-type: none"> <li>• <b>Activities to date. Presented by Loretta Bettiens (ACT)</b></li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Monitoring data. Presented by John Spencer (ARCPOH)</b></li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Facilitated Workshop discussion and reporting</b></li> </ul>
<b>9.30 am</b>	<b>Action Area Six: Aboriginal and Torres Strait Islanders</b>
	<ul style="list-style-type: none"> <li>• <b>Activities to date. Presented by Peter Hill (NSW)</b></li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Monitoring data. Presented by Lisa Jamieson (ARCPOH)</b></li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Facilitated Workshop discussion and reporting</b></li> </ul>
<b>10.45 am</b>	<b><i>Morning tea</i></b>
<b>11.00 am</b>	<b>Action Area Seven: Workforce development</b>
	<ul style="list-style-type: none"> <li>• <b>Activities to date. Presented by Peter Jarman (WA)</b></li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Monitoring data. Presented by Dana Teusner (ARCPOH)</b></li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Facilitated Workshop discussion and reporting</b></li> </ul>
<b>12.15pm</b>	<b>The ‘missing’ action area: Rural dwellers</b>
	<ul style="list-style-type: none"> <li>• <b>Policies and actions from other domains e.g. NRHA – Andrew McAuliffe (NT)</b></li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Monitoring data. Presented by David Brennan (ARCPOH)</b></li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Facilitated Workshop discussion and reporting</b></li> </ul>
<b>1.30 pm</b>	<b><i>Lunch</i></b>
<b>2.30 pm</b>	<b>Summary and discussion of outcomes/recommendations</b>
<b>4.00 pm</b>	<b>Drinks</b>

## Appendix B: List of Workshop attendees

Name	Affiliation
Ms Sue Aldenhoven	President , Dental Hygienists' Association of Australia
Mr Paul Badco	NZ Ministry of Health
Ms Linda Bertram	Queensland Health
Ms Loretta Bettiens	Acting Director, ACT Dental Services
Ms Mary Blackwood	A/Chief Executive Officer, Health and Wellbeing Services DHHS Tasmania
Professor Anthony Blinkhorn	NSW Health Chair for Population Oral Health
Dr Gelsomina Borromeo	Lecturer in Dentistry, University of Melbourne
Dr Tessa Boyd-Caine	Senior Policy Officer, ACOSS
A/Prof David Brennan	ARCPOH
Ms Emma Bridge	Health and Wellbeing Services DHHS Tasmania
Dr Robert Broadbent	Chief Executive Officer, Australian Dental Council
Dr Kerry Chant	Chair of Oral Health Monitoring Group
Dr Len Crocombe	Australian Dental Association
Dr Martin Dooland	Executive Director, SA Dental Service
Mr Lyle Dunne	Australian Government Department of Health and Ageing
Ms Anne Ellershaw	ARCPOH
Dr Susan Gaffney	President , Australian Dental Council
Dr David Griffiths	ACT Health
Ms Veronica Hancock	Australian Government Department of Health and Ageing
Dr Jane Harford	ARCPOH
Dr Peter Hill	Acting Chief Dental Officer , College of Dental Therapy
Dr David Houghton	Australian Dental Association
Ms Eithne Irving	Australian Government Department of Health and Ageing
Dr Lisa Jamieson	ARCPOH
Dr Peter Jarman	Acting Director, Dental Health Services WA
Professor Newell Johnson	Nominee of the Deans of Dental Schools
Ms Susan Killion	Head, Health Group, AIHW
Professor Ratilal Laloo	Colgate Professor of Indigenous Oral Health, Griffith University
Dr Pingzhou Liu	ARCPOH
Mr Andrew McAuliffe	NT Health Department
Dr Helen McLean	Chair, Dental Workforce and Education Committee
Leda Mugayar	President, ASSCID
Professor Ian Meyers	Chief Dental Officer , Queensland Health
Ms Christine Morris	Manager, Health Promotion, SA Dental Service
Ms Margaret Noris	Australian Government Department of Health and Ageing
A/Prof Kaye Roberts-Thomson	ARCPOH
Mr Brenton Rodgers	Australian Government Department of Health and Ageing
Mrs Julie Satur	ADOHTA representative,
Ms Stephanie Scallion	Australian Dental Association
Dr Bruce Simmons	APHA Oral Health SIG / ADA Rural Oral Health Advisory Panel
Professor John Spencer	ARCPOH
Ms Dana Teusner	ARCPOH
Dr Arthur van Deth	Flinders University

