Barwon
Primary Care Forum

A Review of Dental Health in Geelong

A Report:
Created by the Barwon Primary Care Forum
On behalf of the Geelong Strategic Municipal Health Plan – Access to Services Sub-committee

February 2004

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INTRODUCTION

"Oral diseases and disorders have been described as the 'silent epidemic'. They constitute three of the five most prevalent health conditions in Australia and have a direct cost of over $1,935 million to the Australian health sector each year.'

Source: Dental Health Services Victoria, Health Purchasing and Provider Relations Division

The above description of the burden of disease of oral diseases and disorders along with the public demand for dental care, severe workforce shortages and steadily increasing waiting times all combine to tell the story about the dental health status and quality of life of those waiting for care . The **public consultations in 2001 for the Geelong Strategic Health Plan identified 'access to dental services' as a community priority.**

In response, this report looks closely at the 'state of dental health and dental health services' in the Greater Geelong area.

[**Note**: By **dental health services** (or dental services) we mean dentists, dental therapists and dental assistants that provide general dental care including non-emergency fillings, extractions, radiographs, check-ups, cleaning, etc.]

Improving the access to dental services is a task that may not be necessarily achieved at the local government area. However, the Geelong Strategic Health Plan **'Access to Services' Sub-committee** agreed that a comprehensive look at the issue was needed to assist community leaders in their decision-making.

Therefore, the identified **objectives** for the sub-committee are to:

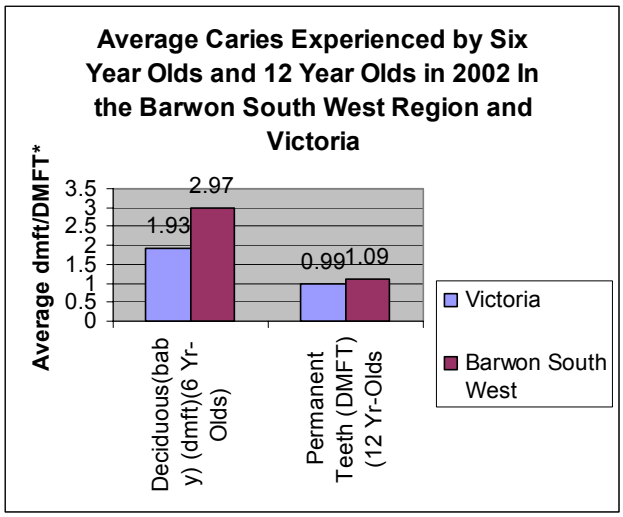
1. Understand the state of dental health in Greater Geelong
2. Identify services in the Greater Geelong area in relation to dental health
3. Raise awareness of the access to dental services issues in the Greater Geelong area

4. The sub-committee has reviewed and discussed all the possible types of barriers to 'access' to services. They are: Physical access, service delivery, cost, internal barriers, and knowledge of the services. The sub-committee has chosen to report on those barriers for which information is available.

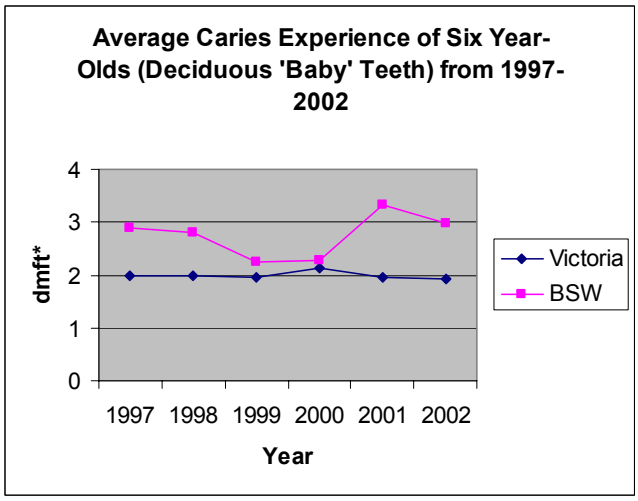
State of Dental Health:

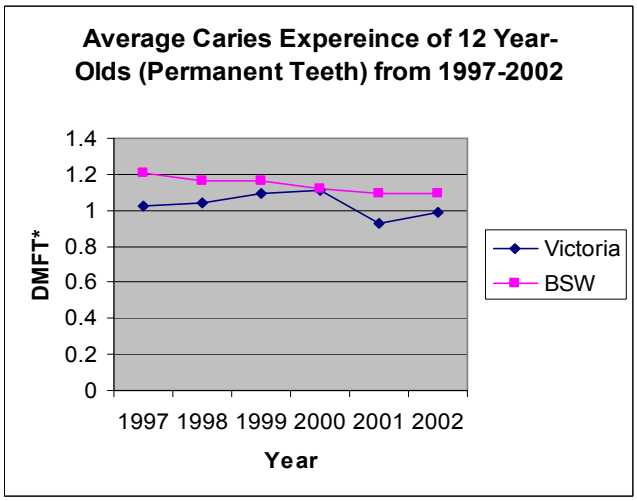
Children in the Barwon South West and Victoria

There is no specific report for the Barwon South West Region (BSW) regarding the state of dental health. However, this section attempts to collate the various data available in order to provide the reader a context within which to gauge the urgency of the problem in this region. ***The BSW Region has consistently higher averages of dental decay in children than the Victorian average.*** The following chart shows the average decayed, missing, and filled teeth (dmft) for both baby teeth and permanent teeth in children in 2002.[1] Of note is the average rate for caries (cavities) in deciduous (baby) teeth, which is 54% higher in the Barwon South West Region compared to the Victorian average.



This next chart shows this pattern to be fairly consistent over a period of six years:





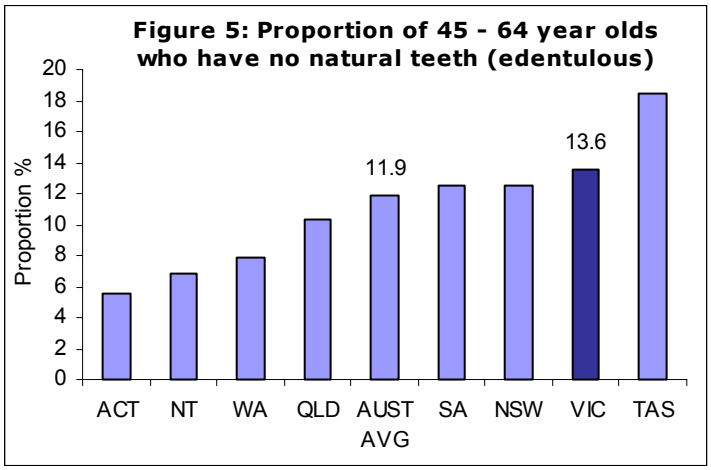
The School Entrant Health Questionnaire (SEHQ) was developed in 1997 by the Department of Human Services as part of the redevelopment of the Victorian School Nursing Program. It was distributed to parents and guardians of children aged 5-7. The results show that while 86.3% of Geelong school entrants had contact with a general practitioner (GP), only 61.1% had ever seen a dentist. This compares to the Victoria state average of 85% saw their GP and only 57.3% had seen a dentist.

Therefore, it would appear that although more Barwon South West school entrants have visited a dentist, the dental health of children 6 years old is much poorer than the average for Victoria.

[1] DHS. School Dental Service 2001. In PHKB/CHP dataset. Feb 2003.

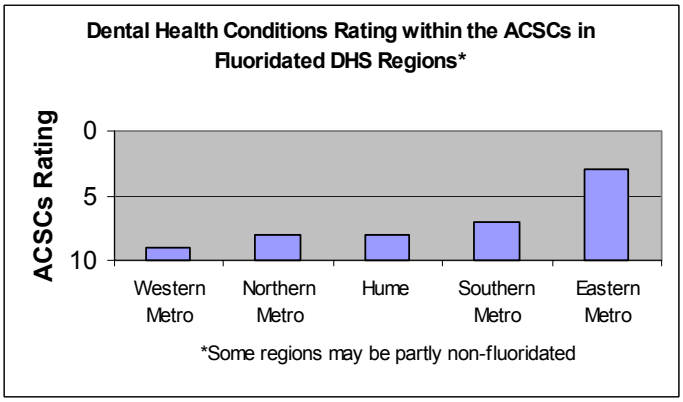
Victorian Adults

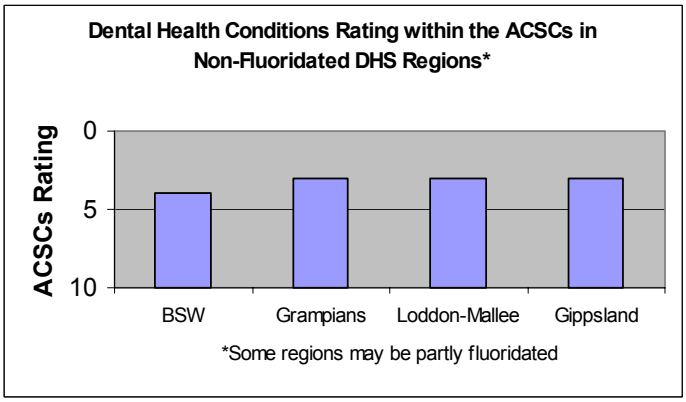
Victorian adults have poorer dental health than other mainland Australians. Fourteen per cent more Victorian 45-60 year olds have had all their teeth extracted compared to the national average (AIHW, DSRU 2001).



Hospitalisation Rates for Dental Conditions – A Regional Comparison

The Victorian Department of Human Services (DHS) examines the access to primary health care services by analysing those hospitalisations that occur for conditions that could otherwise be treated in an ambulatory care setting.[2] The Ambulatory Care Sensitive Conditions (ACSC) Study for 2000-01 lists dental conditions in the Barwon South West Region as being 4th amongst the top five ACSC conditions that incur hospitalisation. (They are diabetes complications, angina, chronic obstructive pulmonary disease, dental conditions and asthma.) In comparison, other DHS Regions that are in mainly metro regions (and thereby mainly fluoridated), dental conditions admissions are generally ranked 7th-9th (with the exception of Eastern Metro).





[2] Victorian DHS. Rural and Regional Health and Aged Care Services Division. *The Victorian Ambulatory Care Sensitive Conditions Study.* December 2002. www.dhs.vic.gov.au/phd/acsc/index.htm

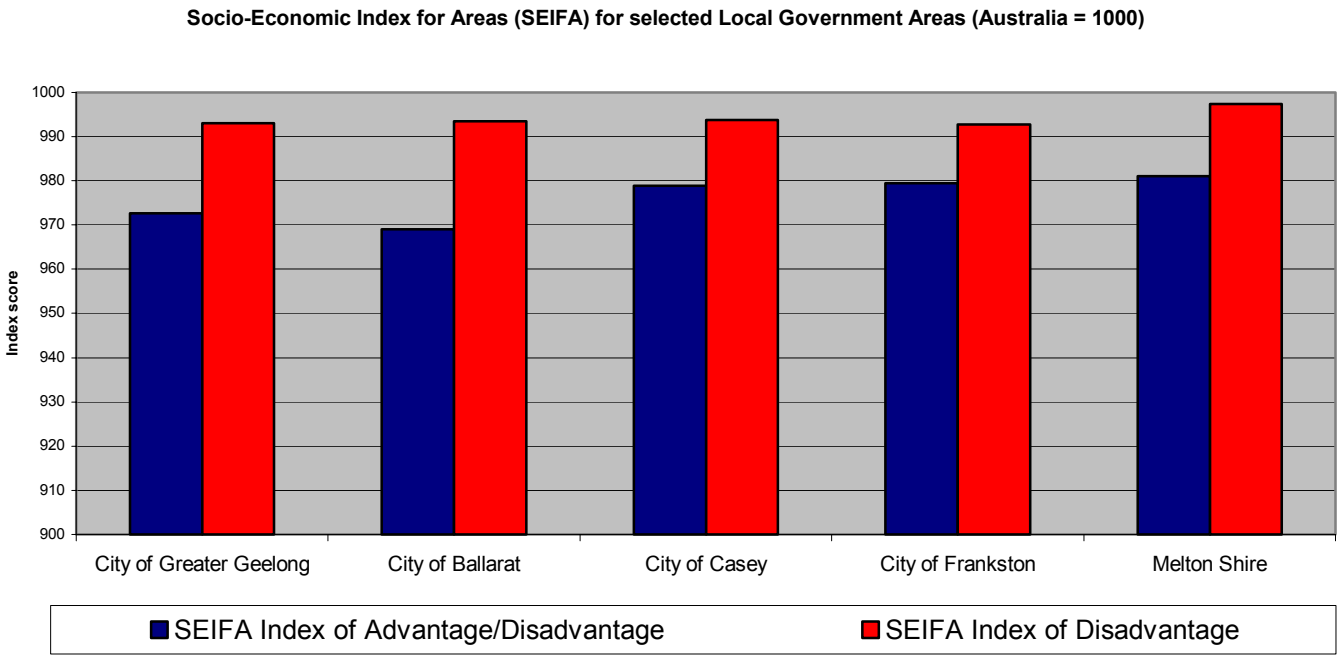
Hospitalisation Rates for Dental treatment for Geelong children (0-9 years) in relation to other similar Local Government Areas (LGAs) in Victoria

The Geelong Strategic Health Plan Consultative Committee recommended comparisons to LGAs that have a similar profile to that of Geelong for comparisons. The Australian Bureau of Statistics (ABS) develops indexes to allow ranking of regions so that it may provide a measure of social and economic wellbeing. The two indexes chosen are the Index of Advantage/Disadvantage and the Index of Disadvantage. Because it is perceived that socio economic factors influence dental health these indexes were selected as criteria for selection of the LGAs. Out of 78 LGAs in Victoria four metthe criteria. ***Of these four, Ballarat is similar to Geelong in that it is a regional non-fluoridated area, while Casey, Frankston and Melton are located in the Metropolitan area and have longstanding fluoridation.***

The Socio-Economic Indexes for Select Local Government Areas

The Index of Advantage/Disadvantage is used to rank areas in terms of both advantage and disadvantage. Any information on advantaged persons in an area will offset information on *dis*advantaged persons in that area. These indexes look at a number of variables such as education, occupation, income, and family type. For all indexes, a low score indicates disadvantage.

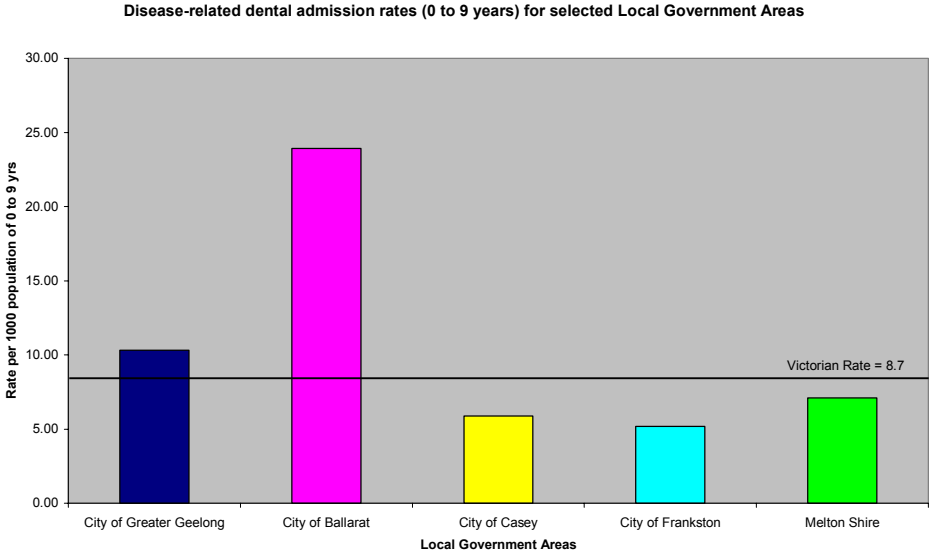
The Index of Disadvantage is the most general index, it includes all variables that either reflect or measure disadvantage. All the LGAs chosen have a score marginally less than the Australian average of 1,000, which indicates they have a slightly more than average number of disadvantaged people in those areas. Similarly these areas have a slightly lower score again on the advantage/disadvantage index, indicating that there are less advantaged people in this area. In other words, these areas have slightly higher disadvantaged people, but less advantaged people that may in other areas offset the disadvantaged. The following graph displays these similarities.



Disease-related dental admission rates (0 to 9 years) for selected Local Government Areas (LGAs)

In the absence of local data regarding dental disease, hospitalisation for dental related conditions may provide some indication of the level of dental health in Geelong. Analysis has been completed on the various admissions to hospital for children between the ages of 0 to 9 years for dental conditions such as dental caries, imbedded and impacted teeth, and other disorders of teeth and supporting structures. To make comparisons hospitalisation rates among the five LGAs (as per the above criteria) were investigated and controlled for population differences by calculating the rate per 1,000 of the 0-9 year old population.

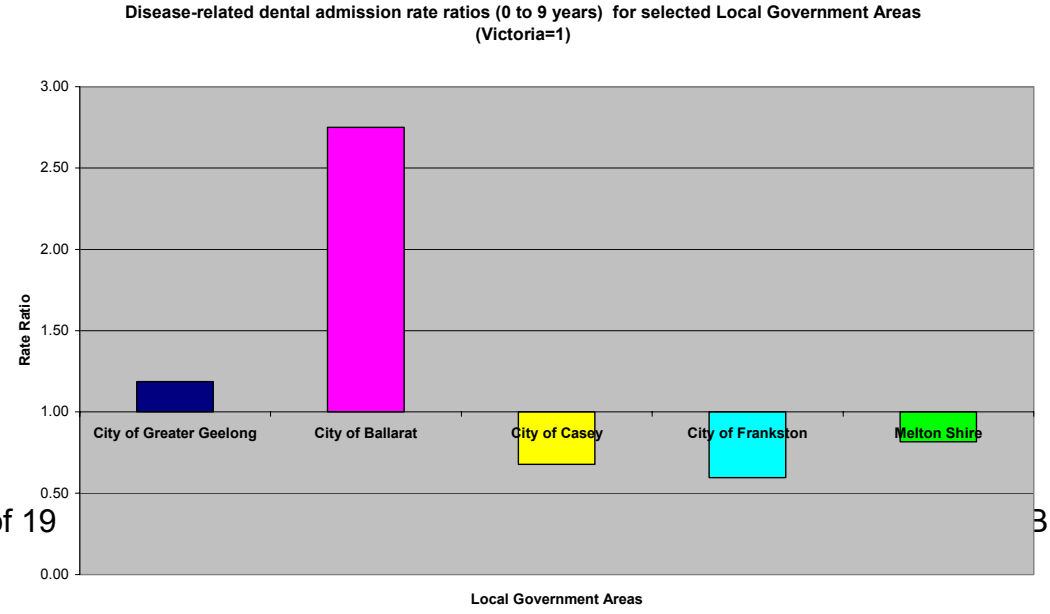
The graph below indicates that both Geelong and Ballarat are above the Victorian rate of 8.7 while the metro LGAs are below.



Note 1: Geelong and Ballarat are regional non-fluoridated LGAs while Casey, Frankston and Melton are urban fluoridated LGAs. All five have similar Indexes of Disadvantage/Advantage.
Note 2: Hospitals have different admitting practices and therefore the large variance between Ballarat and the other areas may not be necessarily only related to disease rates in Ballarat.

Disease-related dental admission rate ratios (0 to 9 years) for selected Local Government Areas (Victoria=1)

The next graph shows the same information but calculated as a rate ratio. A rate ratio helps make a comparison against a standard. Therefore, amongst selected LGAs, Ballarat has a hospitalisation rate ratio for dental admissions of 2.75, which is nearly three times as many admissions per capita compared to the Victorian average. Geelong, at the 1.19 rate ratio, is 19% higher than the Victorian average. Casey (.68), Frankston (.60) and Melton (.82) all are lower (by 32%, 40%, and 18% respectively) than the Victorian rate ratio.



2. Physical Access to Private and Public Dental Services

Workforce:

Dental workforce shortage (dentists, dental therapists, dental prosthetists and dental hygienists included) has been identified as problematic by the Dental Health Services, Victoria (DHSV).[3] In the City of Greater Geelong, with a population of 184,331 there are 86 dentists (73 private dentists listed with the ADA[4] and 13 public 'dental chairs') operating out of 50 (44 private, 7 public) dental sites (i.e. offices). In addition, there are 6 dental providers (5.6 FTE dental therapists and 0.4 FTE dentists) employed by the School Dental Service; operating out of 7 fixed chairs. This equates to an overall (public and private) per capita ratio of ***1 dental provider per 2,004*** people.

The rate of public dental chairs (13 Community Dental Program and 7 School Dental Service) per eligible persons (83,542 Health Care Card and/or Pensioner Concession Card holders eligible for Community Dental Program and 18,777 children/adolescents eligible for treatment via the School Dental Service[2]) in Greater Geelong and Surf Coast is ***1 chair per 5,116***. Current Department of Human Services public dental infrastructure planning principles aims for 1 'chair' (dentist) per 5,000 but the Victorian average is 1 in 10,000. [5]

Though public dental infrastructure planning ratios have been achieved throughout BSW Region, public dental waiting numbers and times are increasing. The range of current waiting times for general conservative care across the entire BSW Region is from 19 to 57 months; the range in the City of Greater Geelong is 19 to 31 months, with denture waiting times 20 to 38 months[2]. According to Dental Health Services Victoria, lengthening waiting times throughout the BSW Region are largely attributable to dental workforce recruitment difficulties. (More on waiting periods on page 11& 12).

Service Mapping:

The number of dentists alone still does not address the physical access issue. There is a need to look at where they are located in relation to the most disadvantaged in the area. 'Service Mapping' assists to spatially identify the location of both public and private dental health services in relation to place of residence of Concession Card/Health Care Card Holders, Indigenous Persons, and the Australian Bureau of Statistics 2001 'Disadvantage Index'. These particular indicators of disadvantage have been selected based upon the Public Health Association of Australia "Draft Oral health Policy 2003" circumstances regarding oral health:[6]

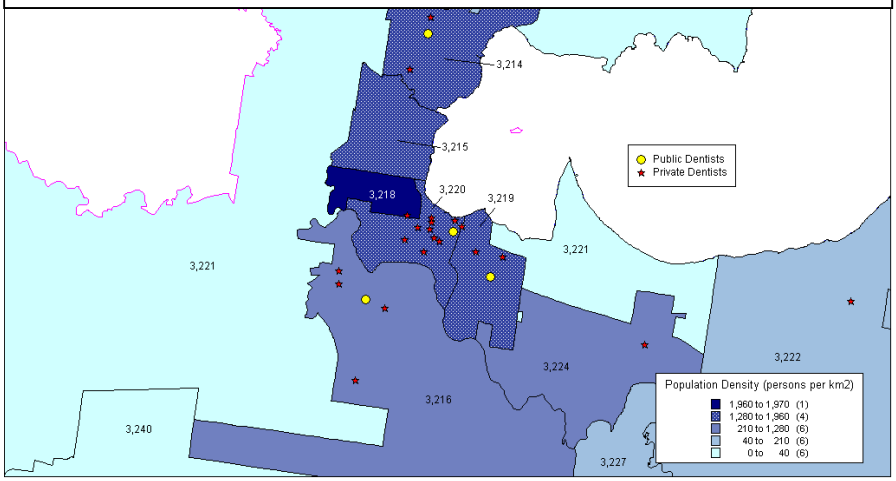
- "There are specific groups of people who experience greater levels of disease, including Aboriginal and Torres Strait Islander peoples, recent arrivals (particularly refugees), low-income earners, people in rural and remote areas and the dependent elderly."
- "Access to affordable, appropriate and timely dental care remains out of reach of many Australians. Low-income persons experience financial barriers; users of public dental services face long waiting lists, and in rural and remote areas accessibility and availabity of practitioners is limited."

Below are thematic maps that show the uneven distribution of public and private dentists in relation to population density, indigenous persons distribution, and especially the SEIFA Index of Disadvantage. Location of dentists all affects accessibility (eg transportation issues).

[3] DHSV, Health Purchasing & Provider Relations Division
[4] Australian Dental Association. List of ADA members by location (Victoria). 2003. and BH and BCH
[5] DHSV. Dr. Martin Whelan, Manager Clinical Analysis & Evaluation. October 2003.
[6] Public Health Association of Australia. Supplementary 'intouch' Draft Policies. 2003

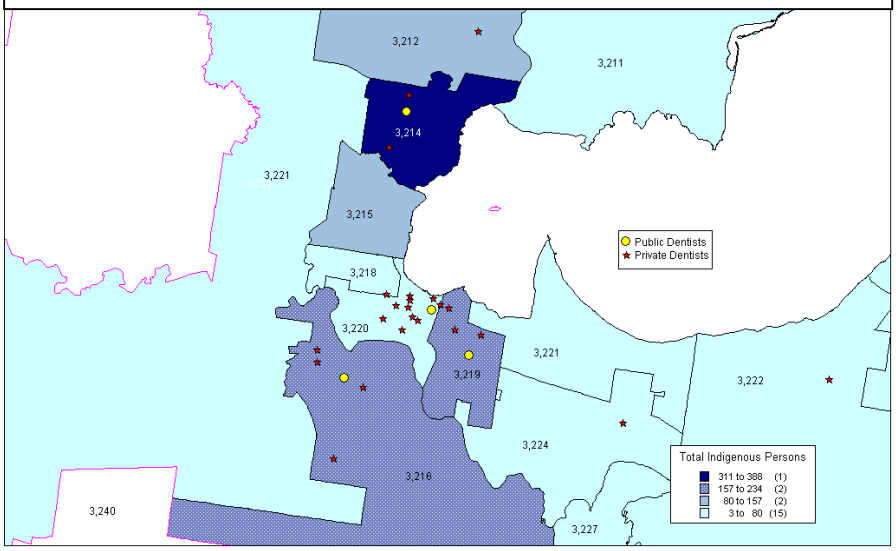
Thematic Map of the Distribution of Population Density and Location of Public and Private Dentists

Compiled by BPCF using ABS 2001 Data & MapInfo



Thematic Map of the Distribution of Indigenous Persons and Location of Public and Private Dentists

Compiled by BPCF using ABS 2001 Data & MapInfo

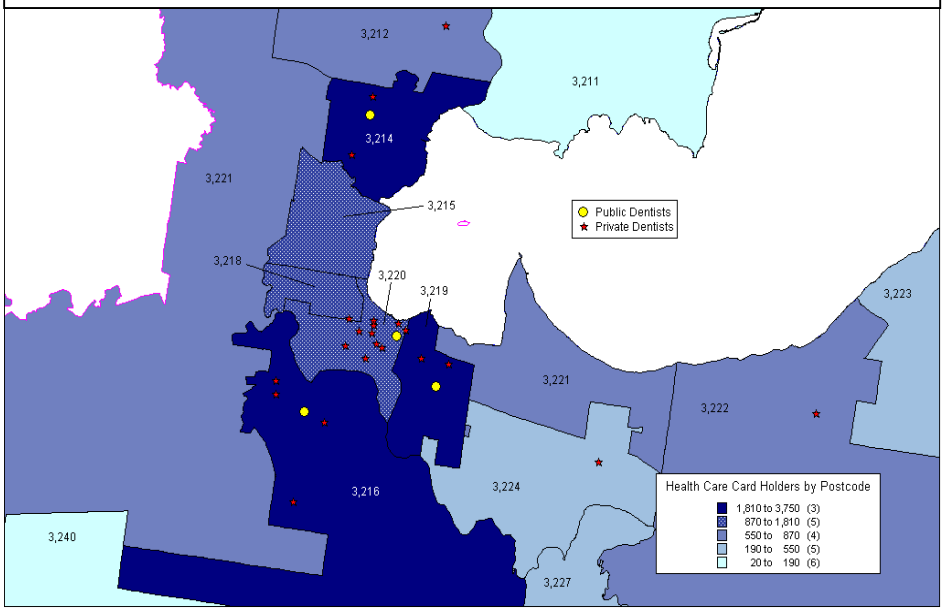


The above thematic maps show the uneven distribution of public and private dentists in relation to population density and indigenous persons distribution. Location of dentists all affects accessibility (eg transportation issues).

Lyn McInnes of the **Wathaurong Aboriginal Cooperative**, based in North Geelong, states that they provide a bi-weekly transportation van to the Aboriginal Dental Services in Melbourne for their people.

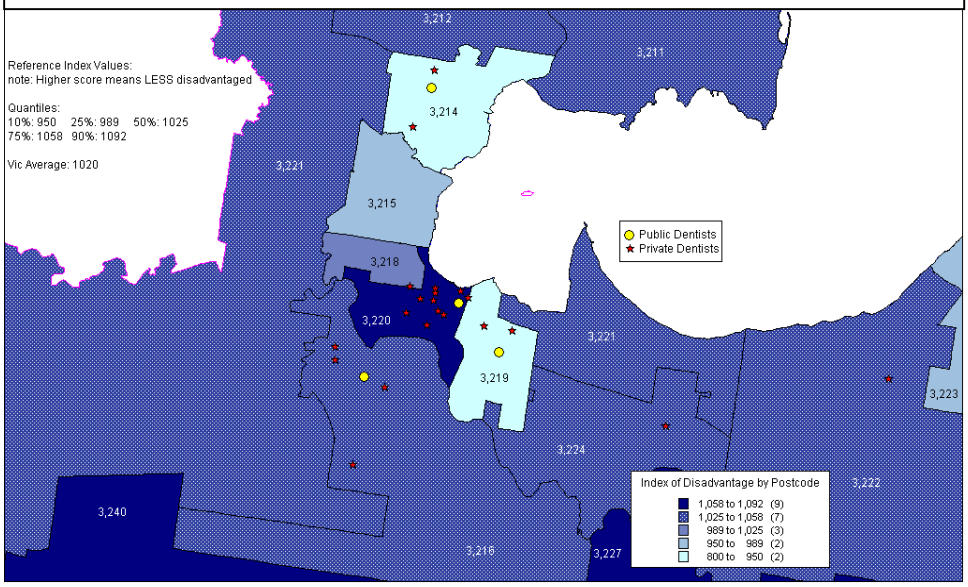
Thematic Map of the Distribution of Health Care Card Holders and Location of Public and Private Dentists

Compiled by BPCF using Centrelink, ABS 2001 Data & MapInfo



Thematic Map of the Distribution of Index of Disadvantage* and Location of Public and Private Dentists

Compiled by BPCF using Centrelink, ABS 2001 Data & MapInfo



The above thematic maps show the uneven distribution of public and private dentists in relation to health care card holders and those most disadvantaged* distribution. ***Location of dentists all affects accessibility (eg transportation issues).***

*Index of Disadvantage is derived from attributes such as low income, low educational attainment, high unemployment; jobs in relatively unskilled occupations and variables that reflect disadvantage rather than reflect specific aspects.

3. Public Dental Service Delivery Issues

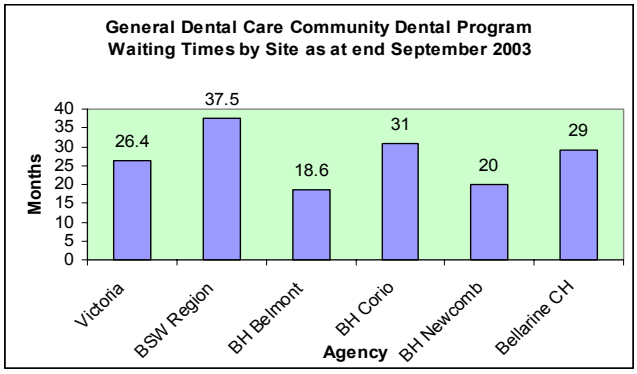
Waiting Periods

Dental Health Services Victoria (DHSV) is responsible for the public dental provision and purchasing of dental services. Services are provided Statewide through the School Dental Service (SDS), clinics operating the Community Dental Program (CDP) and the Royal Dental Hospital of Melbourne (RDHM). In the City of Greater Geelong, DHSV purchases CDP services from Barwon Health and Bellarine Community Health and directly provides child/adolescent services via the traditional SDS. According to DHSV, some of the issues in Victoria with regards to current CDP waiting lists are[2]

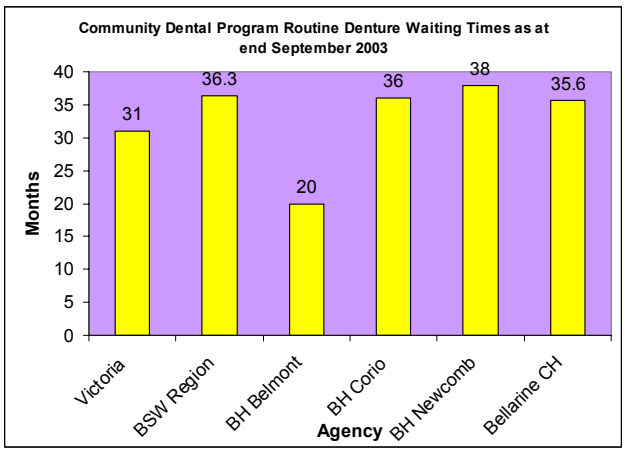
- Long and increasing waiting times
- Wide variations in waiting times across agencies
- Overstatement of numbers of patients waiting
- No systematic emergency triage system
- No prioritisation of need onto general waiting lists
- Inconsistent application of waiting list rules resulting in inequity of access

In Geelong the waiting period for adult public dental services averages 24.65 months. There is on average a 75-80% uptake when people are contacted (on the waiting list) for treatment. Of those who do not respond many have moved within the area and it is estimated about 10-15% re-emerge for treatment. The local public dental services have a systematic emergency system (during office hours) that provides treatment within 24 hrs from where the services are located.

Community Dental Program Waiting Times as at end September 2003.



(General dental care includes non-emergency fillings, extractions, radiographs etc.)



(Routine denture services are generally non-emergency denture replacements and does not include denture repair services.)

In view of the above, DHSV has proposed the implementation of a statewide waiting list database and triage system. This would allow, among other things, for prioritisation of access to care for those with greatest clinical need and more equitable distribution of available resources.

Public Dental Funding per Capita:

Victorians receive the lowest per capita public dental funding than residents of any other State (Table 1).[7] It is estimated that Victoria needs to provide an additional $30 million of funding per annum to reach the Australian per capita average.

Table of the Australian Dental Expenditure by State, FY 2001-02 (excludes co-payment revenue)

	VIC	NSW	Qld	WA	SA
Expenditure per person	**$13.22**	$13.47*	32.14	27.06	24.83
% National average	**69%**	70%	168%	141%	130%

* NSW has recently announced $20million in extra funding for dental services.

In contrast to the position of DHSV (as stated on page 8) the Victorian Healthcare Association maintains that the inadequate allocation of funds for public dental services is responsible for the unacceptable waiting times Victorians endure to access dental services.

In addition, the inadequacies of the dental funding formula means that it is no longer financially viable for the majority of agencies to provide public community dental services in Victoria (VHA, November 2003).

Eligibility Criteria and Fees:

School Dental Service

- Only for primary school children in Years 1-6 inclusive
- Dental therapists are trained to provide the service to school aged children
- Children are examined on a two year cycle with high risk children being recalled within one year (this is dependant upon their level of need)
- Free to dependants of valid *Pensioner Concession Card* or *Health Care Card* holders
- Free if child is enrolled in a Special or Special Development School
- Non card holders pay a fee of $25 per child (maximum $100 per family) per course of care
- Payment may be made either by cheque payable to DHSV or credit card

Community Dental Program

- $20 co-payment is payable at each visit, up to a maximum of $80, for general dental care (max does not apply for more advanced dental treatments such as specialist services)
- $20 co-payment is required for an emergency dental visit
- Acrylic dentures will generally cost a maximum of $100
- Payment is made directly to the community dental agency, generally by cash or EFTPOS
- There are exemptions to co-payments and priority access for clients with other health related conditions.

[7] Victorian Healthcare Association, November 2003.

4. Other factors that prevent access to dental health services: Internal barriers

Perceptions of Dental Health: A Survey in the Corio Norlane Area

In a recent study conducted by Deakin University on behalf of the Department of Human Services, 40 interviews were conducted with service providers who work in the Corio and Norlane suburbs[8]. Of these, dental health was raised as a 'major' or 'huge' issue according to 14 of the interviewees. Some of the issues faced by residents that were raised by the service providers were:

- Waiting list for dental treatment at the Community Health Centre in Corio
- Access to dental services stating high costs of dental services (in both private and community dental clinics) and knowing how to access the available services (eg homeless people in the area may not be able to provide documentation to apply for a health care card).
- Poor oral hygiene by children (in one kindergarten it was estimated that only three of 25 children would regularly brush their teeth in the morning).

Public Perceptions of Dentistry: A National Survey.[9]

There is no known survey in the Barwon South West (BSW) region regarding the attitudes and perceptions of dentists and dental care by local residents. Therefore, the *"Public Perceptions of Dentistry: Stimulus of barrier to better oral health"* paper published by the AIHW Dental Statistics and Research Unit (DSRU) based at the Adelaide University may help us understand some of the internal barriers that may influence access to dental services in the BSW. The following results are a compilation of the results from various surveys conducted in Australia.

Gender, Cultural or Age Preferences:
Generally respondents to a National Survey in 1999 did not show any preference for gender, culture or age preference in their dentist. However, there were some trends in some minority groups. For example, older people prefer a male dentist, 35 years and over and of their cultural group

Dental Anxiety:
Dental anxiety, as opposed to dental phobia, is defined as a vague unpleasant feeling due to past experiences or personality types. It may result in avoidance of dental care. *One in seven persons survey experienced dental anxiety.*

Social Values and Choice of Provider:
Egalitarian values, defined, as the equal opportunity to access government service, were important to the respondents. *This was reflected as strong endorsement for government provided dental assistance for all children*

Public knowledge in prevention of caries (cavities) and gum diseases:
Although dental caries (cavities) and gum disease are preventable with appropriate dental health behaviour, these diseases continue to be prevalent in Australia. In 1992, a questionnaire was sent to residents of South Australia to survey their views on their understanding on how to prevent dental caries (cavities) and disease. *There was a lack of appreciation for the critical importance of fluorides in preventing tooth decay.* In terms of gum disease, knowledge of preventive measures was more accurate. *Women, older people and those with lower*

[8] Savage S, Bailey S, and Wellman D. *Residents of Corio and Norlane: Enhancing well being. The perspective of service providers.* Deakin University. 2003.
[9] AIHW Dental Statistics and Research Unit. **Public perceptions of dentistry: stimulus or barrier to better oral health. 2002.** http://www.adelaide.edu.au/socprev-dent/dsru

educational attainment were more likely to hold incorrect views on effective preventive measures.

Support for Water Fluoridation in Australia:
In 1999, over 1500 residents in Australia were sent a written survey on the perceptions of fluoridated water. *Over two thirds (68.7%) of these favoured water fluoridation to prevent children's teeth decaying.* There was stronger support among young persons, those with higher education, residents of capital cities and those who reported their water supply to be fluoridated and who obtained information from their dentists. These results matched market surveys conducted in the early 1990s and more recently a market research in Brisbane in February 1997 (a city that does not fluoridate its water supply), with 62% in favour of the fluoridation of the Brisbane water supply.

NOTE: Water fluoridation is recommended by the following: Victorian State Government, the Australian Dental Association, and the World Health Organization. The United States Centres for Disease Control have rated fluoridation as one of the top 10 public health measures of the 20th century.[10] Melbourne has been fluoridated since 1977.[11]

Oral Health Education and Oral Health[12]

Research has shown that oral health education, in the short term is effective in promoting behaviour change. To achieve longer-term behaviour change, continued contact with a dental professional is more effective*. In fact, some educational interventions are effective for higher income groups while lower income groups showed little or no change.*

Oral Health and the Vulnerable[13]

In August 2002 the then Minister for Health, John Thwaites was quoted as saying:
"Oral diseases such as dental decay and gum disease are amongst the most common of all diseases. ***While most people are affected by these problems their impact is greatest on the most vulnerable in our community.*** For example, Victorians on low incomes are twice as likely to have had all their teeth extracted." Pg iii

[10] ADA. Press Release: "Part of the Waiting List Solution – Fluoridation. 28 April 2003. www.adavb.com.au
[11] ADA Victoria. Fact Sheet: Dental Waiting Lists and Dentist Shortages. As at November 2002.
[12] DHS Victoria. Public Health Division. *Evidence-based health promotion resources for planning: No.1 Oral Health*. Jan 2000.
[13] DHS Victoria. Rural & Regional Health and Aged Care Services. *Improved oral health for older people*. August 2002.

SUMMARY

Public consultations in 2001 for the Geelong Strategic Health Plan identified 'access to dental services' as a community priority. In response, the Geelong Strategic Health Plan sub-committee decided that a closer look at the 'state of dental health services' in the Greater Geelong area was needed in order to better inform decision makers.

A summary of findings is as follows

At a local level:

- The BSW Region has consistently higher averages of dental decay in children than the Victorian average.
- It would appear that although more Barwon South West school entrants have visited a dentist, the dental health of children 6 years old is much poorer than the average for Victoria
- The hospitalisation rate ratio for dental admissions for Geelong is 19% higher than the Victorian average. While similar LGAs such as Casey (.68), Frankston (.60) and Melton (.82) are all lower (by 32%, 40%, and 18% respectively) than the Victorian rate ratio.
- Victorian adults have poorer dental health than other mainland Australians. Fourteen per cent more Victorian 45-60 year olds have had all their teeth extracted compared to the national average (AIHW, DSRU 2001).
- The overall (public and private) per capita ratio for Geelong is ***1 dental provider per 2,004*** people.
- The rate of public dental chairs per eligible persons (ie concession card holders) in Greater Geelong and Surf Coast is ***1 chair per 5,116***.
- The range of current waiting times for general conservative care in the City of Greater Geelong is 19 to 31 months, with denture waiting times 20 to 38 months[2]. Lengthening waiting times throughout the BSW Region are largely attributable to dental workforce recruitment difficulties.
- Thematic maps that show the uneven distribution of public and private dentists in relation to population density, indigenous persons distribution, and especially the SEIFA Index of Disadvantage. Location of dentists all affects accessibility (eg transportation issues). (Pg 4)
- The inadequacies of the dental funding formula means that it is no longer financially viable for the majority of agencies to provide public community dental services in Victoria. (VHA, Nov 2003)
- Both Geelong and Ballarat are above the Victorian hospitalisation rate of 8.7 per 1,000 children 0-9 years of age (for dental conditions) while the metro LGAs of Casey, Frankston and Melton are below.

Summary of National surveys:

- Generally respondents to a National Survey in 1999 did not show any preference for gender, culture or age preference in their dentist.
- One in seven persons surveyed experienced dental anxiety.
- There is strong endorsement for government provided dental assistance for all children
- There was a lack of appreciation for the critical importance of fluorides in preventing tooth decay
- Women, older people and those with lower educational attainment were more likely to hold incorrect views on effective preventive measures.
- Over two thirds (68.7%) of these favoured water fluoridation to prevent children's teeth decaying.
- Oral health education was seen to be effective for higher income groups while lower income groups showed little or no change.

Victoria focus:

- While most people are affected by these problems their impact is greatest on the most vulnerable in our community.

CONCLUSION

This report documents that there are 83,542 Health Care Card and/or Pensioner Concession Card holders eligible for the Community Dental Program and 18,777 children/adolescents eligible for treatment via the School Dental Service in Geelong and that due to the low public dental funding, the average waiting period for adult public dental services is over 24 months. No one indicator can inform the current state of dental health in Geelong. In the past, reports have focused solely on access to dental services as being an indication of the severity of the problem; yet although waiting lists give some indication of demand, they are only one of many possible variables that impact on dental health.

Therefore this report looked at many measurable variables including access to services such as school dental surveys, hospitalisation rates, rates of cavities and where possible compared these to, similar areas that are either fluoridated or non-fluoridated. Statistics indicate that children in the Barwon South West region have a high tooth decay rate (DHS); that low-income groups are the most vulnerable to tooth decay and gum disease; and dental access is consistently identified as a problem by the community (GSMPHP and Deakin University).

This documentation indicates that the BSW Region has consistently higher averages of dental decay in children than the Victorian average and that the dental health of children 6 years old is much poorer than the average for Victoria

A summary of issues at a Local, state and national level are detailed in the summary on page 15.

In addition the available documentation indicates that low-income groups are least likely to benefit from oral health promotion activities (University of Adelaide Study) and there does not seem to be increased funding projected for public dental services (DHSV). When community consultations were conducted (eg Deakin Study, Community Building, and Municipal Public Health Plan consultations) access to dental services was consistently named as the solution however this is only one factor. It is a problem that affects mostly those people in disadvantaged circumstances and therefore a multi-faceted solution is required.

Since these issues tend to be universal, National and statewide peak bodies state that the most equitable and cost benefit solution to dental health is fluoridation.

APPENDICES

Appendix 1 Eligibility criteria to public dental health services

School Dental Service
All primary school children
Children in year levels 7 & 8 whose parents hold a concession card (pensioner concession card or health care card)

Community Dental Program
Anyone who holds a valid Health Care or Pensioner Concession Card

Delivery of public dental health services
School Dental Service
It is planned that the SDS offer care to all schools every two years. Children with high dental needs are seen every 12 months or less
Offers: examination care, fissure sealants, fluoride application, fillings, radiographs, extractions

Community Dental Program, delivered by community dental agencies
Emergency relief of pain is generally available within 24 hours.
Offer: General dental care, emergency dental care, and denture services

To assist in meeting the demands for public dental services, public dental clinics may decide to authorise the provision of certain services by a private practitioner. These include: the Victorian Emergency Dental Scheme (only certain emergency procedures) or Victorian General Dental Scheme or Victorian Denture Scheme. Patient co-payments still apply.

Appendix 2 'Access to Services' Sub-committee of the Geelong Strategic Health Plan – Membership List

Members
Sandy Austin, Executive Officer, Barwon Primary Care Forum (Sub-committee convenor)
Roy Calic, Client Services, Geelong Ethnic Communities council
Jo Chambers, Community Services Partnership, DHS
Liz Coles, Community Development, CoGG
Grant Hamilton, Primary Care Manager, Bellarine Community Health
Rob Kennedy, Service Coordination project Officer, Barwon Primary Care Forum
Murray Scott, Rural Access, CoGG
Michael Smith, Director of Dental Services, Barwon Health

Occasional Members (as per topic of interest)
Jan Cheatley, Lifeline
Andy Worland, Geelong Info Pages
Miriam Manitveld, Barwon Adolescent Task Force (Batforce)
Kylie Pollock, Neighbourhood Houses Coordinator

Acknowledgments

Special thanks to Dr. Michael Smith, Director of Dental Services for Barwon Health, Mr. Grant Hamilton, Manager, Primary Care Services, Bellarine Community Health, Dr. Helen Marchant and Sandra Falkner at DHS Public Health Division and to Sherrie Knight and Rebecca Northcott at DHSV for their supply of information and advice regarding dental services in Victoria and Geelong.