Tasmanian
Audit Office

Report of the Auditor-General No. 5 of 2023-2024

Access to oral health services

18 June 2024

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- how public sector entities manage resources
- how public sector entities can improve their management practices and systems
- whether public sector entities comply with legislation and other requirements.

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2024 (No. 2)

2024
PARLIAMENT OF TASMANIA

Access to oral health services

18 June 2024

Presented to both Houses of Parliament pursuant to
Section 30(1) of the *Audit Act 2008*

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Tasmanian Audit Office

GPO Box 851
Hobart
TASMANIA 7001

Phone: (03) 6173 0900
Email: admin@audit.tas.gov.au
Website: www.audit.tas.gov.au

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Tasmanian Audit Office

Level 2, 144 Macquarie Street, Hobart, Tasmania, 7000
Postal Address GPO Box 851, Hobart, Tasmania, 7001
Phone: 03 6173 0900
Email: admin@audit.tas.gov.au
Web: www.audit.tas.gov.au

18 June 2024

President, Legislative Council
Speaker, House of Assembly
Parliament House
HOBART TAS 7000

Dear President, Speaker

Report of the Auditor-General No. 5 of 2023-24 – Access to oral health services

This report has been prepared consequent to examinations conducted under section 23 of the *Audit Act 2008*. The objective of the audit was to assess whether access to public oral health services, including early intervention and prevention, was efficient and effective.

Yours sincerely

Martin Thompson
Auditor-General

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Foreword

Poor oral health can directly impact overall health and wellbeing. It can affect a person's ability to eat, speak, socialise, and engage in employment with confidence. This is why early intervention and preventative care, particularly for children, is important in helping reduce the likelihood of poor oral health later in life. However, some people may not understand the importance of practising good oral hygiene, with access to oral health care complicated by financial, geographical and psychosocial barriers.

The public oral health system in Tasmania is focused on treating people most in need including children, concession card holders and priority populations identified in the *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024*.[1]

Public discourse on oral health services is often focused on the size of waitlists and time waited for treatment. The *Health system dashboard* produced by the Tasmanian Department of Health shows statistical information on the number of children and adults seen for dental care and the high number of adults waiting for general care and dentures.[2] The number of adults waiting for non-urgent treatment consistently remained at or around 15,000 for most of 2023.

Access to public oral health services has been impacted by a complex funding model weighted towards treatment rather than prevention, with COVID-19 significantly impacting the capacity of the system. Tasmania also has an ageing and regionally dispersed population and high dependency on social welfare, which all impact access.

In evaluating access to public oral health services in Tasmania, including treatment and preventative care, my intent for this performance audit was to highlight the challenges faced by Oral Health Services Tasmania in providing efficient and effective care. I trust that the recommendations will help improve access to dental treatment for Tasmanians most in need.

Martin Thompson
Auditor-General

18 June 2024

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[1] COAG Health Council, Australian Government (2015), *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024*, accessed 20 February 2024. https://www.health.gov.au/sites/default/files/documents/2022/04/healthy-mouths-healthy-lives-australia-s-national-oral-health-plan-2015-2024.pdf

[2] Tasmanian Department of Health, *Health system dashboard*, accessed 20 February 2024.

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Independent assurance report

This independent assurance report is addressed to the President of the Legislative Council and the Speaker of the House of Assembly. It relates to my audit on whether access to public oral health services, including early intervention and prevention, is efficient and effective.

Audit objective

The objective of the audit was to assess whether access to public oral health services, including early intervention and prevention, was efficient and effective.

Audit scope

The audit assessed whether Oral Health Services Tasmania (OHST) had arrangements in place that efficiently and effectively facilitated access to public oral health services. The focus on access was broader than waiting for treatment, it also included community education on good oral health and access to preventative care.

The audit reviewed arrangements in place to facilitate access to oral health services and examined trends in oral health data since 2013-14.

Whilst OHST cooperated with the private sector in providing dental care for some clients[3], the audit did not assess access to private dental services, nor did it test clinical decision-making.

Audit approach

The audit was conducted in accordance with the Australian Standard on Assurance Engagements ASAE 3500 *Performance Engagements* issued by the Australian Auditing and Assurance Standards Board, for the purpose of expressing a reasonable assurance opinion.

The audit evaluated the following criteria:

1. Are early intervention and preventative programs effective?
    1.1. Were early intervention and preventative programs targeted towards priority populations effectively?
    1.2. Was the importance of practising good oral hygiene, and availability of preventative programs, communicated effectively?
2. Were barriers to accessing oral health services managed effectively?

[3] In this report we use the term clients to refer to people that seek dental treatment with OHST or engage in early intervention programs. We refer to patients when describing a person's treatment in a hospital setting or when citing a document.

3. Is management of demand for public oral health services in Tasmania efficient and effective?
    3.1. Was the way in which demand for access to oral health services is measured effective?
    3.2. What was the capacity and capability of the service system to meet demand?
    3.3. Were adult general care, denture services and general anaesthetic waitlists managed effectively?
4. Is there appropriate oversight and monitoring in place for oral health services?
    4.1. Were key performance indicators effective in assessing performance, and addressing gaps, with access to oral health services?
    4.2. Was there effective reporting on access to oral health services?
    4.3. Was there a coordinated approach and effective partnerships to monitor access to oral health services?

Responsibility of management

The Tasmanian Health Service (THS) is the service delivery arm of the Department of Health and it provides public hospital, medical and community health services. The functions of the THS are to ensure that these services are delivered to quality standards and within the specified funding allocation. OHST is part of the THS and has responsibility for providing efficient and effective access for people eligible for public oral health services. The Secretary of the Department of Health guides, monitors and manages the THS in undertaking its powers and functions.

Responsibility of the Auditor-General

My responsibility was to express a reasonable assurance opinion on whether access to public oral health services, including early intervention and prevention, was efficient and effective.

Independence and quality control

I have complied with the independence and relevant ethical requirements, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

The Tasmanian Audit Office applies Australian Standard ASQM 1 *Quality Management for Firms that Perform Audits or Reviews of Financial Reports and Other Financial Information, or Other Assurance or Related Services Engagements* which requires the Office to design, implement and operate a system of quality management including policies or procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Conclusion

It is my conclusion that access to public oral health services in Tasmania, as measured against the audit criteria was, in all material respects, efficient and effective.

Martin Thompson
Auditor-General

18 June 2024

Executive summary

Summary of findings

Data from Australian Institute of Health and Welfare (AIHW) shows that Tasmania has the worst prevalence of tooth loss in Australia, with 22% of adults having fewer than 21 of their 32 natural teeth. Furthermore, only 71% of adults received a dental check-up in the previous 2 years, the second worst in Australia behind the Northern Territory. On the positive side, most Tasmanians have access to fluoridated water and there have been improvements to the rate of decayed, missing and filled teeth (dmft) amongst children since 2013-14.

Access to public oral health services in Tasmania is negatively affected by Tasmania's older population demographic which along with the higher rate of dependency on social welfare, increases the number of adults eligible for public oral health services, and Tasmania's regionally dispersed population contributing to longer travel times to appointments.

The goal of OHST's *Oral Health Promotion Strategic Plan 2017-2022* (Strategic Plan) is to improve the health of Tasmanians through better oral health.[4] The use of OHST's finite resources is targeted to treating those most in need, primarily children, concession card holders and priority populations. OHST also managed treatment for adults requiring time-critical episodic care efficiently with most clients seen within clinically recommended timeframes.

Resource constraints led to OHST adopting a partnering approach to deliver early intervention and preventative programs

The current funding model for oral health services drives activity towards treatment and reduces the capacity for effective early intervention and preventative programs. This led to OHST adopting a partnering approach to deliver early intervention and preventative programs. While these programs were focused on young children, pregnant women and nationally identified priority populations, the targeting of early intervention and preventative programs was at times ad hoc and not supported by an engagement strategy to support implementation, and OHST's monitoring of these programs did not measure their effectiveness in delivering expected outcomes. We also found that barriers to accessing some early intervention programs led to low referral rates and uptake, limiting their effectiveness.

The data shows that early intervention and preventative programs have helped improve the oral health of children, as measured by dmft. Of concern, however, is the decrease in check-ups for children particularly in the North and North West of Tasmania.

OHST was proactive in exploring partnerships with Tasmanian and Australian government agencies and various organisations to deliver early intervention programs targeting priority

[4] Tasmanian Department of Health (2017), *Oral Health Promotion Strategic Plan 2017-2022*, accessed 20 February 2024. https://www.health.tas.gov.au/sites/default/files/2021-10/Oral_Health_Promotion_Strategic_Plan2017-22_DoHTasmania2017.pdf

populations, such as concession cards holders who may be socially disadvantaged or on low incomes. This enabled OHST to have a broader reach given their limited financial and staffing resources for early intervention and preventive activities.

OHST largely managed barriers to accessing treatment effectively but access to dental care is restricted for some vulnerable groups

OHST largely managed barriers to oral health services effectively.

The cost of the co-payment can be a barrier to adults accessing oral health care. In addressing this barrier, OHST has increased the transparency of payment plans and options on their website, continues to provide care for clients with unpaid balances and writes-off unpaid debts in extenuating circumstances.

OHST has addressed geographic and transport barriers by:

- engaging Community Transport Services Tasmania to provide support to clients wanting to attend non-emergency medical appointments
- establishing an Outsourcing Program to enable people to receive timely dental care with a nearby private provider where public services are not easily accessible
- liaising with the Royal Flying Doctor Service (RFDS) Tasmania, which provides oral health services in rural and remote areas of Tasmania from fixed and mobile sites.

OHST worked with Aboriginal organisations to help reduce cultural barriers in accessing oral health services. For example, OHST partnered with Connected Beginnings and Aboriginal communities to help Aboriginal children and their families navigate referrals and access to dental appointments. OHST also trained staff to engage and support culturally and linguistically diverse people and provided an interpreter service, either in-person, or through video or telephone services.

OHST has addressed fear and anxiety barriers by providing its staff with training to improve their engagement with clients at the dental clinic. OHST also has programs and dental treatment options (such as general anaesthetic and conscious sedation) available to support people who experience anxiety when accessing dental care.

Despite successes in addressing the abovementioned access barriers, OHST continues to face challenges in providing access to dental care for vulnerable groups, such as aged care residents and inmates in the Risdon Prison Complex. In addition, facilitating treatment in the public hospital system continues to be problematic for dental issues requiring general anaesthetic due to limited theatre availability, and data sharing restrictions limiting the sharing of information pertaining to clients. On a positive note, the Conscious Sedation Pilot was successful in diverting clients from the general anaesthetic waitlist.

The demand for adult general dental care has steadily increased since 2015-16

The demand for adult general dental care has been steadily increasing since 2015-16 and the length of time adults wait for general dental care is increasing. The median wait time for adults on the general care waitlist statewide increased from 892 days (around 2.4 years) at

June 2014 to 1,459 days (nearing 4 years) at June 2023. The number of adults on the general care waitlist needing episodic care is also increasing. Failing to address oral health demand and increasing waitlists can have negative consequences, impacting both individuals and the healthcare system.

OHST has implemented strategies and measures to respond to the challenge of increasing demand

OHST has implemented several strategies and measures to respond to the challenge of increasing demand. These include:

- implementing revised appointment processes and phone call and SMS appointment reminders to increase client appointment attendance
- conducting annual audits of the general care waitlist to remove clients no longer identified as needing treatment
- managing adults requiring time-critical episodic care efficiently
- employing risk treatment plans to identify and respond to workforce challenges
- engaging communication services firms to assist with advertising campaigns promoting the Tasmanian lifestyle for prospective applicants
- introducing a Graduate Program to help address staff shortages and deliver more appointments
- using data and projections to forecast demand and help make decisions about models of care, location, suitability and capacity of facilities and the resourcing of those facilities
- implementing digital dentures technology to reduce the number of appointments and wait times for dentures.

Given OHST's resource constraints, we found it managed the challenge of increasing demand efficiently and effectively through the implementation of the strategies and measures outlined above. We did identify, however, that OHST did not have a structured approach to facility management, with some dental clinics operating at capacity.

The COVID-19 pandemic had a significant impact on the operations of OHST, and the after-effects continue to impact the capacity of the service.

OHST prepared frequent, targeted reports which informed decision-making on access to oral health services

OHST worked with Australian Government agencies to understand the number of people eligible for public oral health services in Tasmania. OHST used client data recorded in its client information system called Titanium to determine the proportion of those in the eligible population that seek treatment.

Reporting on the level of access was important in helping identify gaps and develop strategies to address access issues. We found that OHST prepared frequent, targeted reports to Management and the Executive on key performance activities across the system.

The KPIs contained in these reports assessed performance on access to oral health services. OHST expanded its suite of KPIs in the THS Service Plan 2023-24 to improve transparency on the service's performance alongside other parts of the health system.

However, public reporting on oral health activities was limited to occasions of service and waitlists. To further enhance transparency and inform the public on levels of access to the service, the *Health system dashboard* could include additional indicators on oral health.

There is good cooperation between OHST and RFDS to ensure continuity of dental care but data sharing could be improved

OHST had limited monitoring of partnerships but reported on activities. The level of engagement with partners varied, with few partnerships having fixed check-in points or reporting requirements. This has resulted in minimal oversight of intended outcomes. OHST worked closely with the RFDS to ensure continuity of dental care, with both parties working together to address gaps in dental services. However, data sharing has limited the effectiveness of the partnership, but OHST has committed to addressing this issue.

Recommendations

We recommend OHST:

1. Investigate ways to increase funding for early intervention and preventative activity to help reduce demand for treatment.
2. Develop and implement a targeted engagement strategy that outlines how it will work with partners on oral health early intervention and preventative programs.
3. Periodically review the value and effectiveness of programs that are delivered by other dental care providers and funded by the Tasmanian Government.
4. Work with Hospitals and Primary Care division within the Department of Health to improve the management and sharing of categorisation data for clients requiring treatment under general anaesthetic.
5. Where practical, when contacting clients during general care waitlist audits, record the reasons why they may no longer require care.
6. Include additional oral health measures on the *Health system dashboard*, for example, waitlists and occasions of service by region and average wait times.

Submissions and comments received

In accordance with section 30(2) of the *Audit Act 2008,* this report was provided to the relevant Minister, Entity Heads of the audited entities, and other persons who in our opinion had a special interest in the report, with a request for submissions or comments.

Submissions and comments we receive are not subject to the audit nor the evidentiary standards required in reaching an audit conclusion. Responsibility for the accuracy, fairness and balance of these comments rests solely with those who provided the response. However, views expressed by the responders were considered in reaching audit conclusions. Section 30(3) of the *Audit Act 2008* requires this report include any submissions or

comments made under section 30(2) or a fair summary of them. Submissions received are included below.

Response from the Minister for Health, Mental Health and Wellbeing

I appreciate the opportunity to make a submission and confirm that I will not make a submission on this occasion. I am, however, pleased to see that the overall conclusion of the audit highlighted Oral Health Services Tasmania's (OHST) provision of public dental services, assessed against the audit criteria, were found to be efficient and effective. I understand that OHST found the auditing process to be a positive experience, providing an opportunity to share their strengths and achievements, while also reflecting on areas for improvement. I will work with my Department to progress the recommendations.

Hon Guy Barnett MP

Response from the Department of Health

The comprehensive findings provided in the report highlight both areas of progress and achievement, and areas that require attention and improvement. While it is heartening to note the positive strides made in improving children's oral health, the statistics revealing the high prevalence of tooth loss among adults and the low rates of dental check-ups are a known concern, underscoring the need to continue targeting those most in need and at risk.

Despite the challenges noted in the report, I commend Oral Health Services Tasmania (OHST) for its proactive efforts in efficiently managing treatment for adults requiring time-critical episodic care, and for exploring partnerships to deliver early intervention and preventative programs. The initiatives undertaken to manage the increasing demand for public dental services demonstrate OHSTs adaptability in navigating these challenges and I am confident that with continued dedication and innovation, OHST will continue to deliver high-quality oral health care to the Tasmanian community.

Overall, I commend OHST for its dedication and commitment to improving oral health outcomes in Tasmania. By implementing the suggested recommendations and continuing to collaborate with stakeholders, I am confident that we can continue to improve oral health outcomes for Tasmanian's.

Shane Gregory
Associate Secretary

1. Introduction

Introduction

1.1 Oral health refers to the condition of a person's teeth and gums, as well as the health of the muscles and bones in their mouth. Maintaining good oral health helps support overall health and wellbeing and can reduce the prevalence of dental disease and treatment.

1.2 This report uses the term 'oral health services' to refer to early intervention and preventative services, and dental care or treatment delivered by OHST.

1.3 The Australian Dental Association reports approximately 85% of dental services are delivered by the private sector.[5] The remaining dental services are predominantly provided by Australian, state and territory governments through public dental services or by funding private practitioners to provide dental services.

Oral Health Services Tasmania

1.4 OHST is responsible for providing dental and denture services for eligible Tasmanian adults, being Pensioner Concession or Health Care cardholders, and it provides a universal dental service for all children up until the age of 18 years.

1.5 Treatment services for children are usually provided a few weeks from the date of contact. Emergency cases or children in pain are seen on the same day, where possible.

1.6 OHST triages adults seeking dental care and, depending on the urgency of the problem, offers an appointment for treatment. If the problem is non-urgent, they may be placed on the general care waitlist.

1.7 OHST uses its client information system, Titanium to record client data, manage appointments and generate reports on access to its services. Titanium captures client information such as age, address, concession card status and other identifiers, such as Aboriginality, clients in out of home care or women referred to the Healthy Smiles for Two program.

1.8 OHST operates from over 30 sites across Tasmania, including:

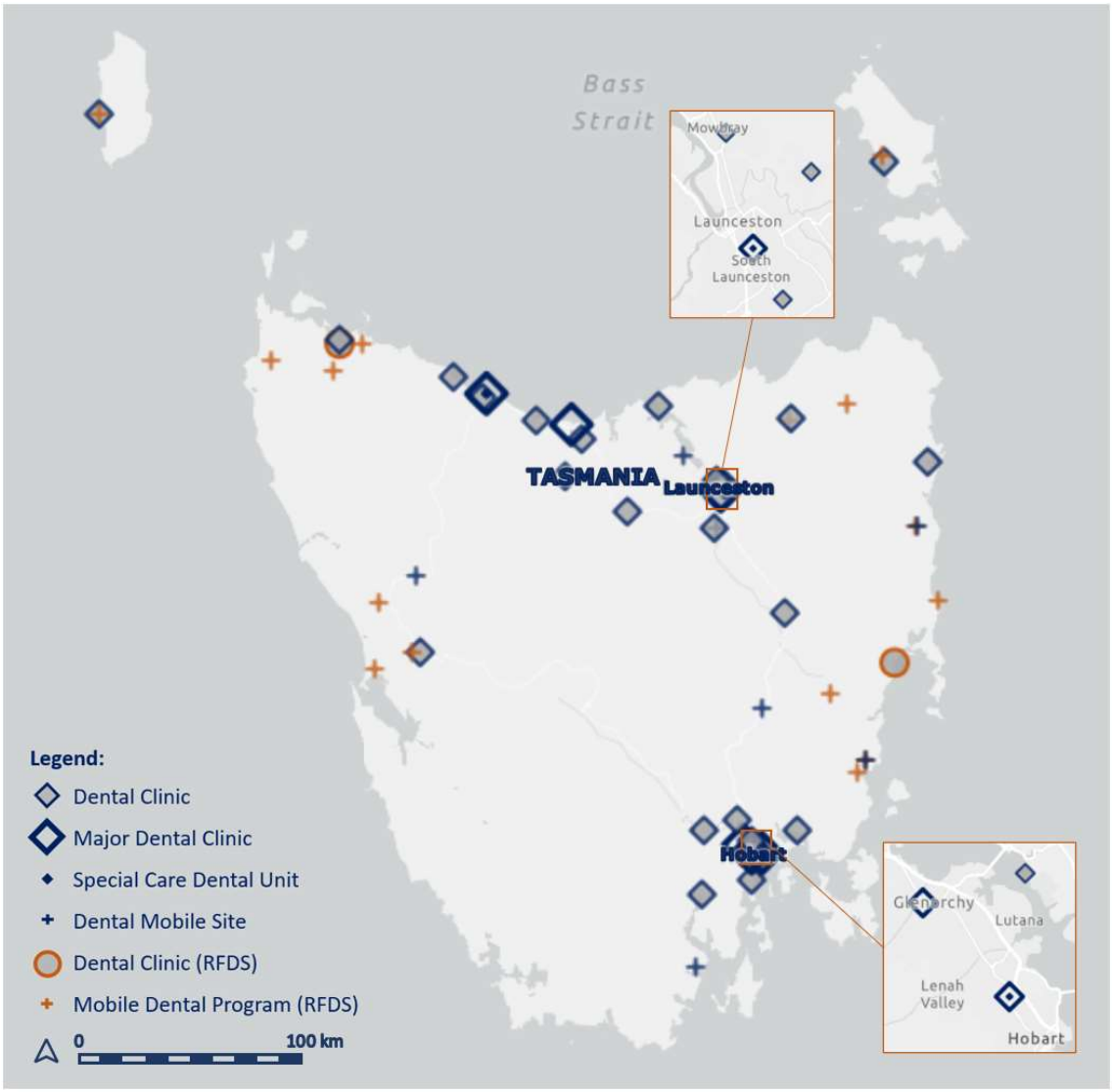
- major centres in Burnie, Devonport, Launceston, Clarence, Glenorchy and Hobart
- clinics in health centres, district hospitals and some public schools
- three special care dental units in the major hospitals

[5] Australian Dental Association Tasmanian Branch (2021), *The Our Healthcare Future – Immediate Actions and Consultation Paper*, accessed 22 February 2024. https://www.health.tas.gov.au/sites/default/files/2022-09/ohf.1.5_adatb_ohf_sub_20210217_0.pdf

- two mobile dental units in rural areas
- three school-based dental vans.

1.9 The RFDS Tasmania has fixed facilities in Smithton and Swansea and operates a Mobile Dental Program which provides dental programs to school communities across rural and remote areas in Tasmania.

Figure 1: Map showing OHST and RFDS service locations

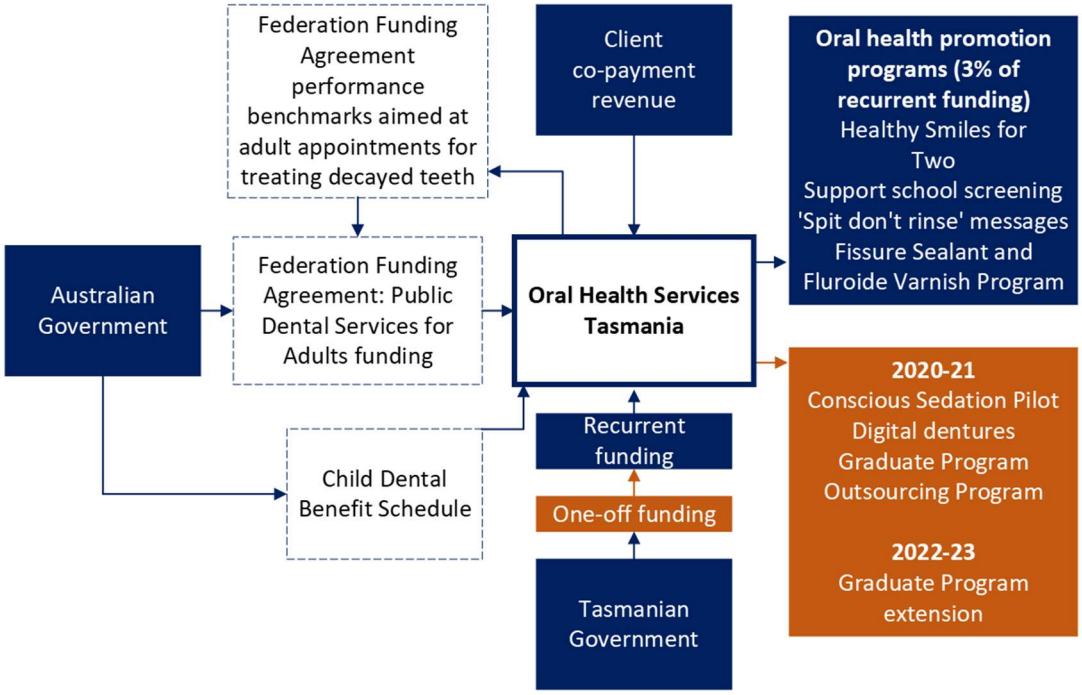


Source: Tasmanian Audit Office

Funding of OHST

1.10 OHST receives funding from the Australian and Tasmanian Governments as illustrated in Figure 2.

Figure 2: Funding model for oral health services



Source: Tasmanian Audit Office

1.11 Expenditure on oral health services over the past 10 years, categorised by the funding source for that expenditure is shown in Table 1.

Table 1: Expenditure by OHST by source

Financial year	Tasmanian Government	Australian Government	Other funds[#]	Total expenditure
2013-14	$23,966,284	$4,747,247	$1,332,133	$30,045,664
2014-15	$24,991,392	$5,209,423	$851,226	$31,052,040
2015-16	$22,323,577	$8,953,454	$683,484	$31,960,516
2016-17	$22,836,066	$9,149,674	$231,137	$32,216,876
2017-18	$23,522,118	$13,508,126	$312,285	$37,342,528
2018-19	$23,940,050	$11,270,522	$296,627	$35,507,199
2019-20	$26,048,831	$8,856,546	$266,920	$35,172,297
2020-21	$25,046,705	$7,728,879	$170,971	$32,946,555

Financial year	Tasmanian Government	Australian Government	Other funds[#]	Total expenditure
2021-22	$27,304,428	$8,091,254	$389,800	$35,785,481
2022-23	$30,054,284	$8,858,376	$428,803	$39,341,462

[#] Other funds comprise amounts received for the Graduate Program, Clinical Training Program, Voluntary Graduate Program and other minor one-off projects funded from non-discretionary revenue. From 2016-17 onwards this funding was predominately from universities for student placement programs.

Source: Department of Health

1.12 As shown in Table 1, the decrease in expenditure funded by the Australian Government from 2019-20 was due to COVID-19. In March 2020, OHST was restricted to providing only emergency care which resulted in a loss of Medicare revenue from the Australian Government. This meant OHST overspent its Tasmanian Government initial budget allocation that year to cover its operating costs.

1.13 Approximately 3% of the recurrent funding from the Tasmanian Government is used for oral health promotion and preventative programs, such as Healthy Smiles for Two, support school screening, 'spit don't rinse' messages, delivery of the Fissure Sealant and Fluoride Varnish Program and working with various organisations to promote healthy food and drinks.

1.14 Between November 2012 and June 2023, the Australian Government provided funding under the following agreements:

- Other Health Payments – National Partnership Agreement on Treating More Public Dental Patients, 27 November 2012 to 31 December 2015
- Other Health Payments - National Partnership Agreement on Adult Public Dental Services, 3 December 2015 to 30 June 2016
- National Partnership on Public dental Services for Adults, 4 October 2017 to 30 June 2020
- Public Dental Services for Adults - 2021-22, 25 August 2021 to 30 June 2022
- Public Dental Services for Adults - 2022-23, 15 December 2022 to 30 June 2023.

Funding provided under these agreements was activity-based funding for adult dental services. Activity based funding is a method of funding health services based on amount and type of activity.

1.15 The Child Dental Benefit Schedule is a means-tested Commonwealth program which enables public and private dental practitioners to claim funding benefits on behalf of the patient if they consent for their treatment to be bulk billed to Medicare. This program enables OHST to provide free dental care to all Tasmanian children. Unlike

the Federation Funding Agreement, funding from the Child Dental Benefit Schedule is not driven by performance benchmarks.

1.16 Adults are required to pay for some of their dental treatment through a co-payment contribution. Table 2 summarises the co-payment amount for dental care and dentures.

Table 2: Co-payments for adult dental services

Type of dental care	Co-payment
General dental care, such as a check-up, scale and clean, and fillings	$45 per appointment
Priority dental care to treat an urgent single dental problem	$45
Some high-cost treatments incur additional co-payments	Discussed with the client
Type of denture	**Co-payment**
Full upper and lower	$393
Full upper or full lower	$222
Partial denture	Discussed with the client
Other denture services	Discussed with the client

Source: adapted from OHST, as at 1 July 2022

1.17 No co-payment is required for:

- adults seeking general anaesthetic in a public hospital
- adults treated for general or episodic care at Risdon Prison Dental Clinic (although they are required to pay a dentures co-payment)
- asylum seekers requiring general care or dentures as long as their immigration status remained unchanged.

Impact of COVID-19

1.18 COVID-19 had immediate and ongoing impacts on service delivery for OHST. From 30 March 2020 to around mid-May 2020, clinical activity was restricted to emergency care to minimise the risk of transmission from the virus. This meant OHST temporarily delayed treatment for clients waiting for general care. The impact of COVID-19 on OHST's capacity to meet demand is explored in Chapter 4.

Oral health plans

Oral Health Promotion Strategic Plan 2017-2022

1.19 The goal of OHST's Strategic Plan was to improve the health of Tasmanian people through better oral health, by:

- supporting programs that will help all Tasmanians manage their wellbeing through good oral health
- prioritising Tasmanians most in need
- focusing on early intervention and prevention
- making healthier choices easier for people.

1.20 The Strategic Plan envisaged working with partners and environments that support good oral health, by:

- building a greater understanding and knowledge of good oral health and how it fits into their role
- working towards oral health being integrated into general health and education programs and curriculums
- supporting programs that make healthy choices easier and working with partners who also address common lifestyle risks.

Strategic Priorities 2023-24

1.21 OHST prepared *Strategic Priorities 2023-24* during 2023, in which it outlined its approach to improving the oral health and wellbeing of all Tasmanians.[6] The priorities included actions under the following strategic themes:

- continuing to respond to infectious respiratory diseases
- improving access and patient flow across our health system
- delivering care in clinically recommended times
- reforming the delivery of care in our community
- prioritising mental health and wellbeing
- building the infrastructure for our health future
- build and develop a sustainable and positive workforce we need now and for the future
- strengthen governance, risk and financial management, performance and accountability
- strengthen Clinical Safety, Quality and Regulatory oversight.

[6] Strategic Priorities 2023-24 was not publicly available at the time of the audit.

Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015-2024

1.22 The goal of the *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015-2024* (National Oral Health Plan) was to improve health and wellbeing across the Australian population by improving oral health status and reducing the burden of poor oral health.[7]

1.23 The National Oral Health Plan outlined the need to provide additional, targeted strategies to overcome inequalities experienced by the following priority populations:

- people who are socially disadvantaged or on low incomes
- Aboriginal and Torres Strait Islander people
- people living in regional and remote areas
- people with additional and/or specialised health care needs.

These groups experience the greatest burden of poor oral health and the most significant barriers to accessing oral health care.

1.24 People who are socially disadvantaged or on low incomes include people on government assistance, the unemployed, the socially isolated and people with low English proficiency. This priority population experiences barriers to accessing oral health care such as access (cost), transport and oral health literacy.

1.25 Aboriginal and Torres Strait Islander people also experience barriers with cost and transport but face cultural barriers when accessing health services.

1.26 People living in regional and remote areas have poorer oral health compared with those living in major cities. This priority population was more likely to have reduced access to fluoridated water and report issues with cost of services and lack of affordable or accessible transport.

1.27 There are people with additional and/or specialised health care needs for whom oral health is only one among a number of other health care issues. This includes people living with mental illness, people with physical, intellectual and developmental disabilities, people with complex medical needs, and frail older people. These people experience many of the same barriers as other priority populations. However, the National Oral Health Plan notes workforce competency as an issue with a shortage of dentists skilled in Special Needs Dentistry. As of January 2024, OHST has employed a Specialist in Special Needs Dentistry to coordinate and deliver care for patients with additional needs across Tasmania.

[7] COAG Health Council, Australian Government (2015), *Healthy mouths, healthy lives – Australia's National Oral Health Plan 2015–2024*, accessed 16 January 2024. https://www.health.gov.au/sites/default/files/documents/2022/04/healthy-mouths-healthy-lives-australia-s-national-oral-health-plan-2015-2024.pdf

Other reviews relevant to this audit

Tasmanian Legislative Council Government Administration Committee "A" *Report on Rural Health Services in Tasmania*[8]

1.28 This report, tabled in October 2022, reviewed health outcomes and access to community health and hospital services for people living in rural and remote Tasmania. This included the availability and timeliness of dental services and barriers to access. The report found that, compared to urban areas, people living in rural areas waited longer and had poorer access to dentists and other oral health professionals.

The report made 13 recommendations for the Tasmanian Government. These included strategies to help address the poor health outcomes experienced by people living in rural and regional areas as well as workforce shortages. Other recommendations focused on collaboration with the Australian Government on funding models and avoiding duplication of services and/or costs in areas where health services attract both Tasmanian and Australian Government funding.

Australian Select Committee into the Provision of and Access to Dental Services in Australia: Final report[9]

1.29 On 8 March 2023, the Senate resolved that the Select Committee into the Provision of and Access to Dental Services in Australia (the Committee) be established. The Committee inquired into and reported on:

- the experience of children and adults in accessing and affording dental and related services
- the adequacy and availability of public dental services in Australia, including in outer-metropolitan, rural, regional and remote areas
- the interaction between Commonwealth, state and territory government legislation, strategies and programs in meeting community need for dental services
- the provision of dental services under Medicare, including the Child Dental Benefits Schedule
- the social and economic impact of improved dental healthcare
- the impact of COVID-19 and cost-of-living crisis on access to dental and related services

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[8] Parliament of Tasmania, Sub-Committee Rural Health Services Inquiry (2022), *Report on Rural Health Services in Tasmania*, accessed 6 December 2023. https://www.parliament.tas.gov.au/__data/assets/pdf_file/0026/59723/final20report20sub-committee20rural20health20services20in20tasmania202520october202022.pdf

[9] Parliament of Australia (2023), *Select Committee into the Provision of and Access to Dental Services in Australia: Final report*, accessed 6 December 2023.

- pathways to improve oral health outcomes in Australia, including a path to universal access to dental services
- the adequacy of data collection, including access to dental care and oral health outcomes
- workforce and training matters relevant to the provision of dental services
- international best practice for, and consideration of the economic benefit of, access to dental services
- any related matters.

1.30 The final report was released on 30 November 2023 and made 35 recommendations. The Australian Government had not responded to the recommendations as at the end of May 2024.

2. Were early intervention and preventative programs effective?

Early intervention and preventative programs are important in reducing the prevalence of dental disease and the likelihood of being hospitalised for dental conditions. Early intervention and preventative programs include clinical prevention programs such as the application of Fissure Sealant and Fluoride Varnish, referral pathways for a dental check-up at a OHST clinic and programs that promote practising good oral hygiene and discourage intake of sugary foods and drinks.

In this chapter we assess whether OHST:

- Implemented strategies to provide early intervention and preventative programs
- engaged in effective partnerships to target oral health early intervention messages and encourage referrals for dental care
- supported access to oral health services for the nationally identified priority populations.

Chapter summary

The current funding model for oral health services drives activity towards treatment and reduces the capacity for effective early intervention and preventative programs. This led to OHST adopting a partnering approach to deliver early intervention and preventative programs. While these programs were focused on young children, pregnant women and nationally identified priority populations, the targeting of early intervention and preventative programs was at times ad hoc and not supported by an engagement strategy to support implementation, and OHST's monitoring of these programs did not measure their effectiveness in delivering expected outcomes. We also found that barriers to accessing some early intervention programs led to low referral rates and uptake, limiting their effectiveness.

The data shows that early intervention and preventative programs have helped improve the oral health of children, as measured by dmft. Of concern, however, is the decrease in check-ups for children particularly in the North and North West of Tasmania.

OHST was proactive in exploring partnerships with Tasmanian and Australian government agencies and various organisations to deliver early intervention programs targeting priority populations, such as concession card holders who may be socially disadvantaged or on low incomes. This enabled OHST to have a broader reach given their limited financial and staffing resources for early intervention and preventive activities.

The funding model for oral health services drives activity towards treatment and reduces the capacity for effective early intervention and preventative programs

2.1 The funding model for oral health services is focused on treatment rather than prevention. Due to the capacity of the public dental system in Tasmania, this funding was largely focused on treating problems, with a small proportion of Tasmanian Government funding allocated for prevention.

2.2 The Tasmanian Government funds OHST around $20 million annually and around 3% of this is used for oral health promotion and preventative programs. These programs included Healthy Smiles for Two, support school screening, Lift the Lip, 'spit don't rinse' messages, delivery of the Fissure Sealant and Fluoride Varnish Program and partnering with various organisations to promote healthy food and drinks.

2.3 Australian Government funding for oral health services is activity-based and focused on providing appointments for adults and not for early intervention and prevention. Tasmania is a party to the Public Dental Services for Adults funding agreement with the Australian, state and territory governments. OHST's capacity to deliver services was limited by performance benchmarks that must be achieved in order to secure funding. The rolling nature of these agreements caused uncertainty with long-term planning and recruitment.

2.4 OHST is a member of the National Dental Reform Oversight Group which was established in March 2023 to investigate funding reform options. This work was underway at the time of our audit.

Resource constraints led to OHST adopting a partnering approach to deliver early intervention and preventative programs

2.5 The constrained funding model to deliver early intervention and preventative programs resulted in the responsibility for the management and communication of oral health promotion engagement and activities across Tasmania being assigned to a single OHST staff member. This led to OHST adopting a partnering approach for the delivery of early intervention and preventative programs.

2.6 This partnering approach involved the establishment of referral pathways and the distribution of promotional materials and dental packs. This enabled OHST to reach a wider audience than would have otherwise been possible using its own internal resources.

2.7 OHST prioritised its early intervention programs and delivery of consistent, evidence based oral health messaging towards young children and pregnant women in

accordance with its Strategic Plan. Most of these programs were delivered by the Department of Health and non-government organisations (NGOs) to support good oral hygiene practices in the community, including schools. OHST worked with and built the capacity of health professionals, midwives, school nurses and NGOs that engaged with priority populations to deliver oral health early intervention messages into curriculums and encourage referrals for dental care. A few of these partnerships were formalised in Working Together Agreements. Examples of these programs include:

- School Food Matters (formerly Tasmanian School Canteen Association): this program is focused on encouraging school children to drink water and reduce their intake of sugary foods by providing nutritious food and health messaging in school canteens and at community events. OHST was fundamental in establishing the Tasmanian School Canteen Association and has continued to support and develop initiatives under the Tasmanian School Canteen banner.
- Move Well Eat Well Primary School and Early Years program: OHST worked with Public Health Services on joint key messages related to oral health, which included this program. This included information exchange and promotion of key messages from OHST through Public Health Services materials, websites and training programs. This partnership helped support communication of key messages on oral health.
- Lift the Lip: OHST worked with Lift the Lip to build the oral health skills of child health professionals to promote good oral practices, promote dental visits from 12 months and to recognise early-stage decay that is supported with a priority referral pathway. This program reaches up to 6,000 children annually and can be used to target high-risk children.
- School Health Nurse Program: OHST worked with school health nurses to collaborate on key joint messages and referral pathways. The program supported the Lift the Lip program which equipped child health nurses to recognise early signs of tooth decay and make a referral to OHST when necessary. Child health nurses also advocated and promoted OHST's preventative programs to school communities.
- Healthy Smiles for Two: This program provided priority access to dental care for eligible pregnant women by referral to OHST from a health professional. The program aimed to embed oral health into general health assessment and encouraged clients to practice good oral hygiene during pregnancy. OHST provided training for health professionals on making referrals and to promote the program.

2.8 OHST also partnered with the Australian Government on preventative programs targeting Aboriginal organisations. This included the development of a Working Together Agreement with Connected Beginnings, an Australian Government grants program supporting Aboriginal and Torres Strait Islander children from 0-5 years to gain the best start in life, to assist with oral health messaging and sharing information

on access to dental services for Aboriginal children. This program is detailed further in the next section.

2.9 Whilst oral health promotion activities are aligned with the Strategic Plan and identified populations most in need, the targeting of early intervention and preventative programs was at times ad hoc and not supported by an engagement strategy to support implementation. Most of the Working Together Agreements described above are focused on the sharing of information with few having fixed check-in points. A few of the organisations involved in running these programs were not obligated to provide OHST with a report on progress. This limited OHST's understanding on whether the programs were working as intended. OHST is in the process of developing an engagement strategy at the time of the audit. Reporting and monitoring of partnerships is explored further in Chapter 5.

Given constrained resources OHST has explored different pathways and partnerships to target early intervention and preventative programs at priority populations

2.10 As outlined in Chapter 1, the National Oral Health Plan details the 4 priority populations that face the most disadvantage when accessing oral health care.

2.11 Most of OHST's activity is directed towards treating children and eligible adults with a Pensioner Concession Card or Health Care Card. OHST advised that many of these people are already categorised into one or more priority population groups. For example, concession card holders are likely to be socially disadvantaged or on low incomes. However, due to constrained resources, children from priority populations were the primary focus of early intervention programs.

2.12 While the families of these children may benefit from access to resources and oral hygiene advice, early intervention is more effective when it starts at a young age. For adults, access to preventative care, such as check-ups, is explored in Chapter 3.

2.13 OHST also partnered with the Australian Government on early intervention and preventative programs targeting Aboriginal and Torres Strait Islander people and people with additional and/or specialised health care needs.

People who are socially disadvantaged or on low incomes

2.14 OHST effectively targeted early intervention and preventative care towards people who are socially disadvantaged or on low incomes. These included high-risk children, and families that may struggle with oral health literacy. OHST partnered with school-based early intervention programs and also managed referrals to capture children and their families that required information and support on maintaining good oral health.

2.15 OHST worked with Child and Family Learning Centres, the Launch into Learning Program and the Move Well Eat Well program to target preventative programs towards socially disadvantaged children and their families. OHST partnered with Public

Health Services staff involved in the Move Well Eat Well program to build their capacity and ensure oral health messages were effectively targeted to the schools and communities they worked in.

2.16 The Fissure Sealant and Fluoride Varnish Program targeted specific school year groups, children in out of home care, and children who had not previously been seen for public dental care. However, as explored later in this chapter, the effectiveness of this preventative program was impacted by COVID-19 and the low uptake resulted in children missing out on treatment. appointments and recall visits for children assessed as high-risk

2.17 OHST managed recall[10] appointments for high-risk children and children referred for the Lift the Lip program through the Telehealth Prevention Program. This program enabled OHST to effectively communicate early intervention messages with the parents and carers of high-risk children without the need to attend a clinic, unless urgent or emergency care was required. It enabled OHST to provide these families with oral health promotion resources and identify possible clinical needs. It was also effective in triaging and responding to referrals made through the Lift the Lip program. This program is not currently available. OHST will consider reimplementing this program when the service has increased its staff capacity.

People living in regional and remote areas

2.18 OHST worked closely with the RFDS to help facilitate access to dental care for people living in rural and remote areas. OHST signed a Memorandum of Understanding (MoU) with the RFDS in September 2021 to provide dental care in select locations. This was undertaken through the RFDS Mobile Dental Program which targeted rural and remote communities and areas with high social disadvantage. This program was designed in consultation with OHST and other organisations with eligibility determined by whether the client resided in the area where the program was delivered.

2.19 The RFDS Tasmania's funding model enabled them to provide dental care for both concession and non-concession card holders in the areas they visited. This model was focused on removing barriers for dental care for people living in rural and remote areas and providing a complete course of care. The RFDS commenced service delivery in the West Coast, Huon Valley and Central Highlands in August 2021, with a contract formally entered into between OHST and RFDS in September 2023.

Aboriginal and Torres Strait Islander people

2.20 Approximately 5.4% of the Tasmanian population (30,000 people) identify as being Aboriginal and/or Torres Strait Islander.[11] According to OHST, approximately 10% of clients seen in 2022-23 were Aboriginal and/or Torres Strait Islander.

[10] Recall refers to scheduled periodic oral examinations, commonly known as check-ups. For children assessed as high-risk, a check-up should occur every 6 months.

[11] Tasmanian Department of Health (2023), Submission 44: Select Committee into the Provision of and Access to Dental Services in Australia, p.7, accessed 6 February 2024.

2.21 According to the Annual Report 2020 & 2021 on the Aboriginal Cultural Respect Across THS Action Plan 2020-2026 there were 2,400 Aboriginal people in 2018-19 who needed dental care but did not access it due to dental services not being culturally appropriate.[12] While these statistics do not differentiate between public and private dental services, it provides lessons for OHST to ensure that its services are culturally appropriate. Compared to other health services, cost was also a significant barrier for Aboriginal people not visiting the dentist. While there were initiatives outlined in the Annual Report to make services more culturally appropriate, further collaboration was needed to address barriers faced by many Aboriginal people.

2.22 OHST services are subsidised with a co-payment to minimise the barrier of cost to accessing public dental services. OHST staff undertook cultural awareness training to provide culturally sensitive and inclusive dental treatment and care. Furthermore, OHST was improving partnerships with local Aboriginal Community Organisations and implementing actions from the Aboriginal Cultural Respect Across THS Action Plan 2020-2026.

2.23 OHST has a partnership with the Tasmanian Aboriginal Centre and the Connected Beginnings program, which targeted Aboriginal children aged 0-5 and their families. This program is co-funded and administered by the Australian Department of Health and Department of Education. The kutalayna Health Centre in Bridgewater is part of Connected Beginnings and staff worked together to help Aboriginal children and their families navigate health services, including dental. For example, the Warm Referrals initiative helped provide children and their families with support accessing oral health care. OHST worked with kutalayna to schedule appointments for Aboriginal children and reduce the stigma and fear associated with visiting the dentist.

2.24 The kutalayna Health Centre in Bridgewater became the first Tasmanian site for Connected Beginnings in 2018, and in 2021 the Australian Government committed additional funding to expand the program to 50 sites across Australia, including Burnie and George Town. While Connected Beginnings has expanded to 3 sites across Tasmania, some Aboriginal communities in other areas of Tasmania may not be able to access these services. To address this, OHST engages with Aboriginal communities in other areas by attending local events to build awareness of oral health messages, provide resources on engagement, information sharing and distributing dental packs.

2.25 As shown in Figure 3, the number of Aboriginal and Torres Strait Islander children seen by OHST for dental care has increased in all regions since 2013-14. OHST saw a total of 3,391 Aboriginal and Torres Strait Islander children in 2013-14 and 5,161 in 2022-23, an increase of 52%. This can be contrasted with the decreases in all children seen by OHST for dental care for the corresponding period, as shown in Figure 5.

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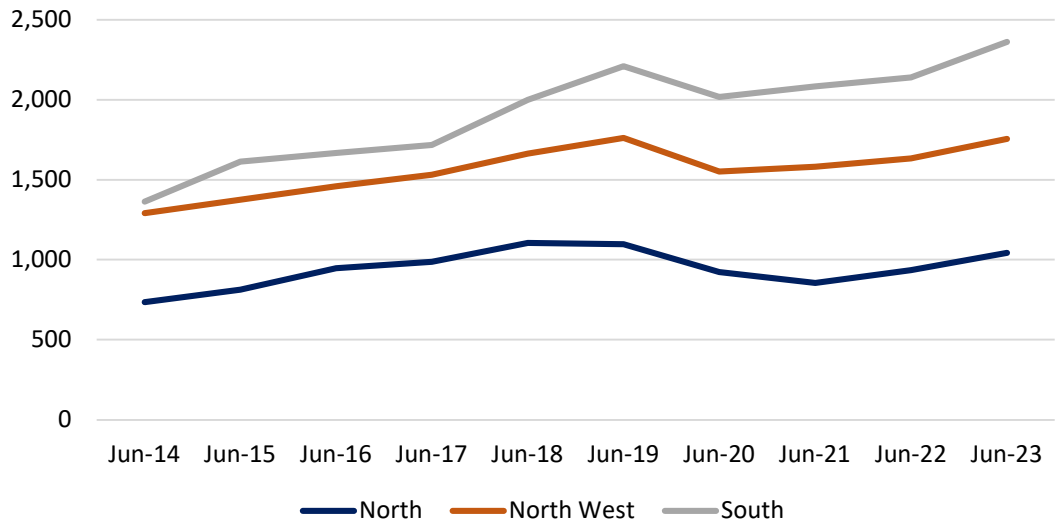
[12] Tasmanian Department of Health, *Improving Aboriginal Cultural Respect Across Tasmania's Health System Action Plan 2020–2026: Annual report 2020 & 2021*, p.88, accessed 15 January 2024. https://www.health.tas.gov.au/sites/default/files/2023-09/doh_annual_report_on_improving_aboriginal_cultural_respect_action_plan.pdf

Figure 3: Number of Aboriginal and Torres Strait Islander children seen by region, 2013-14 to 2022-23



Source: Tasmanian Audit Office analysis of OHST data

2.26 Determining the proportion of Aboriginal and Torres Strait Islander children seen out of the Tasmanian population is complicated by the age clusters used by the Australian Bureau of Statistics (ABS). ABS data for Aboriginal and Torres Strait Islander children was restricted to age clusters 0-15 or 0-19 years of age. We therefore estimated the population of Aboriginal and Torres Strait Islander 0-17 age cohort. This estimate was used to indicate the proportion of children seen by OHST, which was approximately 36% in 2015-16 and 35% in 2020-21.

2.27 ABS data for Aboriginal and Torres Strait Islander children was limited to 2015-16 and 2020-21, with the population growing by 12% between these 2 time points. Over the same period, the number of Aboriginal and Torres Strait Islander children seen by OHST increased by 11%. This indicated that OHST increased its service offering in line with the population increase.

People with additional and/or specialised health care needs

2.28 OHST has sufficient treatment options and programs available to support adults and children with additional and/or specialised health care needs. Dental treatment under general anaesthesia or conscious sedation is also available for these people upon meeting certain criteria. Access to general anaesthesia has been identified as a limiting factor to treat these patients.

2.29 OHST's Special Care Dental Unit provides dental treatment for patients with a complex medical condition that poses a risk to the delivery of routine dental care or due to undergo medical interventions that require a dental assessment. The Special Care Dental Unit also provides dental treatment to patients that have an acute dental issue while undergoing some form of medical treatment. This may include mental health patients and terminally ill patients. In 2022-23, OHST treated 2,227 patients at the Special Care Dental Unit.

2.30 OHST works with support schools and provides dental care for students with a disability. This program was designed to make dental assessment more comfortable and accessible for these students through cooperation with school staff. OHST staff undertake autism training to increase understanding for working with students with additional needs. OHST also employ a Special Needs Dentist to educate staff and support staff and to provide dental care to patients with additional needs.

2.31 Since 2020, OHST has participated in the Primary Care Enhancement Project pilot in partnership with the Australian Department of Health. The pilot was designed to help improve health literacy of people with an intellectual disability and equip health professionals with resources to deliver better care. The Clinical Director OHST presented at a number of forums for Primary Health Tasmania to build the oral health capacity of primary care professionals. This included encouraging them to check the oral care of clients with an intellectual disability and refer to OHST as required. This collaboration helped with early identification of dental issues in people with an intellectual disability, as they have a higher incidence of poor oral health compared to the general population.

Access to water fluoridation for people living in regional and remote areas is an important preventative measure

2.32 TasWater manages and controls community water fluoridation in Tasmania with the Department of Health providing regulatory oversight. According to Public Health Services, 81% of the Tasmanian population in 2020-21 had access to reticulated water, of which, 99% had access to fluoridated drinking water. However, some rural and regional local government areas do not have a reticulated supply and therefore cannot access fluoridated water. This meant there were limitations on OHST reporting in determining whether or not people presenting for dental treatment had access to fluoridated water or not.[13] Tasmania's performance on access to fluoridated water comparative to other states and territories is explored in Chapter 5.

[13] Public Health Services (2021), *Fluoridation Committee 2020-21 Annual Report*, p.13, accessed 29 February 2024. https://www.health.tas.gov.au/sites/default/files/2022-07/environmental_health_fluoridation_committee_annual_report_2020-21_doh_tasmania.pdf

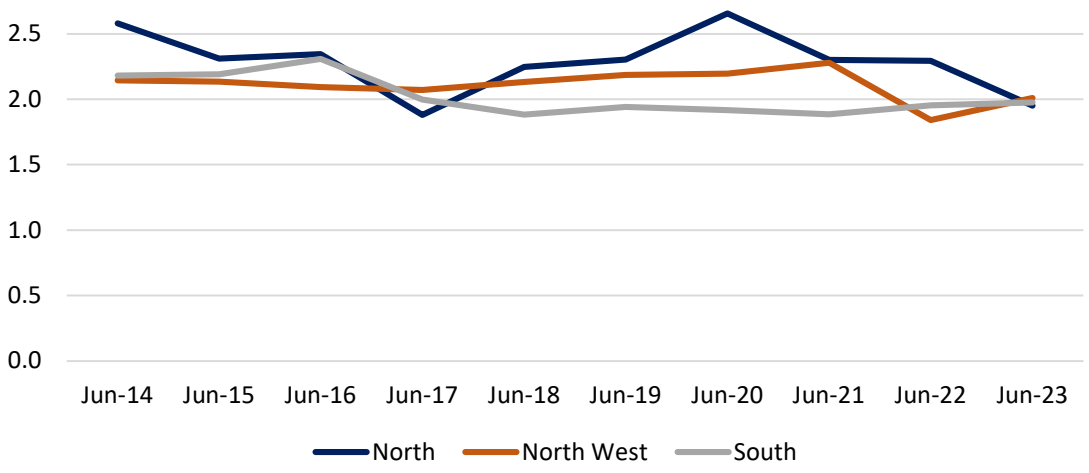
Data analysis shows oral health of children has improved since 2013-14, but declining attendances may be masking the true position

The mean dmft measure for children has reduced across Tasmania's three main regions since 2013-14

2.33 OHST used dmft to measure the oral health status of children. A lower dmft indicates a better oral health status.

2.34 We examined trends in the mean dmft of children in Tasmania from 2013-14 to 2022-23. The mean dmft recorded for all children at 6 years of age decreased in all regions, with all regions recording a similar rate of dmft as at June 2023. Figure 4 shows that the North was most variable over the period and typically maintained the highest rate of dmft, while the South most consistently maintained the lowest rate of dmft. OHST advised the lower rates of dmft observed in the South may be due to more children under 5 being seen and the success of early years programs in the region.

Figure 4 Mean dmft for all children at 6 years of age by region, 2013-14 to 2022-23



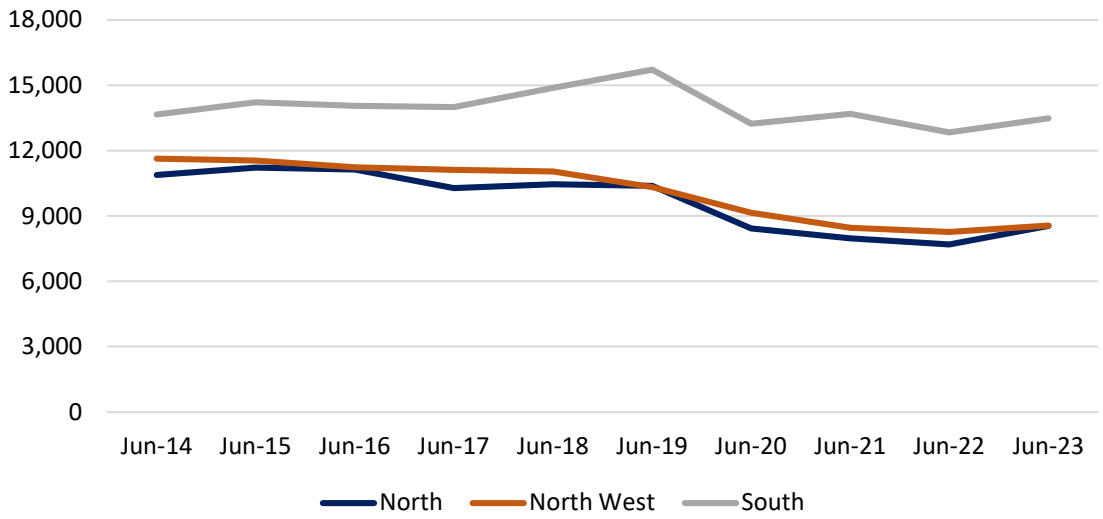
Source: Tasmanian Audit Office analysis of OHST data

The improvements in the dmft measure may be attributed to fewer children being seen for dental treatment, particularly in the North and North West

2.35 The improvements in the mean dmft measure may be attributed to fewer children being seen for dental treatment in some regions since 2013-14.

2.36 The number of unique[14] children seen by OHST has decreased since 2013-14. This decrease was most significant in the North and North West and can be partially explained by a decrease in the population reported in ABS census data. ABS data shows the number of children living in the North and North West decreased by 5% in 2011 and 10% in 2021.

Figure 5: Number of unique children seen by region, 2013-14 to 2022-23



Source: Tasmanian Audit Office analysis of OHST data

A concerning trend is that fewer children are attending regular check-ups

2.37 OHST has a protocol to manage appointments and recall visits for children assessed as high-risk. The protocol aims to deliver services to these children within the recommended timeframe based on risk:

- High-risk: Patient to have a dental check-up every 6 months.
- Medium-risk: Patient to have a dental check-up every 12 months.
- Low-risk patients: Patient to have a dental check-up every 18 months.

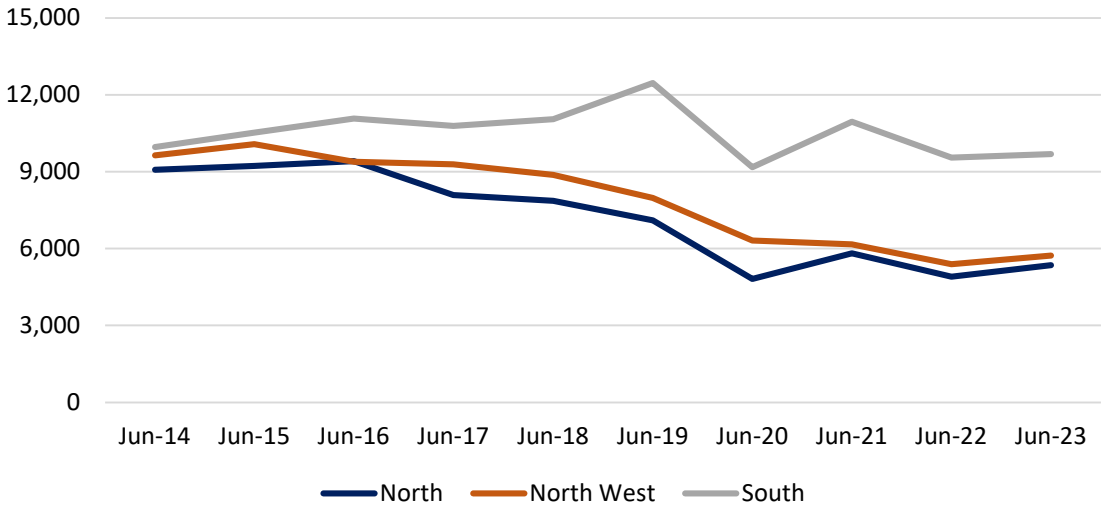
2.38 OHST identified that children assessed as high-risk were not being seen within the 6-month recall timeframe. For example, in 2018, only 10% of children assessed as high-risk were seen by OHST within a 4 to 8 month recall window. As part of its Strategic Priorities 2023-24, OHST investigated the implementation of a High-risk Recalls Project to help ensure children in need receive timely dental care. OHST has also identified paediatric models of care in their longer-term strategy to help deliver care to high-risk children.

2.39 We found there was a decrease in recall visits over the 10-year period. As shown in Figure 6, the South had the greatest resilience in maintaining the number of recall visits from 2013-14 to 2022-23. In contrast, the North and North West experienced a

[14] Unique children refers to the number of individual children seen by OHST. It does not refer to occasions of service which captures the number of appointments, including repeat appointments from the same child.

decrease of around 40% over the same period. There was a proportional relationship between the number of unique children seen and number of recall visits, this was most prominent in the North and North West regions. This means that the number of recall visits were highly dependent on the number of unique children seen. As the number of unique children seen decreased, so too did the number of recall visits.[15]

Figure 6: Number of recall visits by region, 2013-14 to 2022-23



Source: Tasmanian Audit Office analysis of OHST data

2.40 The decrease in recall visits in the North and North West was likely associated with difficulty in recruitment of oral health therapists in those regions. OHST reported the retirement of several dental therapists in these regions and have since faced challenges recruiting oral health therapists to replace them. This is also discussed in Chapter 4.

Barriers to accessing early intervention programs have led to low referrals and uptake, limiting their effectiveness

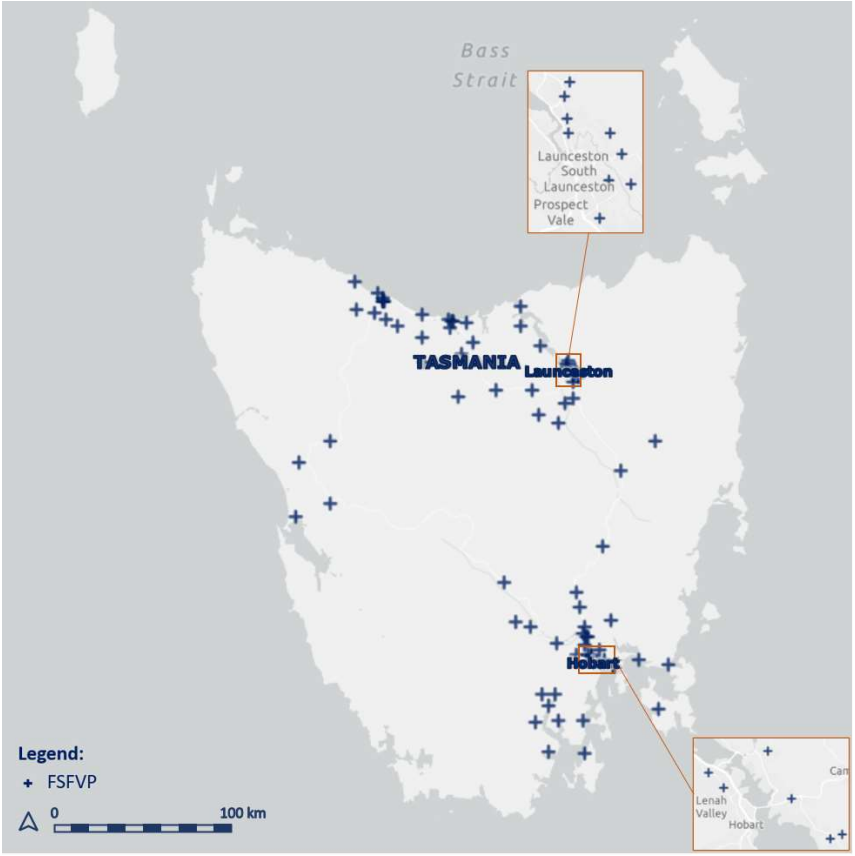
2.41 OHST prepared evaluation reports on 2 of its early intervention and preventative programs which were delivered internally with support from health professionals and participating schools. These included Healthy Smiles for Two and the Fissure Sealant and Fluoride Varnish Program. While OHST had partnership arrangements with various organisations for school-based preventative programs (explored earlier in this chapter), these were smaller scale and not managed by OHST.

[15] This conclusion was supported by the R-squared regression values of 0.91 in the North, 0.98 in the North West and 0.81 in the South. R-squared values range from 0 to 1. A value of 0 indicates that the independent variables do not explain any of the variability of the dependent variable, while a value of 1 indicates that the independent variables explain all of the variability.

Fissure Sealant and Fluoride Varnish Program

2.42 The Fissure Sealant and Fluoride Varnish Program is a preventative program which targeted schools in locations based on their Socio-Economic Indexes for Areas ranking.[16] The program aimed to deliver fissure sealants on newly erupted molars, which typically occurred on children aged 6 and 12 years of age. This program enabled OHST to screen children who have not accessed dental care or who have developed oral disease and refer them on to public or private dental care. This program also enables OHST to build relationships with schools and families and to provide evidence based oral health messaging. OHST prepared an evaluation report on the program which operated in 2019 and 2021.

Figure 7: Map showing location of schools targeted for the Fissure Sealant and Fluoride Varnish Program in 2019 and 2021



Source: Tasmanian Audit Office

2.43 According to the evaluation report, the program saw a total of 5,956 children across 80 schools in 2019, and 3,961 children across 68 schools in 2021. The program was performing against project objectives, but the reduction in the number of schools visited in 2021 compared to 2019, was impacted by COVID-19 and additional set up and pack down procedures from the newly implemented vans. OHST prioritised

[16] The Socio-Economic Indexes for Areas is a product developed by the ABS that ranks areas in Australia according to relative socioeconomic advantage and disadvantage. The indexes are based on information from the five-yearly ABS Census.

schools in 2021 that had the program cancelled in 2020. OHST planned to visit 84 schools in 2024.

2.44 This program enabled more children in the community to be screened, treated, and referred based on their dental needs. The report found that approximately 17% of children in both years had not previously been to an OHST clinic. Additionally, of the children seen, 39% (2019) and 35% (2021) of children were scheduled for follow-up appointments at an OHST clinic. However, there were barriers to the success of the program. While OHST worked closely with schools to schedule a follow-up appointment for children missed during the initial visit, some children failed to attend these appointments and resulted in reduced uptake and children missing out on treatment. Additional work by OHST and schools to encourage student attendance to both the program and follow-up appointments resulted in an increase in attendance.

2.45 The report included 10 recommendations to help improve the effectiveness of the program. OHST used dmft to measure the success and impacts of the program using select children that attended the program consecutively since 2015. However, OHST found this KPI failed to provide a broad perspective across the population and ultimately on the clinical effectiveness of the program. This impacted OHST's ability to understand the oral health of children particularly in areas of socioeconomic disadvantage.

Healthy Smiles for Two Pilot

2.46 OHST prepared an evaluation report on the effectiveness of the Healthy Smiles for Two Pilot in the North West. The pilot was delivered between 1 August 2016 and 31 December 2017. While this was an important preventative program for eligible pregnant women in the North West, the report found that the effectiveness of the pilot was impacted by the following factors:

- low referral rate and uptake
- staff turnover and limited understanding of the program
- cost of the co-payment
- oral health considered a lower priority by participants.

2.47 The evaluation report found that only 49 out of 279 eligible women attended an appointment with OHST during the pilot (an uptake rate of 17.6%). The report provided recommendations to inform planning for a statewide rollout and further improve the project.

2.48 One recommendation from the evaluation report was to provide ongoing oral health education and training for midwifery staff on the importance of oral health and to increase referrals to an OHST clinic. While there is evidence of training and engagement with health professionals on the program, referral rates have continued to be an issue since the pilot. We were also informed that dental care is seen as a lower priority for some pregnant women which has resulted in those referred failing to attend their appointment.

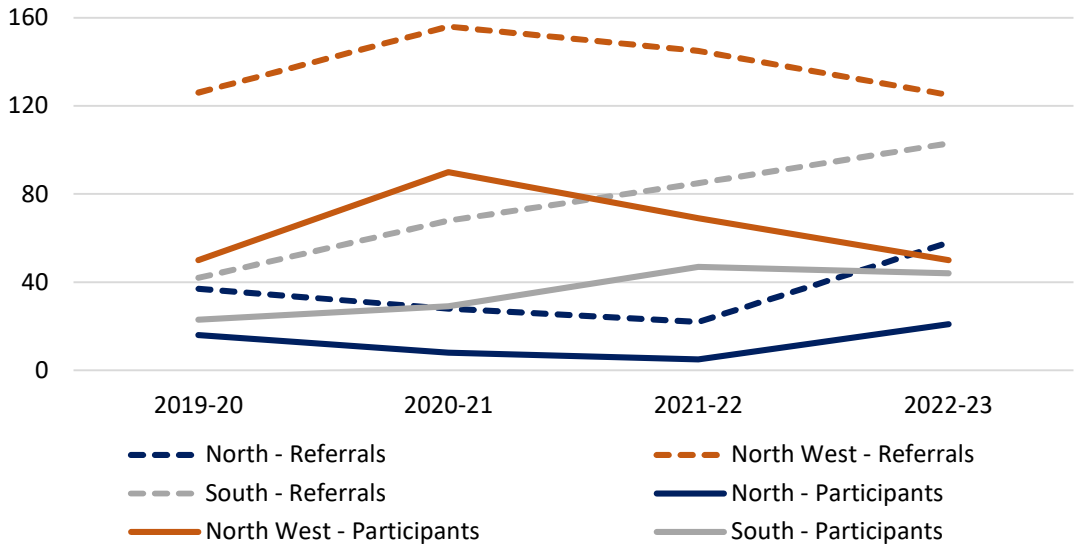
Healthy Smiles for Two statewide rollout

2.49 Low referral rates and uptake have continued to impact the effectiveness of Healthy Smiles for Two since the pilot concluded.

2.50 We analysed referral and participation data on Healthy Smiles for Two since it was rolled out statewide in September 2019 (as shown in Figure 8). From 2019-20 to 2022-23, 995 referrals for Healthy Smiles for Two were received by OHST which resulted in 452 participants, or an overall 45% participation rate statewide. From 2019-20 to 2022-23, 55% of referrals and 57% of participants came from the North West.

2.51 The higher number of referrals in the North West was likely attributed to the pilot and health professionals in that region being more familiar with the referral process.

Figure 8: Referrals and participants in Healthy Smiles for Two by region, 2019-20 to 2022-23



Source: Tasmanian Audit Office analysis of OHST data

2.52 In the North West, the number of referrals in 2022-23 reverted to the same level as 2019-20 with a marginal decrease from 126 to 125. In contrast, the South doubled its referrals over the same period from 42 to 103. The number of referrals and participants in the North declined from 2019-20 to 2021-22. However, the North finished the 4-year period with a 57% increase in referrals (37 to 58) in 2022-23.

2.53 While declining referral and participation rates have impacted the effectiveness of the program, it has captured people who have not had dental treatment for some time. OHST has implemented both phone call and SMS reminders to encourage uptake and minimise clients not attending appointments without advising OHST.

3. Were barriers to accessing oral health services managed effectively?

Managing barriers to accessing oral health services involves identifying and addressing the various obstacles that prevent individuals from accessing oral health care. Barriers can include financial constraints, geographic distance, lack of transportation, cultural and language barriers, and fear or anxiety associated with dental care.

This chapter assesses OHST's strategies for removing or reducing these obstacles to ensure equitable access to oral health services for all individuals, regardless of their circumstances.

Chapter summary

Effectively managing barriers to accessing oral health care is crucial for promoting equitable access to essential dental services and improving oral health outcomes for individuals and communities. Dental health plays a significant role in overall wellbeing, impacting not only physical health but also social, emotional, and economic aspects of life. However, various barriers can hinder individuals from accessing timely and appropriate dental care, exacerbating oral health disparities and inequalities.

One of the key reasons why it is important to address barriers to accessing oral health care is to ensure that everyone can maintain good oral health and prevent dental diseases. Barriers such as cost of oral health services, geographic distance to dental providers, cultural or language barriers and fear or anxiety can prevent individuals from seeking preventive care and timely treatment for dental problems. As a result, untreated dental conditions may progress to more severe stages, leading to pain, infection, tooth loss, and other adverse health outcomes. Effective management of barriers to accessing oral health care is essential for promoting health equity, preventing oral diseases, and improving the overall quality of life for individuals and communities.

OHST largely managed barriers to oral health services effectively.

The cost of the co-payment is a barrier to adults on low incomes accessing oral health care. In addressing this barrier, OHST has increased the transparency of payment plans and options on their website, continues to provide care for clients with unpaid balances and writes-off unpaid debts in extenuating circumstances.

OHST has addressed geographic and transport barriers by:

- engaging Community Transport Services Tasmania to provide support to clients wanting to attend non-emergency medical appointments
- establishing an Outsourcing Program to enable people to receive timely dental care with a nearby private provider where public services are not easily accessible
- liaising with the RFDS Tasmania, which provides oral health services in rural and remote areas of Tasmania from fixed and mobile sites.

OHST worked with Aboriginal organisations to help reduce cultural barriers in accessing oral health services. For example, OHST partnered with Connected Beginnings and Aboriginal communities to help Aboriginal children and their families navigate referrals and access to dental appointments. OHST also trained staff to engage and support culturally and linguistically diverse people and provided an interpreter service, either in-person, or through video or telephone services.

OHST has addressed fear and anxiety barriers by providing its staff with training to improve their engagement with clients at the dental clinic. OHST also has programs and dental treatment options (such as general anaesthetic and conscious sedation) available to support people who experience anxiety when accessing dental care.

Despite successes in addressing the abovementioned access barriers, OHST continues to face challenges in providing access to dental care for vulnerable groups, such as aged care residents and inmates in the Risdon Prison Complex. In addition, facilitating treatment in the public hospital system continues to be problematic for dental issues requiring general anaesthetic due to limited theatre availability and data sharing restrictions limiting the sharing of information pertaining to clients. On a positive note, the Conscious Sedation Pilot was successful in diverting clients from the general anaesthetic waitlist.

Cost is a barrier to accessing oral health care

3.1 We found the cost of the co-payment as a barrier for adults accessing oral health care. In addressing this barrier, OHST has increased the transparency of payment plans and options on their website, continues to provide care for clients with unpaid balances and writes-off unpaid debts in extenuating circumstances.

3.2 Dental care in Australia can be expensive, especially for those without private health insurance. Many low-income individuals and families may struggle to afford dental treatment. The financial co-payment has been identified as a barrier for adults accessing oral health services.

3.3 The Tasmanian Council of Social Service informed us that adults eligible for public oral health services, but on low incomes, still faced disadvantage when accessing dental care. These people prioritised food, housing, heating and health care above dental care. Furthermore, people that are financially insecure may be less likely to seek dental care due to the cost of the co-payment.

3.4 The Tasmanian Population Health Survey found that over a quarter of Tasmanians in 2019 delayed a visit to the dentist due to cost. This was consistent across regions. Furthermore, adults with children aged 15 years and under were more likely to defer a dental visit because of cost (36.3%) compared to Tasmanians who do not have children (23.4%).[17] While dental care was free for children, the survey highlighted the financial pressures faced by some adults.

[17] Tasmanian Department of Health (2020), *Report on the Tasmanian Population Health Survey 2019 (Published 2020)*, p.80, accessed 28 February 2024.

3.5 OHST conducted a consumer survey in 2019 to evaluate the experience of clients engaging with its services. This enabled OHST to identify potential barriers to access. The survey identified that only 56% of respondents knew they could set up a payment plan for co-payment costs. Following the survey, OHST published information on the co-payment and payment plans on their website and instructed staff to inform clients of payment options.

3.6 OHST continues to care for clients with unpaid balances and has processes to write-off unpaid debts in extenuating circumstances.

The OHST Outsourcing Program and Royal Flying Doctors Service assisted OHST in responding to geographic barriers

3.7 People living in rural and remote areas often need to travel long distances for dental care. The cost of petrol, bus fares and limited public transport options, may discourage some from accessing treatment. OHST has addressed this barrier by:

- engaging Community Transport Services Tasmania to provide support to clients wanting to attend non-emergency medical appointments
- Establishing an Outsourcing Program to enable people to receive timely dental care with a nearby private provider where public services are not easily accessible
- liaising with the RFDS Tasmania, which provides oral health services in rural and remote areas of Tasmania from fixed and mobile sites.

The effectiveness of the Outsourcing Program and RFDS are discussed in further detail below.

The Outsourcing Program has assisted OHST in responding to geographical constraints, but funding uncertainty may result in increased demand for treatment

3.8 The Outsourcing Program enables OHST to offer eligible adults vouchers to access timely general care, Emergency and P1 care or denture services with a private provider. OHST also considered the proximity of the provider to the client's residential address and their capacity to accept the vouchers.

3.9 We found the program increased OHST's capacity to deliver appointments. This service enabled more appointments to be delivered by private providers, alleviating demand and waitlist pressure faced by OHST.

3.10 Recurrent funding for the Outsourcing Program was cut in 2019. However, OHST still has capacity to provide vouchers for those living in regional and remote areas requiring emergency dental care or dentures. OHST used part of the one-off funding of $5 million provided by the Tasmanian Government in 2020-21 to deliver more vouchers and appointments for eligible adults. While this funding was exhausted by 31

December 2023, OHST still occasionally receives one-off funding for vouchers. However, the uncertainty of the voucher system affects OHST's long-term planning and also impacts the operations of private providers. This is because they are unable to appropriately plan staffing and appointments required to meet this additional, short-term demand.

3.11 Ongoing uncertainty with funding for the Outsourcing Program meant that OHST managed treatment for all Emergency and P1 clients. This subsequently limited its capacity to provide general care.

3.12 OHST has previously undertaken client surveys cost/benefit analysis on the Outsourcing Program, but there has not been a thorough evaluation on its value and effectiveness.

The RFDS Tasmania helped manage demand for dental services in rural and remote areas

3.13 The RFDS receive funding from the Tasmanian and Australian Governments, as well as from sponsorships and donations, to deliver services. Since 2020-21, the Tasmanian Government has provided the RFDS with funding of $300,000 per year to provide oral health support in regional areas with an initial focus on the West Coast, Huon Valley and Central Tasmania. Like OHST, the RFDS has been affected by workforce challenges such as recruitment and retention. As at 30 June 2022, the RFDS had 6.5 FTEs working in dentistry in the Tasmanian section.[18]

3.14 The RFDS dental program in Tasmania commenced in May 2017. As noted in Chapter 2, oral health services provided by the RFDS were in rural and remote areas of Tasmania, operating from fixed and mobile sites. The mobile dental service targeted areas with socioeconomic disadvantage in consultation with OHST and other stakeholders. The RFDS use the Service Planning and Operations Tool to understand the level of demand for services and identify areas of need in rural and remote communities. The tool accounted for current and potential future service provision by RFDS and other providers and could help identify areas with unmet need or to fill short-term gaps in services.

3.15 The RFDS mobile dental service operates in Circular Head, Queenstown, Smithton, Swansea, Scottsdale and King and Flinders Islands. The RFDS also ran school education programs to promote good oral health and offered a dental visiting service to schools and aged care facilities. From May 2017 to the end of 30 June 2021, the RFDS saw 3,799 clients over 10,030 appointments, delivering 58,911 dental treatments.[19]

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[18] Royal Flying Doctor Service (2022), *Nationally Consolidated Statistics 2021-22*, p.24, accessed 7 March 2024. https://files.flyingdoctor.org.au/dd/annual_report/file/RN121_Statistics_Report_2021-22_D7.58b2.pdf?_ga=2.177143333.1494161558.1709759548-466072457.1705634280

[19] Royal Flying Doctor Service Tasmania (2021), *Annual Report 2020-21*, p.9, accessed 16 January 2024. https://files.flyingdoctor.org.au/dd/annual_report/file/RFDS_Tasmania_Annual_Report_2021.26e0.pdf?_ga=2.254088584.1494161558.1709759548-466072457.1705634280

3.16 The RFDS reported that the delivery of services in Tasmania was more efficient comparative to other states and territories, largely because Tasmania's population, although quite dispersed, is generally accessible by road, limiting the need for air travel. This helps increase the time available to deliver services.

3.17 OHST has mechanisms in place through its MoU with RFDS to monitor the partnership arrangement including sharing of activity data. This is explored further in Chapter 5.

OHST has strategies to help reduce cultural and language barriers

3.18 OHST worked with Aboriginal organisations to help reduce cultural barriers in accessing oral health services. For example, OHST partnered with Connected Beginnings and Aboriginal communities to help Aboriginal children and their families navigate referrals and access to dental appointments. Connected Beginnings staff provided transport for local Aboriginal children and their families to access dental appointments at the kutalayna Health Centre, or taxi vouchers for adults needing access to treatment at the Southern Dental Centre.

3.19 OHST trained staff to engage and support culturally and linguistically diverse people and provides an interpreter service. Interpreters primarily engaged in-person, or through video or telephone if an interpreter is not available in-person.

Support is provided for people who experience fear and anxiety when accessing dental care services

3.20 OHST acknowledges there are some people who may be fearful or anxious when accessing dental care services, and it provides staff with education and training on how to interact with these clients to help them feel welcomed and supported.

3.21 OHST provides an annual oral health screening program at the 3 support schools for children with specialised health care needs. The program is voluntary but requires agreement from child's parent or guardian. The program is conducted at the school rather than in a clinical setting and is supported by school staff, enabling participating students to receive an oral health check-up in a familiar and comfortable environment.

3.22 As discussed later in this chapter, OHST provides general anaesthesia and conscious sedation for people who experience dentophobia or with low level special needs. OHST also supports the Primary Care Enhancement Project pilot to help make oral health care accessible for people with an intellectual disability (as discussed in Chapter 2)

Access to dental care is restricted for some vulnerable groups

3.23 Due to resourcing constraints, OHST prioritises oral health care for those most in need. This means the service is unable to provide efficient and effective oral health care for some groups without impacting care provided to other priority populations. Examples of these groups of people are discussed below.

Residential aged care is poorly serviced

3.24 Frail older people are included within the priority population of people with additional and/or specialised health care needs. This includes people living in residential aged care. These residents are eligible for public oral health services, but this area was poorly serviced. Staff in aged care homes often fail to identify dental issues, resulting in the family initiating dental check-ups on behalf of the resident. There were also logistical challenges and barriers associated with getting frail older people to appointments at a dental clinic. The RFDS and the private sector have, to some extent, helped address this gap through their respective mobile programs.

3.25 The Australian Dental Association and Council on the Ageing Australia have advocated for a Senior Dental Benefit Schedule to be implemented by the Australian Government. This scheme would target people aged 50 years and over who are on low incomes or living in residential aged care. This would help support access to affordable dental care, address barriers to access and reduce the burden on the public health care system.

Dental care at Risdon Prison has been affected by lockdowns and resourcing

3.26 OHST's provision of dental care at Risdon Prison is guided by an MoU with Correctional Primary Healthy Services, which has responsibility for managing general healthcare for people in custody. Each correctional facility is staffed by Correctional Primary Healthy Services doctors and nurses with access to oral health services for clients at Risdon Prison managed by a Dental Services Coordinator. OHST provides education and training for these staff to help improve triage processes.

3.27 OHST provides a visiting dentist to Risdon Prison once a week. Prisoners accessing dental services are triaged and booked for an appointment. While outside the control of OHST, the frequency and continuity of dental care for prisoners has been affected by lockdowns and correctional officer shortages in the Tasmania Prison Service. According to a 2020 Prison Survey conducted by the Office of the Custodial Inspector, 64% of prisoners found dentists difficult to access.[20] Prisoners experiencing a dental emergency are either escorted to hospital or escalated on the waitlist to be seen by a OHST dentist on a scheduled visit.

[20] Office of the Custodial Inspector (2021), *Prison Surveys 2020*, accessed 16 January 2024. https://www.custodialinspector.tas.gov.au/__data/assets/pdf_file/0006/619980/Prison-Surveys-2020.pdf

3.28 OHST has installed a second one-chair clinic at Risdon Prison to maximise appointment availability in the event of a lockdown. In addition to this, OHST provides a prosthetist to manage prisoner dentures and free-up availability of visiting dentists.

OHST has mechanisms to cooperate with emergency departments on oral health presentations, but receives limited information from the hospitals on patients treated

3.29 OHST operates Monday to Friday during business hours, so clients who are triaged as emergency may be redirected to the nearest public hospital emergency department if OHST staff are unable to stay after hours to provide care. In the instance where OHST refers clients to the hospital, OHST notifies the triage doctor or nurse of the relevant emergency department to discuss the case and also books an appointment for the next day to provide for continuity of care between OHST and the hospital. According to Department of Health records, between July 2017 and June 2023, there were 8,302 presentations to emergency departments in Tasmania for dental conditions, this number does not distinguish OHST referrals from the general population. This included clients with a toothache or tooth decay, with a small number presenting for injuries which required oral and maxillofacial surgery.

3.30 OHST provides training for health professionals to manage patients presenting to emergency departments for dental conditions, but we found there was limited data sharing from hospitals with OHST. For example, if a client eligible for public oral health services was hospitalised, OHST would not automatically receive the discharge summary or other notification. This may prevent OHST from getting a real-time understanding of the demand for emergency dental care that they do not directly provide.

Access to general anaesthetic is hampered by limited access to operating theatres and data sharing restrictions

3.31 Treatment for dental issues under general anaesthetic can only be accessed in a hospital theatre, with the THS responsible for determining theatre availability. Upon receiving a referral from OHST, THS provide advice on the urgency of the client's condition before they are placed on the outpatient waiting list. The urgency categories and desirable timeframe for treatment are listed as follows:

- Category 1 – appointment within 30 days
- Category 2 – appointment within 90 days
- Category 3 – appointment within 365 days.

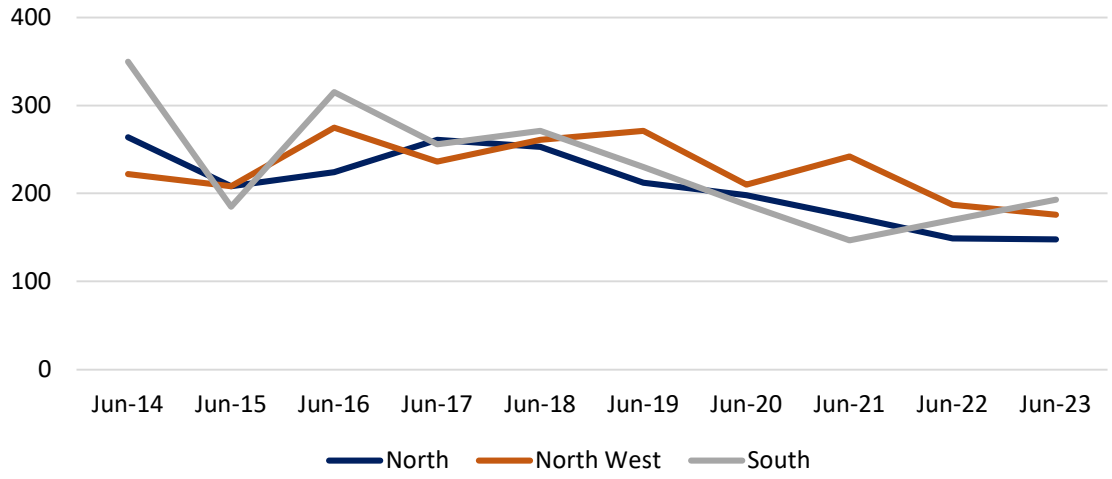
Dental treatment under general anaesthetic usually requires only one appointment.

3.32 While OHST has a patient management protocol to support children waiting for treatment under general anaesthetic, there was no protocol for managing adults requiring general anaesthetic. Unlike general care and dentures, general anaesthetic data for dental treatment is not reported on the *Health system dashboard*.

3.33 The public hospitals are responsible for managing, recording, and sharing waitlist data, such as urgency categories, with OHST. There was variable performance across the regions as to how patients were managed and how this information was collated and shared with OHST. OHST is unable to determine whether general anaesthetic clients across all regions are seen within clinically recommended timeframes. Based on data provided by THS:

- the South had no general anaesthetic data on time waited, as category data was not available in Titanium
- the North had partial data for Category 1 and complete data for Category 3, Category 2 data is captured under Category 3
- the North West had complete data for Category 1 and 3, and partial data for Category 2, which is otherwise captured under Category 3.

Figure 9: Number of general anaesthetic clients seen by region, 2013-14 to 2022-23



Source: Tasmanian Audit Office analysis of OHST data

3.34 In the South, there were barriers for some clients waiting for dental treatment under general anaesthetic at the Royal Hobart Hospital. In 2020 and 2021, close to half of the general anaesthetic theatre sessions were cancelled due to COVID-19, healthcare pressures and/or staffing constraints. While OHST had previously engaged the private sector to mitigate against cancellations, the service investigated alternative options to ensure clients were seen for treatment in a timely manner. OHST implemented the Conscious Sedation Pilot to help address these barriers which is discussed further in the next section.

3.35 As shown in Figure 9, the North saw an overall decline of 44% of general anaesthetic clients seen over the 10-year period, starting with 264 clients by end of 2013-14 to

148 clients by the end of 2022-23, the fewest compared to the other regions. However, we were informed by OHST that uptake for general anaesthetic treatment at the Launceston General Hospital was a challenge. This was due to limited hospital theatre availability and prioritisation of emergency care.

3.36 The North West also saw a decrease in general anaesthetic clients seen, but unlike the North and South, access to theatre sessions was reportedly not an issue. The North West Regional hospital cooperated with OHST to provide general anaesthetic treatment for clients assessed as high-risk.

The Conscious Sedation Pilot was successful in diverting clients from the general anaesthetic waitlist

3.37 In December 2022, OHST implemented the Conscious Sedation Pilot, where clients were treated in a dental chair at the Southern Dental Centre instead of in an operating theatre, so as to divert some clients in the South from the general anaesthetic waitlist.

3.38 The Australian Dental Association defines conscious sedation as, 'A technique in which the use of a drug or drugs administered to produce a state of depression of the central nervous system enabling treatment to be carried out, and in which:

- verbal contact with the patient can be maintained or the patient responds appropriately to tactile stimulation throughout the period of sedation, and
- the drugs and techniques used have a margin of safety wide enough to render unintended loss of consciousness unlikely.'[21]

Conscious sedation was only available for people over 16 years of age and excluded, for clinical reasons, people that were non-verbal or with significant and complex intellectual needs.

3.39 OHST's assessment of Phase 1 of the Conscious Sedation Pilot, conducted between 2 December 2022 and 30 June 2023, found that 51 people were treated at the Southern Dental Centre, diverting them from the Royal Hobart Hospital general anaesthetic waitlist. As conscious sedation was only available for clients in the South and excluded most children, there will still be continued demand for general anaesthetic and reliance on the major hospitals to provide timely dental treatment. OHST commenced Phase 2 of the Conscious Sedation Pilot on 1 July 2023 and will conclude on 30 June 2024. OHST expects that conscious sedation will continue beyond June 2024.

[21] Australian Dental Association (2023), Policy Statement 6.17 - Conscious Sedation in Dentistry, accessed 19 December 2023.

4. Was the demand for public oral health managed efficiently and effectively?

Managing demand for oral health services involves optimising the delivery of care to meet the needs of those seeking care efficiently and effectively. The demand for oral health services can be influenced by various factors, including population demographics, oral health needs, awareness of available services, socioeconomic factors, and cultural norms.

In this chapter we assess how well OHST managed demand by implementing strategies to optimise the utilisation of available resources, ensure timely access to care, and prioritise services based on clinical need and client preferences. We expected these strategies to include effective appointment scheduling, triaging clients based on urgency, workforce development, infrastructure improvements, and leveraging technology to streamline service delivery.

Chapter summary

The demand for adult general dental care has been steadily increasing since 2015-16 and the length of time adults wait for general dental care is increasing. The median wait time for adults on the general care waitlist statewide increased from 892 days (around 2.4 years) at June 2014 to 1,459 days (nearing 4 years) at June 2023. The number of adults on the general care waitlist needing episodic care is also increasing. Failing to address oral health demand and increasing waitlists can have negative consequences, impacting both individuals and the healthcare system.

OHST has implemented several strategies and measures to respond to the challenge of increasing demand. These include:

- implementing revised appointment processes and phone call and SMS appointment reminders to increase client appointment attendance
- conducting annual audits of the general care waitlist to remove clients no longer identified as needing treatment
- managing adults requiring time-critical episodic care efficiently
- employing risk treatment plans to identify and respond to workforce challenges
- engaging communication services firms to assist with advertising campaigns promoting the Tasmanian lifestyle for prospective applicants
- introducing a Graduate Program to help address staff shortages and deliver more appointments
- using data and projections to forecast demand and help make decisions about models of care, location, suitability and capacity of facilities and the resourcing of those facilities
- implementing digital dentures technology to reduce the number of appointments and wait times for dentures.

Given OHST's funding constraints, we found it managed the challenge of increasing demand efficiently and effectively through the implementation of the strategies and measures outlined above. We did identify, however, that OHST did not have a structured approach to facility management, with some dental clinics operating at capacity.

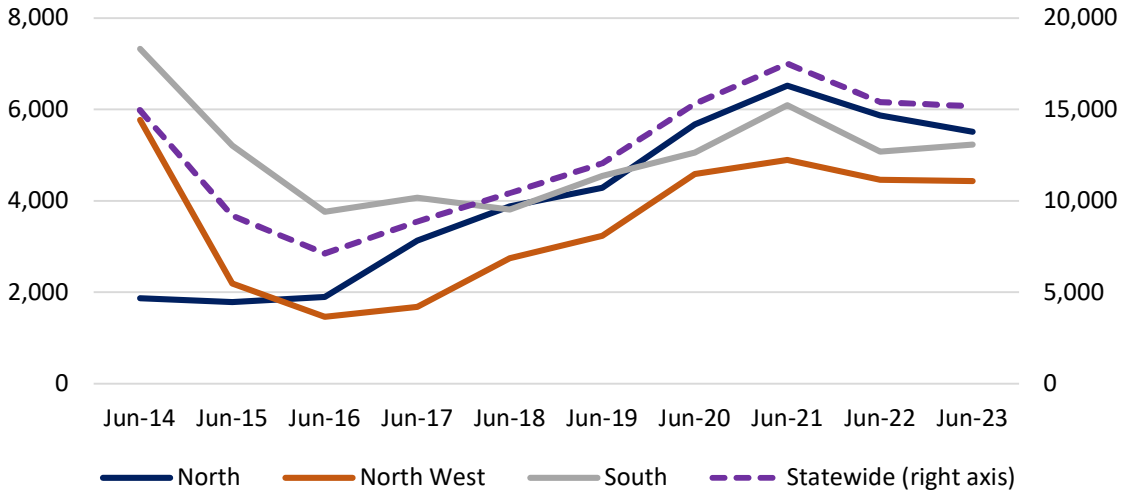
The COVID-19 pandemic had a significant impact on the operations of OHST, and the after-effects continue to affect the capacity of the service system.

The demand for adult general dental care has steadily increased since 2015-16

4.1 General dental care includes full dental assessment and then provision of a range of clinical services to stabilise and improve a patient's oral health. This may include treatments such as cleaning, restorations, extractions and more complex options such as tooth replacement, if deemed appropriate. Eligible adults seeking general care are usually placed on a waitlist. Waitlist information is publicly reported on the *Health system dashboard* and is updated monthly. As at December 2023, there were 13,763 adults on the general care waitlist.

4.2 Changes to the general care waitlist over a 10-year period by region and statewide, using data provided by OHST, are shown in Figure 10.

Figure 10: Number of adults waiting for general care by region (left axis) and statewide (right axis), 2013-14 to 2022-23



Source: Tasmanian Audit Office analysis of OHST data

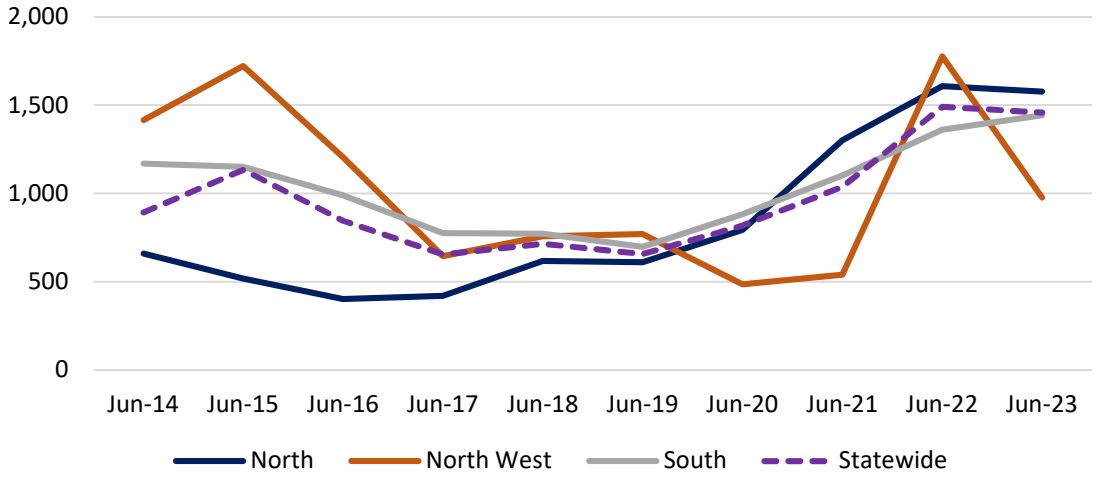
4.3 Figure 10 shows a similar correlation of the number of adults on the waitlist for each region since 2017-18. OHST advised that the regional variation in waitlist numbers was likely due to one-off funding investments introduced over the last 10 years. For the North, this occurred prior to 2013-14, which may explain why that region had the lowest number of people waiting in that year. The North West and South had funding investments around 2014-15 before waitlists started to increase again. The decrease in waitlists in all regions from 2020-21 was due to subsequent one-off investments of

$5 million (2020-21) and $1.5 million (2022-23) from the Tasmanian Government to deliver more appointments.

The length of time adults wait for general dental care is increasing

4.4 There has been an increase in the length of time adults were waiting for an appointment. The median wait time for adults on the general care waitlist statewide increased from 892 days (around 2.4 years) at June 2014 to 1,459 days (nearing 4 years) at June 2023, as shown in Figure 11.

Figure 11: Change in median time (days) between first contact and last appointment by region, 2013-14 to 2022-23



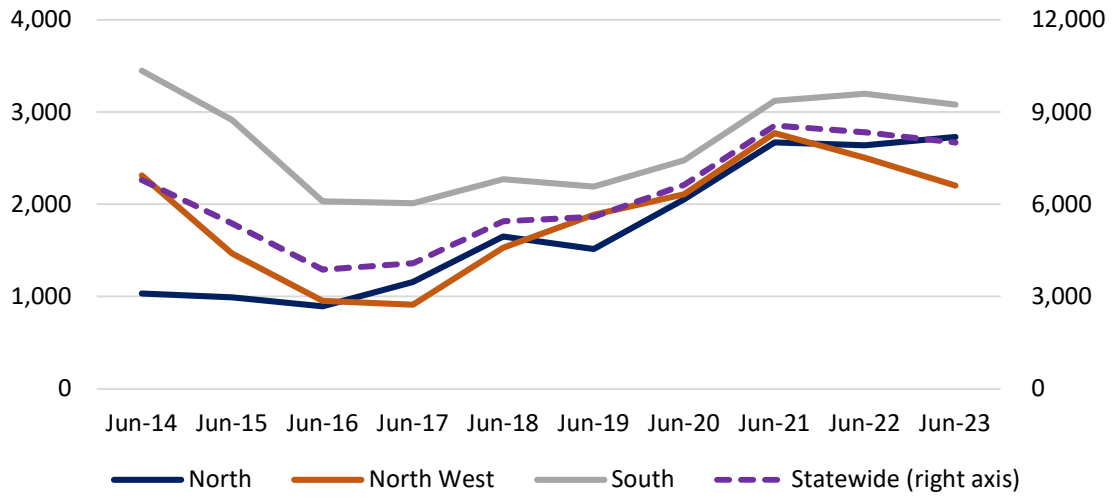
Source: Tasmanian Audit Office analysis of OHST data

4.5 The North experienced an increase of 139% in the length of time waited for general care between June 2014 and June 2023, but started from the lowest base in June 2014, due to the low number of adults on the waitlist at that time compared to the other regions.

The number of adults on the general care waitlist needing episodic care is increasing

4.6 The longer a person is on the waitlist, the more likely it is they will need episodic care. Figure 12 shows the number of adults escalated from the general care waitlist to episodic care over the 10-year period.

Figure 12: Clients escalated from the general care waitlist to episodic care by region (left axis) and statewide (right axis), 2013-14 to 2022-23



Source: Tasmanian Audit Office analysis of OHST data

4.7 Figure 12 show a decrease in the number of adults being escalated to more urgent episodic care between June 2014 and June 2016 particularly in the North West and the South. These decreases were likely correlated with the decline in the number of people waiting for general care and therefore fewer people being escalated to episodic care.

4.8 The North experienced a 164% increase in clients escalated from the general care waitlist to episodic care, compared with a decrease of 5% in the North West and 11% decrease in the South. However, the North started with the lowest number of clients that were escalated to episodic care in June 2014. The increase in escalation to episodic care from June 2017 was likely correlated with an increase in adults on the general care waitlist (shown in Figure 10) and one-off funding to address waitlists being expended in the previous years.

Failing to address oral health demand and increasing waitlists can have negative consequences, impacting both individuals and the healthcare system

4.9 Failing to manage the demand for oral health care can perpetuate a cycle of poor oral health outcomes, with untreated dental conditions resulting in pain, discomfort, and complications that impact overall wellbeing. Moreover, the increase in healthcare costs stemming from untreated dental issues can further exacerbate the economic burden on individuals, families, and the healthcare system.

4.10 Examples of the consequences of delayed oral health care are:

- Prolonged wait times can exacerbate pain and discomfort for clients experiencing dental problems, affecting their quality of life and overall

wellbeing. Clients may have trouble eating, sleeping, and performing daily activities, leading to physical and emotional distress.

- Longer wait times for oral health services can lead to delayed diagnosis and treatment of dental conditions, resulting in worsened oral health outcomes for clients. Conditions that could have been treated early may progress to more severe stages, leading to increased pain, discomfort, and the need for more extensive and costly treatments.
- Delayed access to oral health care can increase the risk of complications and adverse outcomes for clients. Untreated dental conditions such as tooth decay, gum disease, and oral infections can progress to more serious complications, including abscesses, tooth loss, and systemic health problems such as cardiovascular disease and diabetes.
- Increasing waitlists for oral health services can strain healthcare resources and exacerbate existing capacity challenges within the healthcare system. Dental clinics may experience overcrowding, longer appointment wait times, and difficulties in meeting client demand, leading to decreased efficiency and client satisfaction.
- Longer wait times for oral health services can disproportionately affect vulnerable and underserved populations, exacerbating existing health inequities and disparities.

The above examples highlight the importance of addressing access barriers and improving oral health service delivery to ensure timely and equitable care for all.

Revised appointment processes and phone call and SMS appointment reminders have increased client appointment attendance

4.11 Appointment scheduling and management is crucial for managing client flow and optimising clinic efficiency as oral health care is constrained by appointment availability. Clinical rostered hours and booked appointment hours over a 5-year period[22] to 30 June 2023 are summarised in Table 3.

Table 3: Clinical rostered hours by region, 2018-19 to 2022-23

	Number of clinical rostered hours			Number of booked appointment hours		
Region	2018-19	2022-23	Change	2018-19	2022-23	Change
North	34,354	27,493	-20%	30,495	24,809	-19%
North West	27,948	22,541	-19%	25,321	20,951	-17%
South	37,863	33,234	-12%	35,148	30,261	-14%

Source: Tasmanian Audit Office analysis of OHST data

4.12 The number of clinical rostered hours experienced declines ranging from 12% to 20% across all regions, with the North and North West the most impacted. There was also a decline in the number of booked appointment hours across all regions. The decline in clinical rostered hours and booked appointment hours have not recovered from pre-pandemic levels. COVID-19 has impacted on appointment availability with the introduction of preventive measures in health facilities to prevent outbreaks and increased sick leave rates resulting in less clinical activity. Since 2022, OHST has focused on training and recruiting graduates which has resulted in less activity as they take time to learn and develop compared to more experienced dentists.

4.13 To minimise the effect of reduced clinical rostered hours, OHST introduced phone call/SMS appointment reminders and modified its appointment booking processes to minimise the number of clients that fail to attend (FTA) for an appointment. Depending on the day these FTAs occur, these appointments can be absorbed by sit and wait[23] clients, such as urgent care patients seeking care on the same day.

4.14 As shown in Table 4, the number of FTA hours has declined across all regions with the North West showing the most improvement. The reduction in FTA hours was likely attributed to measures implemented by OHST to prevent clients from missing their appointment, such as phone call/SMS reminders. As FTA rates improved, OHST

[22] Due to technical issues, data on clinical rostered hours and number of booked appointment hours was only available from 2018-19 to 2022-23.
[23] Refers to clients that visit a clinic for treatment without making an appointment.

allocated fewer hours to sit and wait clients to ensure appropriate client numbers for staff.

Table 4: Number of FTA and sit/wait hours by region, 2018-19 to 2022-23

	Number of FTA hours			Number of sit and wait hours		
Region	2018-19[24]	2022-23	Change	2018-19	2022-23	Change
North	2,914	2,088	-28%	543	238	-56%
North West	2,483	1,642	-34%	595	222	-63%
South	3,755	2,674	-29%	1,069	319	-70%

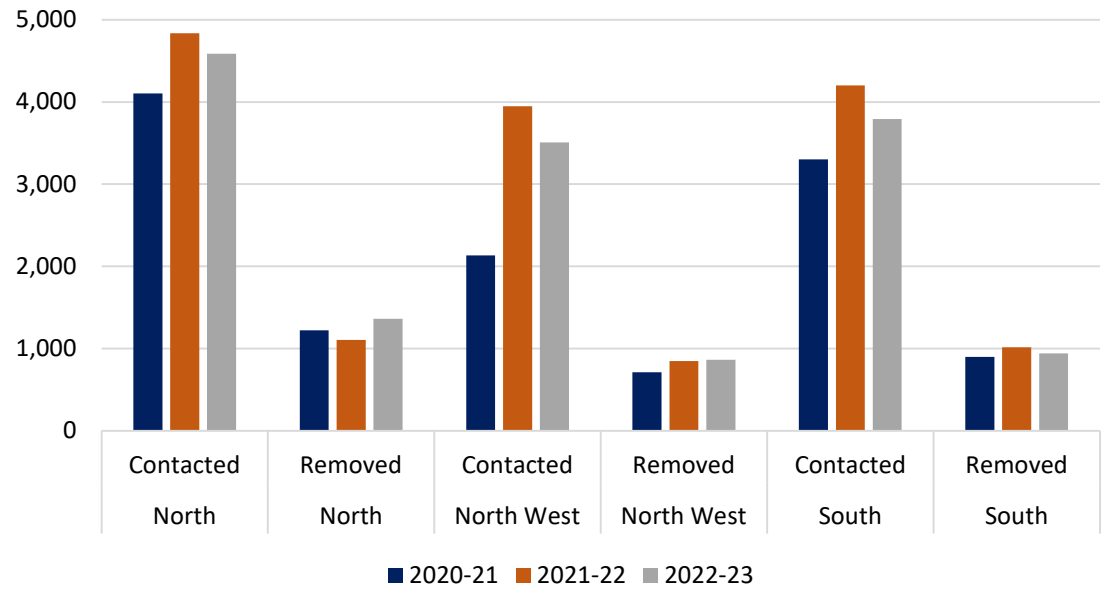
Source: Tasmanian Audit Office analysis of OHST data

Annual audits of the general care waitlist removes clients no longer identified as needing treatment

4.15 Due to the long wait time for general care, OHST conducts an annual audit of the general care waitlist.[25] If a client was on the waitlist for longer than one year at the time of the audit, they were contacted by OHST by SMS message or letter asking if they wanted to remain on the waitlist for treatment. Figure 13 shows the results of audits conducted between 2020-21 and 2022-23 by region.

[24] Due to technical issues, data on FTA and sit/wait hours was only available from 2018-19 to 2022-23.
[25] OHST have been doing audits of the general care waitlist since 2015.

Figure 13: Number of general care waitlist records removed by region, 2020-21 to 2022-23



Source: Tasmanian Audit Office analysis of OHST data

4.16 During the 2022-23 audit, OHST removed 3,162 clients, representing 27% of the 11,884 clients contacted. According to OHST, clients removed from the waitlist either no longer wanted care or were unable to be contacted due to contact details being inaccurate or out-of-date. If a client who could not be contacted for legitimate reasons makes contact again, they do not lose their place in the waitlist queue.

4.17 According to OHST's Waiting List Audit protocol, clients that receive an SMS message or letter asking if they wish to remain on the waitlist will be asked to either reply 'Yes' or 'No'. Clients that responded 'No' had their waitlist record removed with a note on their record saying, 'removed at client's request'. Based on this process, it is unclear whether OHST captured accurate information on the reason why clients no longer wanted care or were unable to be contacted. For example, some clients removed may have had treatment elsewhere.

Adults requiring time-critical episodic care were treated efficiently

4.18 Triage protocols allow oral health clinics to identify and prioritise clients based on the urgency of their dental needs. This ensures that clients with urgent conditions receive prompt attention and appropriate care, while also optimising resource allocation and clinic workflow. By triaging clients, clinics can effectively manage demand, reduce treatment delays, and improve clinical outcomes. This is important because it prioritises client safety, ensures timely access to care for those in need, and enhances overall clinic efficiency.

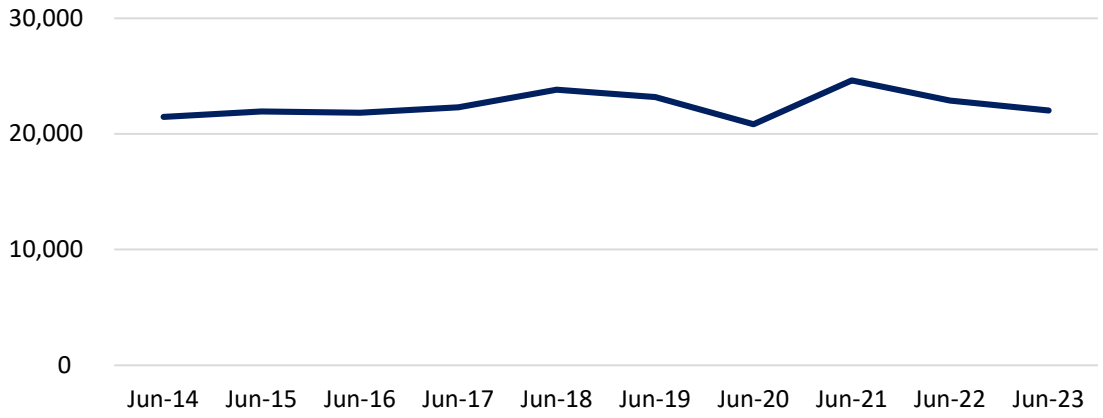
4.19 OHST managed adults requiring time-critical episodic care efficiently. For adults requiring episodic care, OHST triaged them into one of the following categories:

- Emergency – appointment on day of contact
- Urgent (P1) – appointment within 2 days
- Priority (P2) – appointment within 4 weeks

4.20 Most adults needing episodic care were categorised as either P1 or P2. For example, of the 22,014 clients seen for episodic care in 2022-23, 9,612 were classified as P1, 11,947 were classified as P2 with 1,282 requiring Emergency care.

4.21 Figure 14 shows the number of adults by region who received episodic care (all categories) over a 10-year period.

Figure 14: Number of adults receiving episodic care, 2013-14 to 2022-23

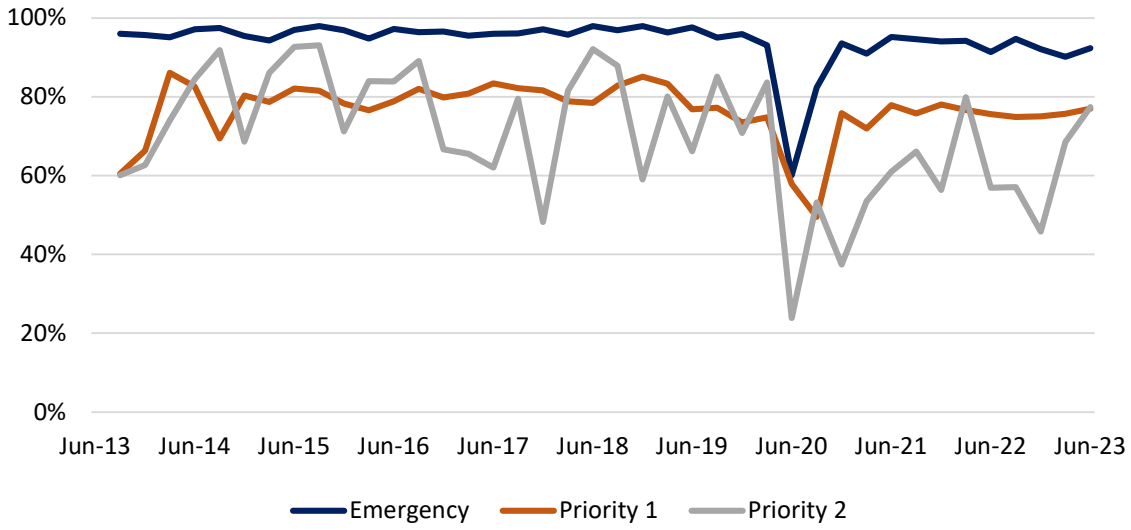


Source: Tasmanian Audit Office analysis of OHST data

4.22 The number of adults seen for episodic care increased by 2% between June 2014 and June 2023. There was a dip and subsequent peak in the number of adults requiring episodic care between June 2019 and June 2021. This was attributed to COVID-19 service restrictions from March to May 2020 and the subsequent easing of restrictions resulting in a higher volume of episodic clients as the backlog was cleared.

4.23 The majority of clients needing emergency care are provided an appointment on the day of contact. For example, in 2022-23, OHST saw between 90% and 95% of Emergency clients on day of contact. This exceeded the THS Service Plan target of not less than 80%. Figure 15 shows the proportion of clients seen within clinically recommended timeframes for Emergency, P1 and P2.

Figure 15: Proportion of clients seen within clinically recommended timeframes by episodic category, June 2013 to June 2023



Source: Tasmanian Audit Office analysis of OHST data

4.24 Figure 15 shows that since June 2013, OHST provided the majority of clients needing an appointment for Emergency care on the day of contact. However, this dropped to around 60% in June 2020 as a result of service restrictions during COVID-19 which has since stabilised, with most clients being seen within the recommended timeframe. OHST saw P1 clients within 2 days around 80% of the time for most of the 10-year period but dropped below 60% in 2020. The majority of P2 clients were being seen within 4 weeks. However, this did fluctuate with COVID-19, dropping below 60% for a few years but reaching close to 80% around 2022-23. Please refer to Appendix 1 for a breakdown on all episodic care categories by region.

Securing dental professionals to work in Tasmania is challenging

4.25 Workforce management is essential for ensuring equitable access to oral health services, particularly in underserved and remote areas. By incentivising dental professionals to practice in areas with workforce shortages, dental clinics can improve access to care, reduce disparities in oral health outcomes, and address unmet client needs. This is important because it helps alleviate workforce shortages, expands access to care for vulnerable populations, and promotes health equity.

4.26 The University of Tasmania does not provide dental degrees or diplomas and TasTAFE only provides certificate courses in dental assisting and other skills-based training, e.g. Dental Radiography. Consequently, OHST is highly reliant on securing dentistry professionals from other Australian states and territories or from overseas countries.

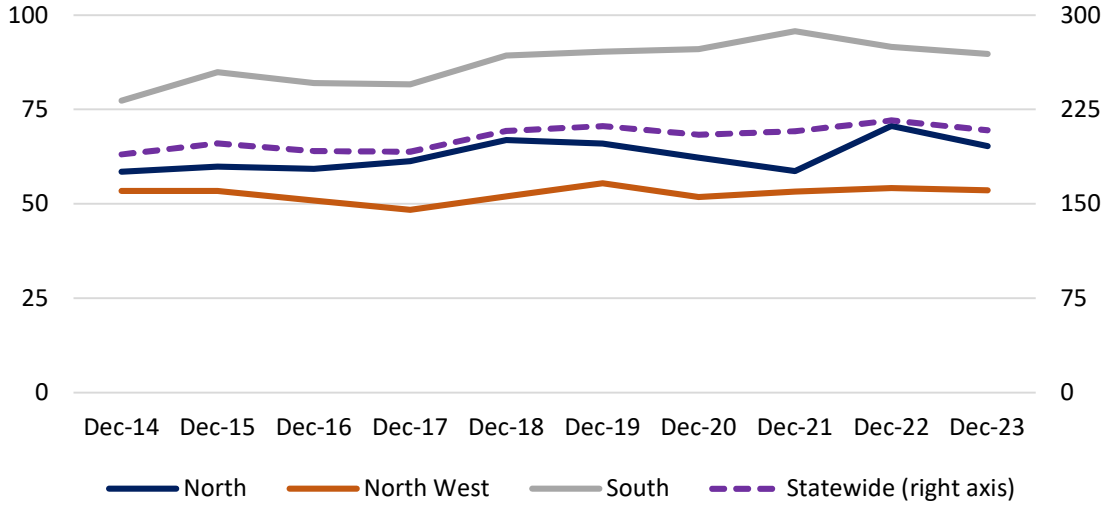
4.27 OHST advised that North West Tasmania has had a particular shortage of oral health therapists which provide primary dental care for children and dental hygiene services

to eligible adults. Most dental positions at OHST have been concentrated in the South, but at times positions have been relocated to other regions to help meet demand.

4.28 OHST's approach to determining the size of its dental workforce is based on funding, facility capacity and forecasting increases in the eligible adult population. OHST employs risk treatment plans to identify and respond to workforce challenges including filling vacant positions.

4.29 OHST's dental workforce overall has increased from around 189 FTEs in December 2014 to 208 FTEs in December 2023. The South had the largest increase in its dental workforce over the 10-year period, followed by the North. The North West maintained around the same number of FTEs (as shown in Figure 16). This highlights the difficulty the North West has in filling vacant dental positions.

Figure 16: Size of the dental workforce (number of FTEs) by region (left axis) and statewide (right axis), December 2014 to December 2023



Source: Tasmanian Audit Office analysis of OHST data

4.30 As at December 2023, the dental workforce comprises:

- dental assistants, 58%
- dental/oral health therapists, 19%
- dental officers, 18%
- prosthetists, 5%.

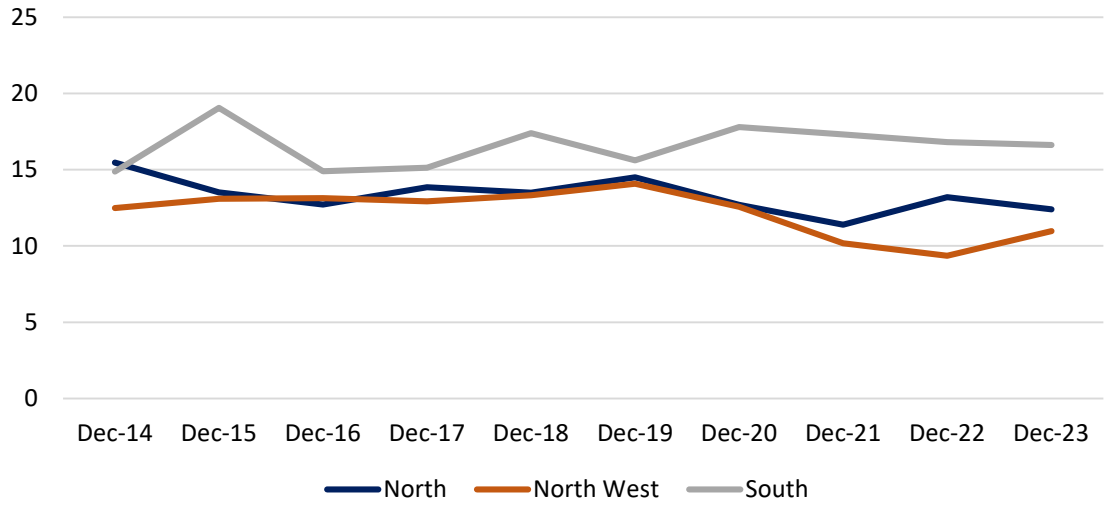
Table 5: Size of the dental workforce by position (full time equivalents), as at December 2023

Region	Dental assistants (FTEs)	Dental officers (FTEs)	Prosthetists (FTEs)	Dental/oral health therapists (FTEs)
North	40.1	9.8	3.0	12.4
North West	30.0	10.4	2.2	11.0
South	51.4	16.8	4.8	16.6
Statewide	121.5	37.0	10.0	40.0

Source: Tasmanian Audit Office analysis of OHST data

4.31 Dental/oral health therapists provide dental care for children. The reduction in the number of these positions, particularly in the North West as shown in Figure 17, has impacted OHST's capacity to meet demand for recall visits, as discussed previously in Chapter 2.

Figure 17: Number of dental/oral health therapists (FTEs) by region, 2014 to 2023



Source: Tasmanian Audit Office analysis of OHST data

4.32 The decline in dental/oral health therapists in the North and North West from 2019 is attributed to the retirement of several dental therapists and difficulty in recruiting qualified staff to replace them. Although the North has been able to recover to a great extent, the North West has been much slower to recover.

4.33 To help address its workforce challenges, OHST modified its recruitment processes from multiple regional panels and advertisements to single statewide panels and advertisements. This enabled OHST to engage communications services firms and deliver more communications media and social media strategies, such as an

advertising campaign promoting the Tasmanian lifestyle to prospective applicants. Recruitment panels have also been restructured to include management from the North and North West to encourage prospective candidates to consider working in these regions.

4.34 In 2022, OHST introduced a Graduate Program to help address staff shortages and deliver more appointments. This program was designed to provide supervised support for clinicians looking to work in the public oral health system. In the first year of the Program, OHST delivered an additional 10,000 dental appointments. OHST also cooperated with mainland universities on an 8-to-18-week clinical placement program for undergraduate students.

4.35 While the Graduate Program was positive in helping meet demand for dental care and addressing workforce shortages, graduates take more time with appointments compared to experienced staff. This meant that OHST, at least in the short-term, was delivering fewer appointments. However, retention of these graduates will have long-term benefits as they gain more experience and choose to live and work in the public dental system in Tasmania.

OHST used population data to forecast potential demand for oral health services to support decision making

4.36 In responding to the projected demand, OHST makes decisions about models of care, location, suitability and capacity of facilities and the resourcing of those facilities. For example, since 2019, OHST has increased its capacity to meet demand with the construction and redevelopment of facilities across Tasmania. These included:

- upgrades to the Southern Dental Centre in New Town and new/expanded facilities in Glenorchy and Kingston
- the opening of a new dental clinic within the St Helens District Hospital
- an additional 3 dental vans assisting with school-based programs
- upgrades to the Devonport Dental Centre.

4.37 OHST considered socioeconomic and population data in understanding the potential level of demand and helped inform the placement of facilities and allocation of resources.

4.38 Public Health Services prepares a Tasmanian Population Health Survey which has occurred every 3 years since 2009. The survey included questions on oral health. The purpose of the survey was to inform planning for services and programs to improve health and wellbeing. The 2019 survey found there was a link between socioeconomic status and frequency of dental visits. According to the survey, Tasmanians experiencing high levels of disadvantage were more likely to defer dental visits for 2 or more years. These people may also experience barriers to access which would impact their timely visit to the dentist.

4.39 OHST used Department of Treasury and Finance population projections to guide workforce planning. For example, while the population of the North West overall was projected to decline over the next 20 years, there was a projected increase in older residents by 20%. Due to the ageing population, it was expected that more people would be eligible for public oral health services. These projections were used to plan for an additional prosthetist in the region in response to the potential demand for denture services.

4.40 OHST also used population projections to plan for the development of new dental clinics. For example, there was a projected growth in children in the West Tamar municipality compared to a projected decline in children in the Central Coast and Latrobe municipalities. OHST's current service in the West Tamar municipality was a mobile dental unit located at Exeter Primary School which was near the end of its operational life. Most children in this municipality travelled to the Northern Dental Centre for treatment which was at capacity. OHST used these population projections to investigate co-locating a dental clinic at the Legana Primary School to service this growing area.

OHST did not have a structured approach to facility management, with some dental clinics at capacity

4.41 Infrastructure improvements are critical for enhancing the capacity and quality of oral health services delivery. By investing in facility expansion, equipment upgrades, and accessibility improvements, oral health clinics can accommodate growing client demand, improve treatment efficiency, and enhance client experience. This is important because it ensures that dental clinics are equipped to meet the needs of clients, enhance clinical outcomes, and provide a conducive environment for care delivery.

4.42 OHST manages various dental facilities, such as the 6 major dental centres, mobile dental units, school-based dental units and clinics in health centres, district hospital and some public schools.

4.43 We expected OHST to have an infrastructure strategy which determined the location, size and condition of its facilities. OHST managed infrastructure through risk management, working with the Department of Health on master planning and addressing potential facility capacity issues using population data.

4.44 We found several clinics in the North and North West are at capacity. For example, we were informed that some of the major centres in the North West had limited space with a few of the smaller clinics having limited services and equipment.

4.45 OHST identified a risk with the dependency on the Northern Dental Centre for the provision of emergency dental care for adults, which was also at capacity. In response, OHST considered increasing the capacity of the dental clinic within the Kings Meadows Community Health Centre from 2 chairs to 4. This would enable the service to meet demand in this growing area and also be an alternative site in providing emergency

care if the Northern Dental Centre was not available. However, alternate options need to be explored, as Australian Government funding for this project enables OHST to refit a facility, not expand it.

4.46 OHST also identified the need for another clinic in the West Tamar municipality and to alleviate pressure on the Northern Dental Centre. OHST worked with the Department for Education, Children and Young People to place a 2-surgery clinic at the Legana Primary School to service this growing area. Planning for this new clinic considered population projections and capacity of existing services in the area.

4.47 OHST acknowledged the need for a more structured, state-wide approach to managing its facilities. OHST's Strategic Priorities 2023-24 included an action to improve planning processes for infrastructure and facilities. This included the development of a clinic redevelopment plan that identifies clinic/areas for possible redevelopment/ development according to needs and cost.

Implementation of digital dentures technologies is expected to reduce the number of appointments and wait times for dentures

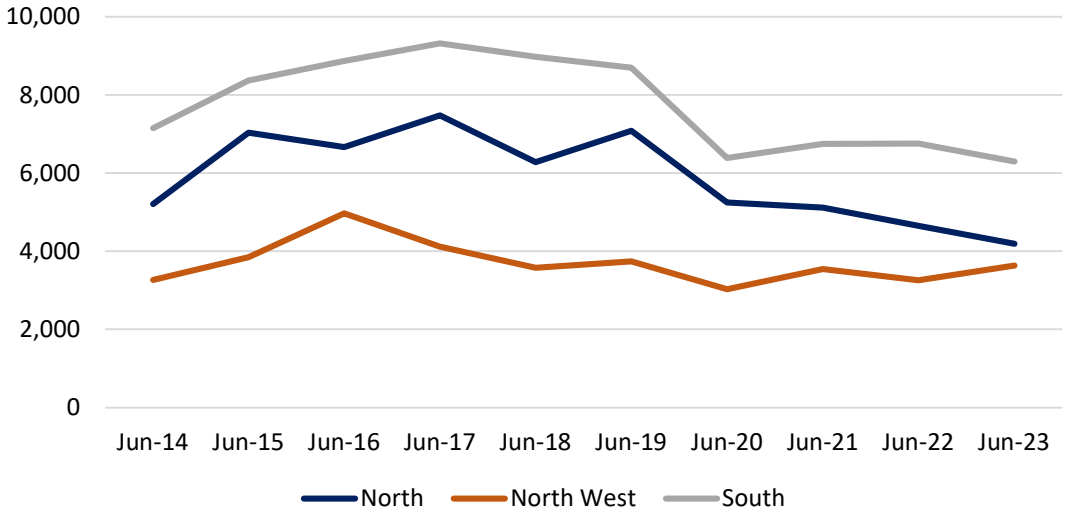
4.48 Technology plays a vital role in streamlining service delivery and improving client care in oral health settings. By leveraging digital health solutions, oral health clinics can enhance communication, optimise clinical workflows, and enhance client engagement. This is important because it improves efficiency, enhances access to care, and promotes client-centred, high-quality oral health services.

4.49 OHST triages clients requesting new dentures, including repairs or adjustments, before placing them on the waitlist. OHST triage protocols provide guidance around how and where appointments should be allocated depending on whether the dentures were made at OHST or with a private provider. As at December 2023, the *Health system dashboard* reported 1,120 adults were waiting for dentures.

4.50 In January 2022, OHST implemented the Digital Dentures project to reduce the number of appointments required to fit and review dentures and help reduce the size of the waitlist. It was also intended to provide dentures with a better fit, of higher quality and make Tasmania a more desirable place to work for dentists with an interest in the technology. OHST was the first public dental service provider in Australia to invest in digital dentures technology to be rolled out across the entire state.[26] As Digital Dentures has only been in operation since 2022, we were unable to determine what impact it has had on reducing the waitlist for dentures.

[26] A small number of private clinics in other jurisdictions had invested in the technology prior to OHST.

Figure 18: Total number of prosthetic occasions of service by region, 2013-14 to 2022-23



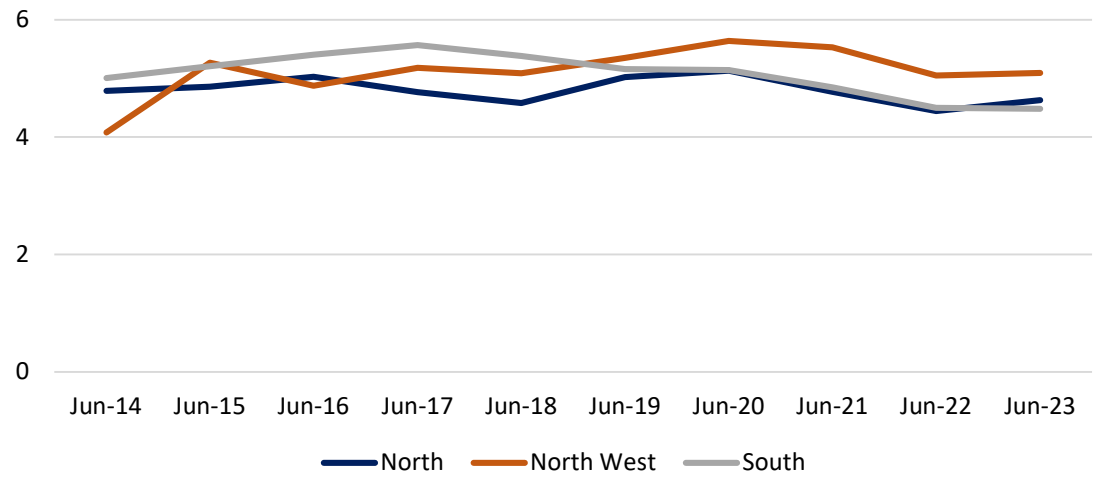
Source: Tasmanian Audit Office analysis of OHST data

4.51 The South had the highest number of occasions of service for dentures averaging 7,757 appointments over the 10-year period. The North West was the only region to record an increase in occasions of service over this period, from 3,267 in 2013-14 to 3,631 in 2022-23. The increase in the North West around June 2016 may be attributed to the higher number of prosthetists employed during this time (3.8 FTEs in 2015 and 2.8 FTEs in 2016). As shown in Table 5 (Chapter 4), the number of prosthetists in the North West, as at December 2023, has reduced to 2.2 FTEs which may result in fewer clients seen.

4.52 Figure 19 shows the average number of appointments from initial assessment to final review[27] by region. During the 10-year period, clients required on average 5 appointments to construct, fit and review dentures statewide.

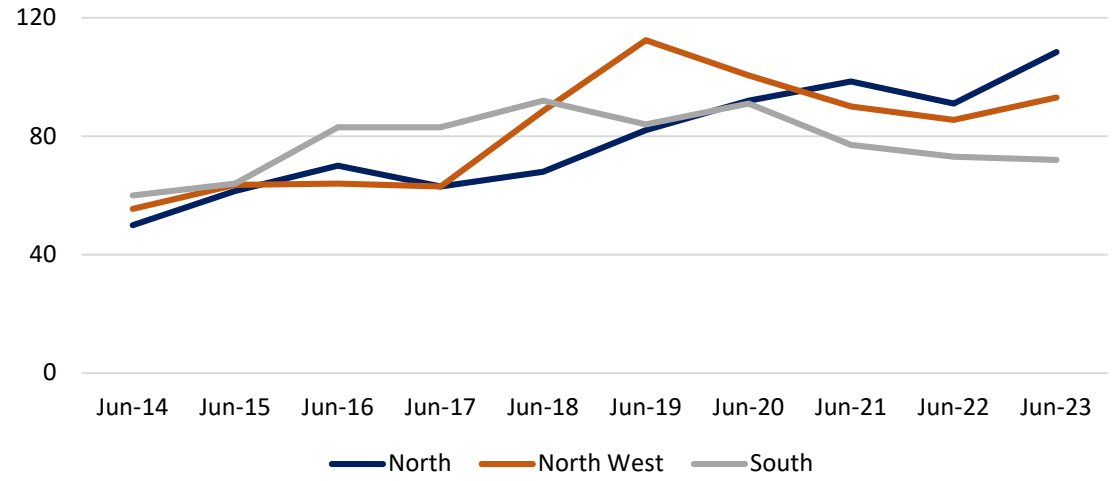
[27] The average number of days between a client's first appointment and last appointment in their prosthetics course of care.

Figure 19: Average number of prosthetic appointments from initial assessment to final review by region, 2013-14 to 2022-23



Source: Tasmanian Audit Office analysis of OHST data

Figure 20: Change in median time (days) between initial assessment and review for prosthetics by region, 2013-14 to 2022-23



Source: Tasmanian Audit Office analysis of OHST data

4.53 As shown in Figure 19, the average number of appointments needed for dentures decreased in all regions except for the North West. This may be attributed to resourcing, where prosthetists comprise a small proportion of the dental workforce (as shown in Table 5, Chapter 4). Clients are also waiting longer to complete their prosthetics course particularly in the North and North West with wait times of 108.5 days and 93 days respectively as at the end of June 2023 (as shown in Figure 20).

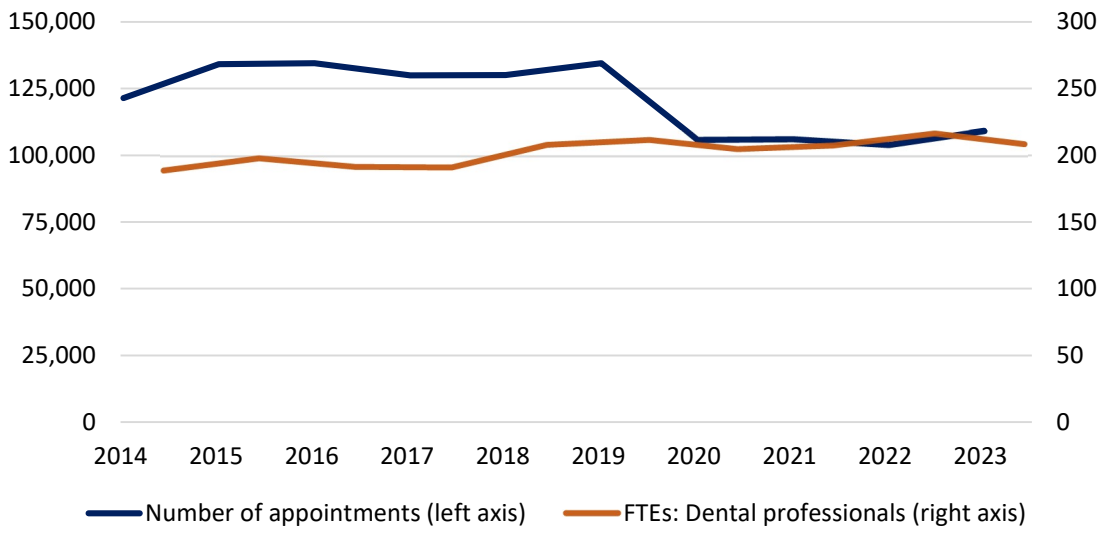
4.54 According to OHST, Digital Dentures will significantly reduce the wait time for dentures and number of appointments required. The digital process is intended to reduce the number of appointments required and the time taken to complete and fit dentures.

The COVID-19 pandemic continues to affect the capacity of the service system

4.55 OHST restricted access to dental care from 30 March 2020 to 27 May 2020. During this period, OHST provided emergency care at its major dental centres in Hobart, Launceston, Devonport and Burnie with the service only operating at around 10% of its usual capacity. OHST cancelled approximately 12,000 general care appointments scheduled for April and May 2020.

4.56 The number of appointments provided by OHST since 2020 has been lower than it was compared to pre-pandemic levels. As shown in Figure 21, OHST delivered around 130,000 appointments per year in 2019, which then dropped to a little over 100,000 appointments per year from 2020 to 2023. The number of dental professionals has also remained relatively unchanged since 2018 at around 200 FTEs.

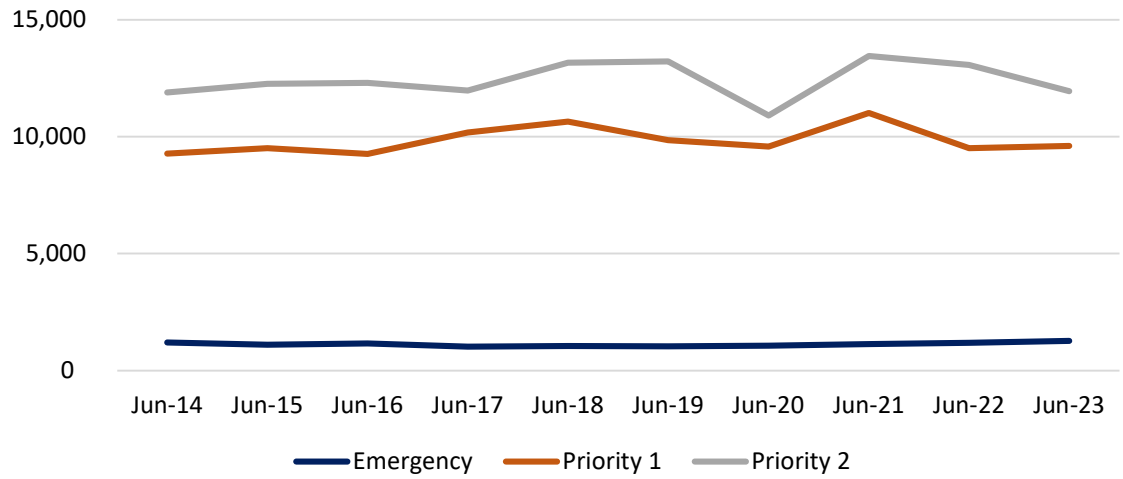
Figure 21: Total number of appointments (left axis) provided and full time equivalents for all dental professionals (right axis), 2014 to 2023



Source: Tasmanian Audit Office analysis of OHST data

4.57 For the reasons outlined in paragraph 4.12, the decline in the number of appointments delivered from 2020 indicates an inability to keep up with demand. During the COVID-19 lockdown period, OHST only offered care to P1 clients, while P2 clients were advised to contact the service if their symptoms worsened. While P2 clients were normally seen within 4 weeks, OHST did not have the capacity to provide them with an appointment. OHST managed these clients by either referring them to the private sector or being re-triaged at a higher level of categorisation.

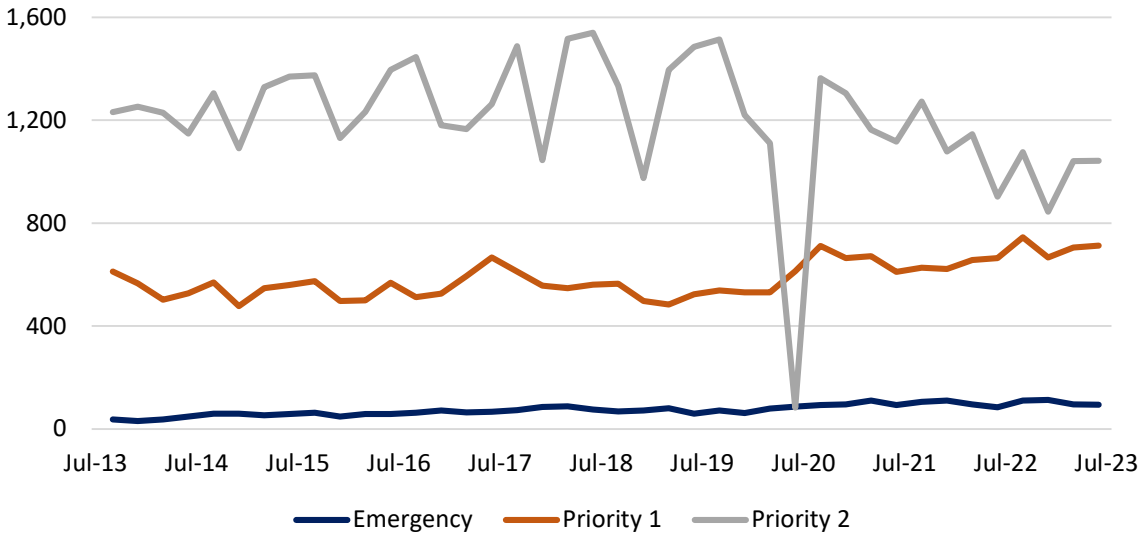
Figure 22: Number of unique clients seen by episodic category (Statewide), Q1, 2013-14 to Q4, 2022-23



Source: Tasmanian Audit Office analysis of OHST data

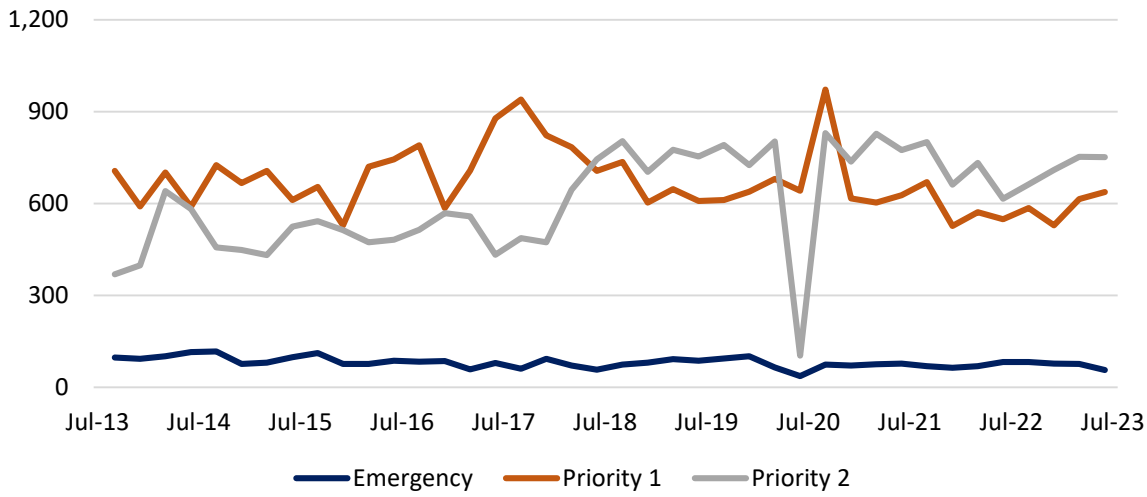
4.58 Figure 22 shows a drop in the number of P2 clients seen statewide during 2020. It is possible that some of these clients were re-triaged into Emergency or P1. Figures 23, 24, and 25 provide a regional breakdown on the number of episodic clients seen in the North, North West and South, respectively.

Figure 23: Number of unique clients seen by episodic category (North), Q1, 2013-14 to Q4, 2022-23



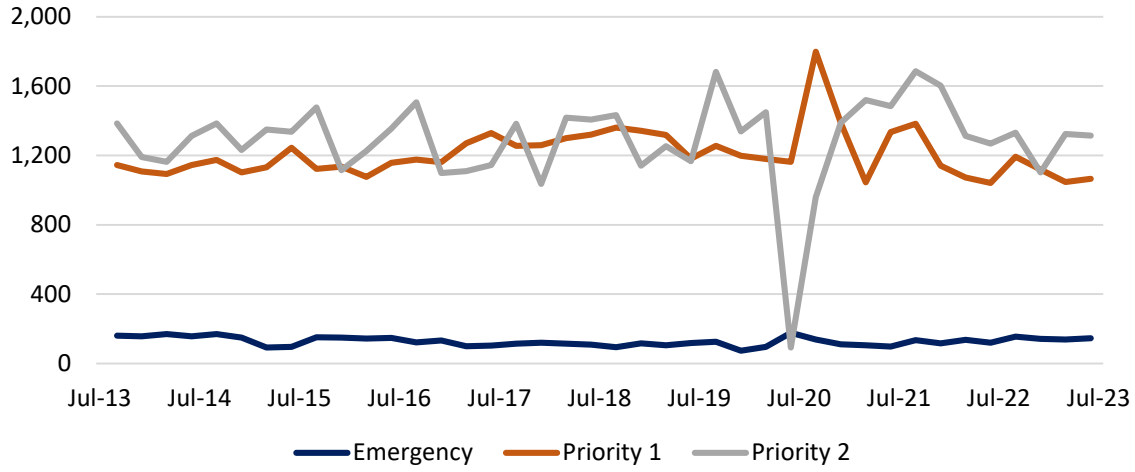
Source: Tasmanian Audit Office analysis of OHST data

Figure 24: Number of unique clients seen by episodic category (North West), Q1, 2013-14 to Q4, 2022-23



Source: Tasmanian Audit Office analysis of OHST data

Figure 25: Number of unique clients seen by episodic category (South), Q1, 2013-14 to Q4, 2022-23



Source: Tasmanian Audit Office analysis of OHST data

4.59 The data shows a decline in the number of P2 clients seen in all regions around July 2020. The North West and South showed a spike in the number of P1 clients seen in the months following July 2020. However, in the North, there was only a small increase in P1 clients around this time compared to the other 2 regions. As discussed, OHST were unable to provide appointments for P2 clients which meant some clients were re-triaged to P1 if their symptoms worsened.

4.60 In response to COVID-19, the Tasmanian Government provided one-off funding of $5 million in 2020-21 to help OHST deliver an additional 20,000 appointments. OHST delivered these through the Conscious Sedation Pilot, Digital Dentures, the Graduate Program and Outsourcing Program. Further funding of $1.5 million was provided in 2022-23 to extend the Graduate Program, delivering an additional 5,350 appointments.

5. Was there appropriate oversight and monitoring in place for oral health services?

Monitoring performance and continuously improving strategies are essential for ensuring that OHST provides high-quality, efficient, and client-centred care. By regularly assessing performance, identifying areas for improvement, and taking proactive measures to address deficiencies, OHST can enhance client satisfaction, optimise resource utilisation, and adapt to changing client needs and trends, ultimately improving overall clinical performance and client outcomes.

This chapter assesses whether OHST:

- implemented robust performance monitoring and quality improvement processes to track client wait times, identify bottlenecks, and implement targeted interventions to reduce waitlists
- regularly solicited feedback from clients and staff to identify opportunities for improvement and implement changes accordingly
- monitored key performance indicators such as appointment adherence, client satisfaction, and treatment outcomes to assess the effectiveness of interventions and drive continuous improvement efforts
- monitored the performance of its partnerships, including intended outcomes, and ensure there was no gaps in service delivery.

Chapter summary

OHST worked with Australian Government agencies to understand the number of people eligible for public oral health services in Tasmania. OHST used client data recorded in Titanium to determine the proportion of those in the eligible population that seek treatment.

Reporting on the level of access was important in helping identify gaps and develop strategies to address access issues. We found that OHST prepared frequent, targeted reports to Management and the Executive on key performance activities across the system. The KPIs contained in these reports assessed performance on access to oral health services. OHST expanded its suite of KPIs in the THS Service Plan 2023-24 to improve transparency on the service's performance alongside other parts of the health system.

However, public reporting on oral health activities was limited to occasions of service and waitlists. To further enhance transparency and inform the public on levels of access to the service, the *Health system dashboard* could include additional indicators on oral health.

OHST had limited monitoring of partnerships but reported on activities. The level of engagement with partners varied, with few partnerships having fixed check-in points or reporting requirements. This has resulted in minimal oversight of intended outcomes. OHST worked closely with the RFDS to ensure continuity of dental care, with both parties working together to address gaps in dental services. While information sharing has limited the

effectiveness of the partnership, OHST has committed to addressing this issue in cooperation with the RFDS.

OHST understand the proportion of those in the eligible population that seek treatment

5.1 OHST measured the level of demand for its services by understanding the number of people in Tasmania eligible for public oral health services and the proportion of those people who contact them seeking an appointment for dental treatment.

5.2 The eligible population includes adults with a Pensioner Concession Card or Health Care Card and all children. There is also a proportion of the eligible population that seek treatment but are not seen. This includes adults who have voluntarily left the waitlist for general care during a waitlist audit (explored in Chapter 3).

5.3 There are also people from the eligible population who will not seek treatment with OHST. They may either seek treatment at a private dental clinic, have poor oral health literacy or there are barriers to access. Aside from the various partnership arrangements which may capture some of these people (explored in Chapter 2) and national reporting on access to private providers, there is little understanding on why these people do not want, or are unable to, access treatment.

5.4 OHST uses data obtained from the ABS and the Australian Department of Social Services (DSS) to understand the number of adults and children eligible for public oral health services in Tasmania. OHST has established that only a small proportion of the eligible population receive treatment from OHST each year.

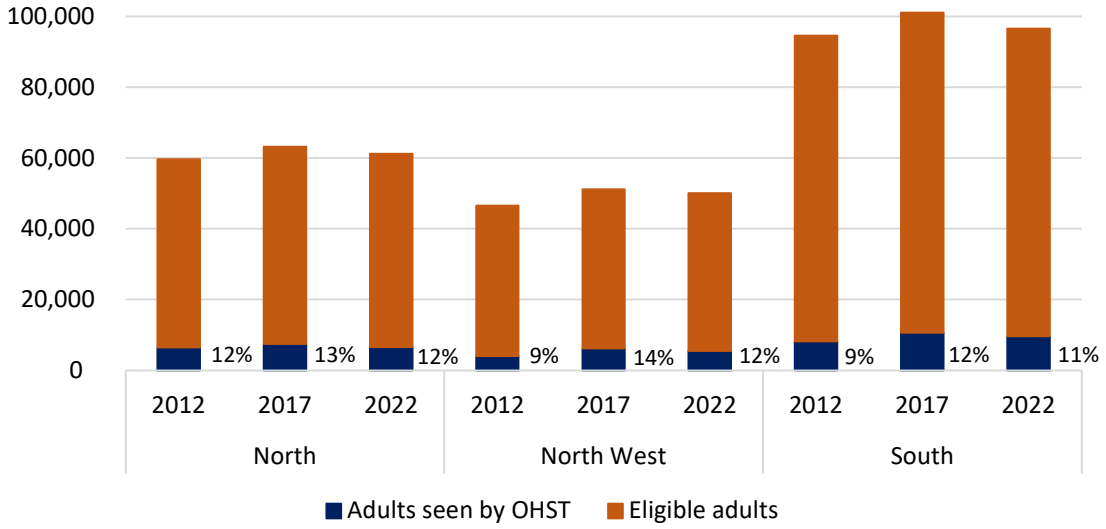
5.5 Using DSS data, we examined the proportion of adults with a Pensioner Concession Card or Health Care Card who received treatment in the last 3 census years (2012, 2017 and 2022). As shown in Table 6, the proportion of adults presenting to OHST statewide in the 2020 census was 12%, an improvement from 2012 despite a decline from the 2017 census.

Table 6: Proportion of eligible adults seen by OHST statewide in 2012, 2017 and 2022

Census year	Number of eligible adults seen by OHST	Number of Pensioner Concession / Health Care Cardholders	Proportion of eligible adults seen
2012	18,705	182,130	10.3%
2017	24,251	191,255	12.7%
2022	21,635	186,180	11.6%

Source: Tasmanian Audit Office analysis of OHST and DSS data

Figure 26: Proportion of eligible adults seen by OHST by region in 2012, 2017 and 2022



Source: Tasmanian Audit Office analysis of OHST and DSS data

5.6 Between 2012 and 2022, the number of eligible adults seen increased by 36% in the North West (4,006 to 5,439), 1% in the North (6,513 to 6,585), and 17% in the South (8,186 to 9,611). Although there has been an increase in adults seen by the service, these clients were primarily seen for episodic care, with other services (general care and prosthetics) seeing fewer adults statewide (as shown in Chapter 3).

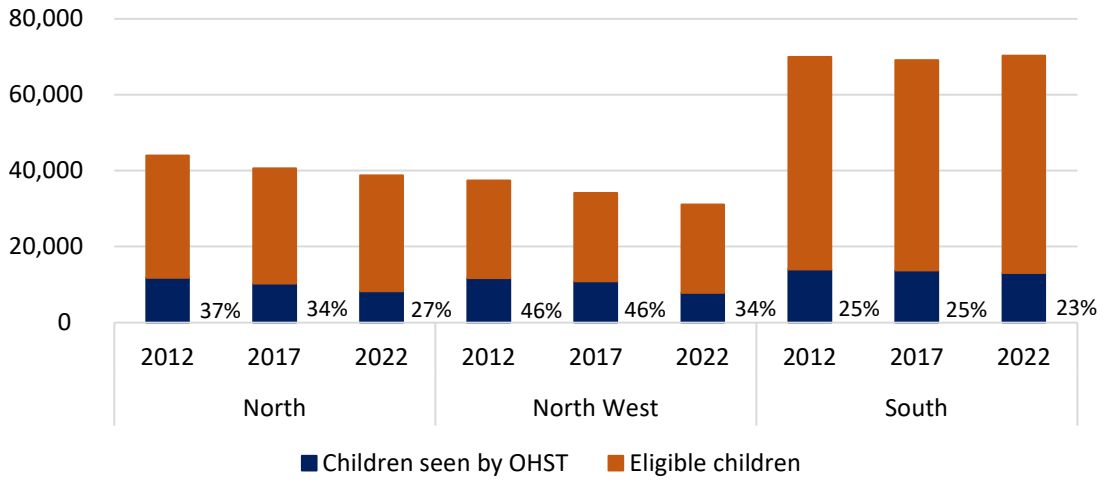
5.7 As shown in Table 7, the proportion of children seen by OHST statewide in 2022 was 26%, a decline from 33% in 2012.

Table 7: Proportion of children seen by OHST statewide in 2012, 2017 and 2022

Census year	Number of children seen by OHST	Number of children (Census)	Proportion of children seen
2012	37,527	113,906	33%
2017	34,826	109,018	32%
2022	29,120	110,936	26%

Source: Tasmanian Audit Office analysis of OHST and ABS data

Figure 27: Proportion of children seen by OHST by region in 2012, 2017 and 2022



Source: Tasmanian Audit Office analysis of OHST and ABS data

5.8 OHST accept that they cannot see the entire eligible population in a year even if many of those people need treatment. However, depending on the person's oral health status, it may not be necessary to have a check-up every year. For children, OHST had a protocol which managed high-risk appointments and recall management. According to this protocol, children assessed as low risk only needed a recall appointment every 18 months. For adults waiting for general care, the National Oral Health Plan references a guideline that adults should receive a check-up every 2 years and that adults with greater oral health care needs should be seen more frequently.[28] However, OHST is unable to follow this guideline and we are not aware of any other jurisdiction in Australia that does.

OHST prepared frequent, targeted reports which informed decision-making on access to oral health services

5.9 OHST recorded client data, managed appointments and generated reports on the level of demand for its services using its client information system, Titanium. The system was used to generate regular Key Activity Performance Indicator reports on occasions of services, waitlist numbers, as well as sit and wait/FTA data at the 6 major dental clinics. This information helped OHST understand trends in demand (such as waitlists) and number of people accessing appointments.

5.10 OHST prepared frequent, targeted reports for its executive and management which informed decision-making on access to oral health services. These reports covered

[28] COAG Health Council, Australian Government (2015), *Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2015–2024*, accessed 20 February 2024. https://www.health.gov.au/sites/default/files/documents/2022/04/healthy-mouths-healthy-lives-australia-s-national-oral-health-plan-2015-2024.pdf

oral health promotion, partnerships, activities, and changes across the service, including access, risks, resource management and endorsement of operational reports. These inputs helped guide decision-making on future planning. For example, management reviewed briefing papers and minutes on planning for new clinics in certain local government municipalities which was supported by demographic data.

5.11 Public reporting on access to oral health services was available on the *Health system dashboard* and in the Department of Health Annual Report. The *Health system dashboard* provided monthly updates on occasions of service and waitlists but would benefit from inclusion of further indicators to improve transparency such as general anaesthetic waitlists, average wait times and breakdown of activities by region. This would provide the community with an understanding of the level of demand for services by region. The Department of Health Annual Report included occasions of service and waitlists, as well as funding, number of FTEs and performance measures. While there was mention of digital dentures technologies in the 2022-23 Annual Report, there were limited insights into other initiatives undertaken by OHST to manage waitlists and improve efficiencies in the system.

OHST used KPIs to assess performance on, and address gaps in, access to oral health services

5.12 OHST was effective in using KPIs, as part of its reporting processes, to identify and address gaps with access to oral health services. While these KPIs were focused on activities (number of appointments and waitlists), OHST initiated a project in 2022-23 to expand its suite of KPIs for reporting in the THS Service Plan 2023-24.

5.13 Internally, OHST prepared Key Activity Performance Indicator reports for the Department of Health Deputy Secretary for Community, Mental Health and Wellbeing. These reports provide a snapshot of activities against KPIs such as occasions of service and meeting clinically recommended timeframes for emergency care (refer to Appendix 2). This enabled the service to respond to gaps and identify trends and demands for services.

5.14 OHST expanded its suite of KPIs to support its Strategic Priorities 2023-24 and included them within the THS Service Plan 2023-24 (refer to Appendix 3). These KPIs monitored waitlists, FTA rates and proportion of clients seen within clinically recommended timeframes for episodic care. While a few of these measures (such as waitlists and clinically recommended timeframes) have been used by OHST for some time, they were not included in previous THS Service Plans. OHST's performance against each KPI in the THS Service Plan 2023-24 was monitored in a report provided to the THS Executive. The intent was to provide more transparency around the performance and capacity of OHST to meet demand for services.

5.15 OHST contributed to national reporting on KPIs contained within the National Oral Health Plan. The National Oral Health Plan 2015-2024: performance monitoring report included progress against 26 KPIs and Tasmania's performance comparative to other

states and territories.[29] Some of these KPIs included dmft scores, level of access to fluoridated water, proportion of people experiencing toothache, frequency of dental health check-ups, and prevalence of tooth loss. While a monitoring report was expected to be prepared every 2 years during the life of the National Oral Health Plan, the last one was released in 2020 using data from 2017-18. This has limited the public understanding of Tasmania's performance against the National Oral Health Plan.

5.16 According to the 2020 monitoring report, around 89% of Tasmanians in 2017 had access to fluoridated water, which helps reduce the chance of tooth decay. This was much higher than Queensland and the Northern Territory, but lower than other states and the Australian Capital Territory.

5.17 Tasmania had the worst prevalence of inadequate dentition prevalence (tooth loss) in Australia, with 22% of adults having fewer than 21 of their natural teeth. The best performing jurisdiction was the Australian Capital Territory, where only 7.8% of adults had fewer than 21 of their natural teeth. Tooth loss affects a person's ability to chew properly and can negatively their quality of life.

5.18 The 2020 monitoring report revealed an unfavourable decrease across Australia in the proportion of adults who received an oral health check-up in the previous 2 years. In Tasmania, the proportion of people aged 15 years and over who received an oral health check-up was 71%, performing slightly better than the Northern Territory (69%). However, for Tasmanian children aged 5-14, the proportion was 91% which was comparable to other states and territories.

5.19 Tasmania's performance against some of these KPIs highlights the importance of ensuring that eligible populations receive timely general care to prevent the rate of dental disease and tooth loss.

OHST had limited monitoring of partnerships but reported on activities

5.20 OHST did not have a coordinated or effective approach in monitoring the outcomes of partnerships. This limited OHST's capacity to understand the reach and impact of programs delivered by partners. While most Working Together Agreements discussed in Chapter 2 included information sharing, partners were not obligated to check-in or report progress on their respective programs.

5.21 The level of engagement with each partner varied. For a few partners, we were advised that communication dropped off after the initial exchange of oral health promotion materials. Other programs, such as the School Health Nurse Program, had

[29] Australian Institute of Health and Welfare (2020), *Australia's National Oral Health Plan 2015-2024: performance monitoring report in brief*, accessed 18 January 2024. https://www.aihw.gov.au/getmedia/cd7f8326-26f0-4d6e-bed1-1e181bbed812/aihw-den-234.pdf?v=20230605172015&inline=true

quarterly meetings which included discussion on referrals and enabled OHST to monitor the program's success.

5.22 The frequency of engagement was also impacted by resourcing and the willingness of partners to engage with OHST. This limited OHST's capacity to deliver health promotion messages in a strategic way.

5.23 OHST reported on oral health promotion activities and engagement with partners. These were documented in monthly/bi-monthly reports and provided to the Clinical Governance Committee and then onto OHST management.

5.24 We analysed health promotion reports prepared between January 2022 and September 2023. The oral health promotion activities documented in these reports were focused on pregnant mothers, young children, Aboriginal children and their families, people from low socioeconomic areas, and people with additional health care needs or disability. These reports clearly demonstrated engagement with priority populations, and other groups in alignment with the Strategic Plan. This provided OHST Management with an understanding of the level of engagement and diversity of programs on early intervention and prevention.

There is good cooperation between OHST and RFDS to ensure continuity of dental care but information sharing could be improved

5.25 OHST and RFDS meet monthly to discuss activities and gaps in access to services. OHST has an MoU with the RFDS which was evaluated annually by both parties, ensuring stakeholders are consulted on its effectiveness. This MoU is due to end on 30 June 2024 and was being reviewed by both parties at the time of the audit with a new MoU to take effect from 1 July 2024.

5.26 The MoU clarifies roles and responsibilities in the delivery of school-based and community-based oral health programs, and delivery of oral health services to King and Flinders Islands. Under the MoU, if one party was unable to schedule a visit to King or Flinders Island, both parties cooperated to ensure continuity of care in the short-term. We found one instance where a gap in service did occur as King Island was temporarily without a dental service for 3 months due to staffing challenges at the RFDS. OHST addressed the gap in service once they were made aware that the RFDS was temporarily unable to provide a dental service to King Island. While the matter took time to resolve, both parties collaborated to address the ongoing need for dental services on King Island under the MoU.

5.27 In September 2023, THS and RFDS entered into a contract for RFDS to deliver dental services to the West Coast, Central Highlands and Huon Valley, with priority given to adults referred by OHST on the general care waitlist. RFDS is also able to treat children as well as adults and children requiring emergency dental care. Under the contract, RFDS must submit a monthly activity report to enable OHST to update its clinical record, monitor levels of access and the services being delivered. Prior to receiving

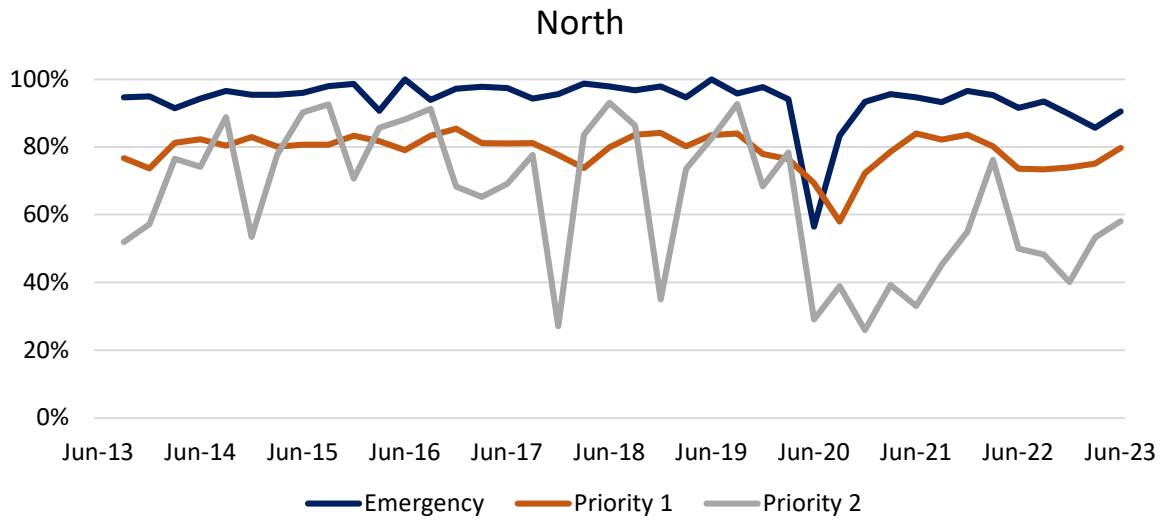
payment for services, the RFDS provides OHST with activity data from its client information system, Titanium. This ensured OHST had a complete clinical record of Tasmanian Government publicly funded patients for quality and safety purposes. The contract also included a process to manage client complaints with mechanisms to ensure that the supplier notified OHST of a complaint within 2 business days. The MoU is expected to remain in place alongside the contract as each agreement focuses on different local government areas.

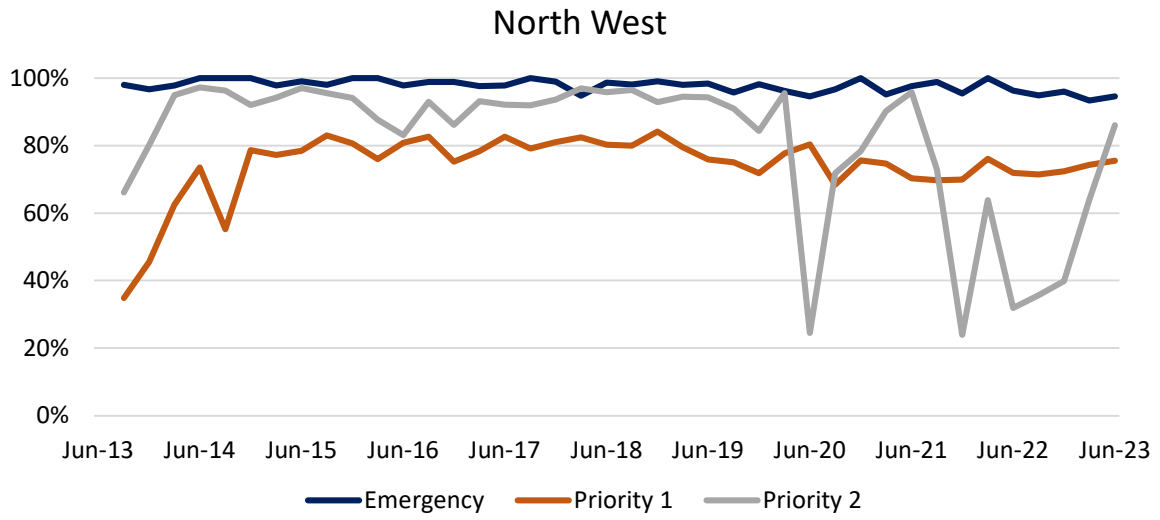
5.28 We found that data sharing between both parties was inconsistent. The transition to the new model of care by the RFDS resulted in delays to data sharing and reporting. OHST and the RFDS recognise that data sharing was an area for improvement and were seeking to address this issue in 2024.

Acronyms and abbreviations

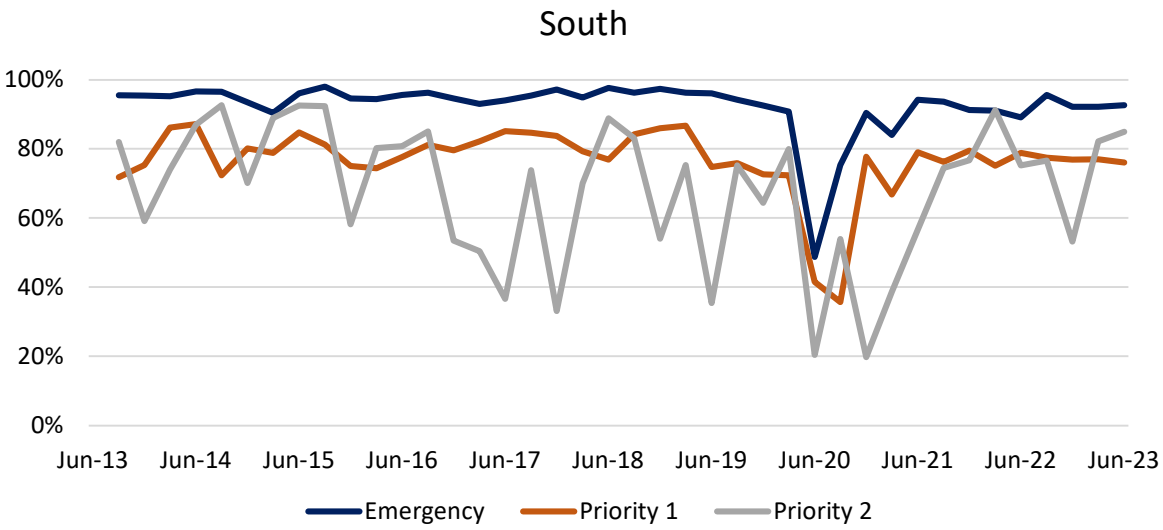
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
Audit Act	*Audit Act 2008*
dmft	Decayed, missing and filled teeth
FTA	Failure to Attend
KPI	Key Performance Indicator
MoU	Memorandum of Understanding
OHST	Oral Health Services Tasmania
RFDS	Royal Flying Doctor Service
THS	Tasmanian Health Service

Appendix 1 – Proportion of episodic clients seen within clinically recommended timeframes by region, 2013-14 to 2022-23[30]





[30] Statewide commentary is included in Chapter 3. These figures show the proportion of episodic clients seen within clinically recommended timeframes by region. As discussed in Chapters 3 and 4, COVID-19 had an impact on the provision of episodic care statewide during 2020.


South
100%
80%
60%
40%
20%
0%
Jun-13
Jun-14
Jun-15
Jun-16
Jun-17
Jun-18
Jun-19
Jun-20
Jun-21
Jun-22
Jun-23
Emergency
Priority 1
Priority 2

Appendix 2 – Measures included in Key Activity Performance Indicator report[31]

Adult Dental Services

Occasions of Services – Year to Date

Occasions of Service – Monthly

Current to previous year comparison activities:

- Clinical FTE
- Episodic care
- General care
- Prosthetic
- Total year to date activity

Child Dental Services

Occasions of Services – Year to Date

Occasions of Service – Monthly

Current to previous year comparison activities:

- Clinical FTE
- Total year to date activity

Waiting lists

- General care
- Prosthetic
- General anaesthetic (by region)

Service Plan

Dental Weighted Activity Units

Emergency timeframes (by region and statewide)

Appointments delivered by month using $5 million and $1.5 million investments:

- Outsourcing Program
- General anaesthetic sessions
- Conscious Sedation sessions
- North West prosthetist
- 2022-23 Graduate Program

[31] From March 2023 report, sourced from OHST.

Appendix 3 – THS Service Plan 2023-24 Oral Health KPIs[32]

Strategic Priority 2 - Improving Access and Patient Flow across our Health System

KPI Number	KPI	Target
SP2-3	Number of general care waiting list entries reviewed for appropriateness within last 12 months	90%
SP2-4	Proportion of all adult appointments resulting in a 'did not attend'	Not more than 6%
SP2-5	Proportion of all child appointments resulting in a 'did not attend'	Not more than 6%

Strategic Priority 3 - Delivering Care in Clinically Recommended Times

KPI Number	KPI	Target
SP3-2	Adult general care – occasions of service	8,600
SP3-3	Adult prosthetic care – occasions of service	12,600
SP3-4	Proportion of all adult patients seen within clinically recommended timeframes • Triage category priority one (appointment within two days)	70%
SP3-5	Proportion of patients seen within clinically recommended timeframes • Triage category priority two (appointment within four weeks)	70%
SP3-6	Proportion of patients receiving treatment under general anaesthetic within clinically recommended timeframes	Not less than 88%
SP3-7	Proportion of emergency adult clients managed on same day as triage	Not less than 80%

[32] Tasmanian Health Service (2023), *Annual Service Plan 2023-24*, pp.25, 28, 38, 39, accessed 6 March 2024. https://www.health.tas.gov.au/sites/default/files/2023-09/Tasmanian%20Health%20Service%20Annual%20Service%20Plan%202023-24.pdf

Internal Foundation 3 – Strengthen Clinical Safety, Quality and Regulatory Oversight

KPI Number	KPI	Target
IF3-5	Consumer satisfaction with the quality and treatment of care – Oral Health	Not less than 80%
IF3-8	Hand hygiene compliance – Oral Health	Not less than 80%

Audit Mandate and Standards Applied

Mandate

Section 23 of the *Audit Act 2008* states that:

(1) The Auditor-General may at any time carry out an examination or investigation for one or more of the following purposes:

- (a) examining the accounting and financial management information systems of the Treasurer, a State entity or a subsidiary of a State entity to determine their effectiveness in achieving or monitoring program results;
- (b) investigating any matter relating to the accounts of the Treasurer, a State entity or a subsidiary of a State entity;
- (c) investigating any matter relating to public money or other money, or to public property or other property;
- (d) examining the compliance of a State entity or a subsidiary of a State entity with written laws or its own internal policies;
- (e) examining the efficiency, effectiveness and economy of a State entity, a number of State entities, a part of a State entity or a subsidiary of a State entity;
- (f) examining the efficiency, effectiveness and economy with which a related entity of a State entity performs functions –
  - (i) on behalf of the State entity; or
  - (ii) in partnership or jointly with the State entity; or
  - (iii) as the delegate or agent of the State entity;
- (g) examining the performance and exercise of the Employer's functions and powers under the *State Service Act 2000*.

(2) Any examination or investigation carried out by the Auditor-General under subsection (1) is to be carried out in accordance with the powers of this Act

Standards Applied

Section 31 specifies that:

> 'The Auditor-General is to perform the audits required by this or any other Act in such a manner as the Auditor-General thinks fit having regard to -
>
> (a) the character and effectiveness of the internal control and internal audit of the relevant State entity or audited subsidiary of a State entity; and
>
> (b) the Australian Auditing and Assurance Standards.'

The auditing standards referred to are Australian Auditing Standards as issued by the Australian Auditing and Assurance Standards Board.

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Hobart Office

Phone (03) 6173 0900
Email admin@audit.tas.gov.au
Web www.audit.tas.gov.au

Address Level 2, 144 Macquarie Street
Hobart, 7000
Postal GPO Box 851, Hobart 7001

Launceston Office

Phone (03) 6173 0971

Address 4th Floor, Henty House
1 Civic Square, Launceston