Oral health care delivery system in Australia

Dr Mohammed Junaid
BDS, MDS (Public Health Dentistry), MFDS RCPS (Glasg.), DDPH RCS (Eng.), MDentPH (USyd), SFHEA, PhD (UWA)
Senior Lecturer – Dental Public Health

Australian Government

Services Australia

THE UNIVERSITY OF WESTERN AUSTRALIA

Oral Health Centre of Western Australia

Acknowledgement of country

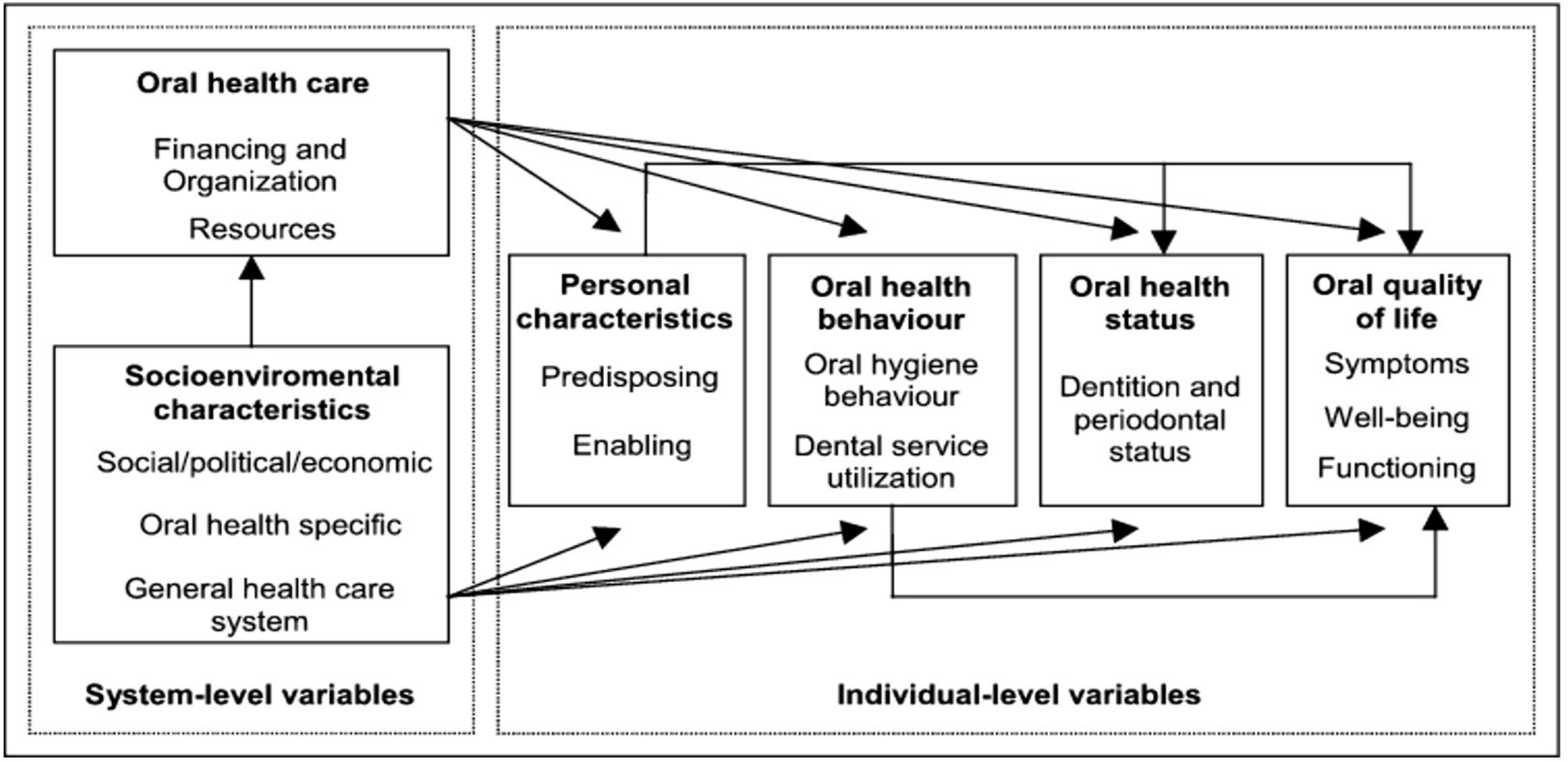
I would like to acknowledge the traditional custodians of the land, in whose land, I recorded this lecture and where you are listening to this recording, and pay my respects to elder's past, present and emerging.

Image sourced from Sister Kate's Home Kids Aboriginal Corporation https://www.skhkac.org.au/art-is-healing/

Learning outcomes

1. Understand the basic oral health care delivery framework.
2. Oral health care delivery models followed globally and in Australia.
3. Describe the current dental public system in Australia and Western Australia (specifically).
4. Improve understanding and appreciate relevance of current public dental schemes in Australia.

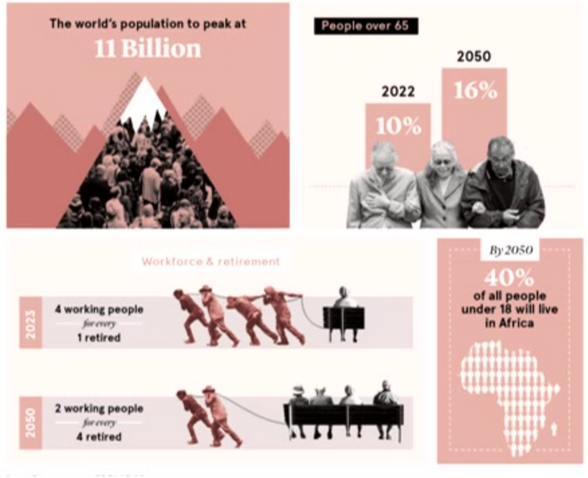
Overview of the oral health system



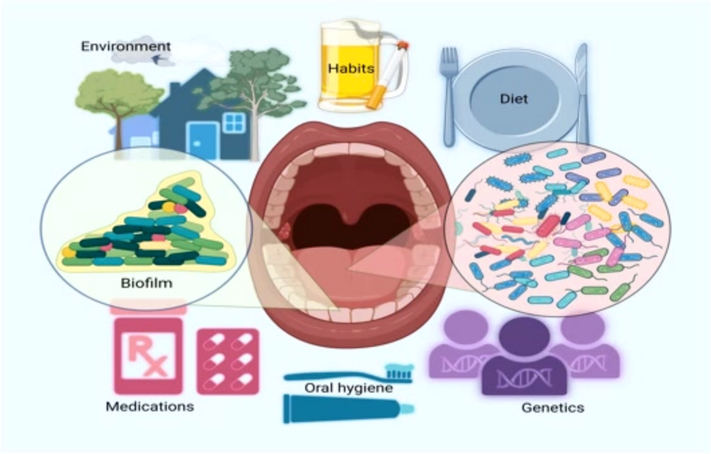
Klingenberger, D. (2008). Health System in Dentistry . In: Kirch, W. (eds) Encyclopedia of Public Health. Springer, Dordrecht. https://doi.org/10.1007/978-1-4020-5614-7_1481

Factors influencing development of health care systems

1. Demographic change

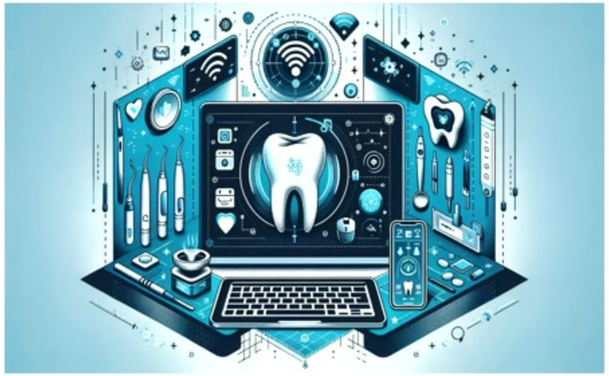


2. Evolving patterns of disease and their impacts



3. Public demand for healthcare

4. Technology



5. Globalisation

6. Economy

Content Source:
Daly, Blánaid, and others, 'Overview of health care systems', *Essential Dental Public Health* (Oxford, 2013; online edn, Oxford Academic, 12 Nov. 2020), https://doi.org/10.1093/oso/9780199679379.003.0024, accessed 20 June 2024.
Image sources:
Sydney Business Insights https://sbi.sydney.edu.au/megatrends/demographic-change/ accessed 20 June 2024.
Shanmugasundaram, S., Nayak, N., Karmakar, S. *et al.* Evolutionary History of Periodontitis and the Oral Microbiota—Lessons for the Future. *Curr Oral Health Rep* **11**, 105–116 (2024). https://doi.org/10.1007/s40496-024-00370-7 accessed 20 June 2024.
Journal of Economic Society of Australia, https://eap-journal.com.au/public-demand/ accessed 20 June 2024.
Dentist Magazine, https://dentistmagazine.co/insight/teledentistry-and-its-future-potential/ accessed 20 June 2024.
StreetFins, https://streetfins.com/intro-to-healthcare-economics/ accessed 20 June 2024.

Components of health care systems

Gift and Andersen (2007) suggest that health care systems can be divided into a number of aspects. These are:

- Structure: how the system is structured.
- Functions: what the system set out to achieve.
- Personnel: who delivers the work.
- Funding: where the funds are derived from.
- Reimbursement: how workers are paid.
- Target population: which groups are prioritized.

Content Source:
Daly, Blánaid, and others, 'Overview of health care systems', *Essential Dental Public Health* (Oxford, 2013; online edn, Oxford Academic, 12 Nov. 2020), https://doi.org/10.1093/oso/9780199679379.003.0024, accessed 20 June 2024.
Image source: Australian Institute of Health and Welfare, https://www.aihw.gov.au/

Components of health care systems

Fig 17-2 Taxonomy for systematic cross-national comparative analysis of oral health care systems*

Personnel
- Dentist
- Dental hygienist
- Dental therapist
- Expanded-duty assistant
- Dental assistant
- Oral health community worker
- Community worker
- Other health care and social work professionals (e.g., physicians, nurses)

Target population
- Infants
- Preschool children
- School-age children
- Young adults
- Adults
- Older adults
- Special care populations (e.g., nursing home residents)
- Identified occupational groups (e.g., military)
- Identified racial or income groups (e.g., Native American in the USA)

Structure/location
- Government facilities
- Universities
- Worksites
- Hospitals, institutions
- Schools
- Health/dental clinics
- Mobile Units
- Individual dental offices
- General community facilities

Functions
- Policy development and implementation
- Administration
- Quality control
- Research
- Professional education
- Public oral health education
- Preventive services
- Emergency services
- Treatment services

Financing
- General government revenue
- Specific taxation
- Compulsory insurance
- Insurance or prepayment supported by employer or individual
- Direct payment, private income

Reimbursement
- Fee-for-service
- Capitation
- Contract
- Salary

With what effect (examples)
- Appropriate dental care
- Improved knowledge, values, opinions and behaviors regarding oral health
- Less dental caries among adults
- Reduced tooth loss
- Improved oral health

*A comprehensive assessment of a national oral health care system minimally requires description of who provides what services/functions for whom in what locations with what resources by what payment mechanisms with what effect.

Content Source:
Cynthia Pine and Rebecca Harris, 'The Principles of Organisation and Models of Delivery of Oral Health Care', *Community Oral Health* (Quintessence books, 2007), page no:426,

Oral health service delivery models – A global context

Health care models	Important features	Countries
Bismarck model (government-regulated social insurance system)	- Oral care mainly financed through compulsory social insurance. - Contributions from employees and employers as a fixed percentage of their income. - Provision relies on private dental practitioners - Benefits cover restorative care.	Austria, Belgium, France, Germany, Luxembourg, Netherlands, Switzerland, Japan
Beveridge model (government-organised and tax-financed national health system)	- Financing through general taxation. - Oral health services are provided by publicly owned and managed institutions. -Universal access to oral care.	Denmark, Finland, Sweden, United Kingdom, Norway, Portugal, Spain, Italy, Greece, Ireland, Iceland, New Zealand, Cuba
Semashko model [(mixed system of Bismarck (financing) and Beveridge (provision)]	- Oral care mainly financed through compulsory social insurance. - Dentists are salaried public employees. - Oral health facilities are publicly owned.	Central and eastern European countries (CEE)
The National Health Insurance Model	- Government run insurance program funded by citizen. - Dental services not covered adequately but will cover uninsured Canadians family annual income under CA$ 90,000 from 2025.	Canada, Taiwan and South Korea
Out of pocket model	- Individuals responsible for costs of dental care	Especially Low Middle-Income countries
Hybrid model	Combination of any of the above systems along with private insurance BUT DENTAL COVERAGE INADEQUATE.	Australia, USA and many OECD countries.

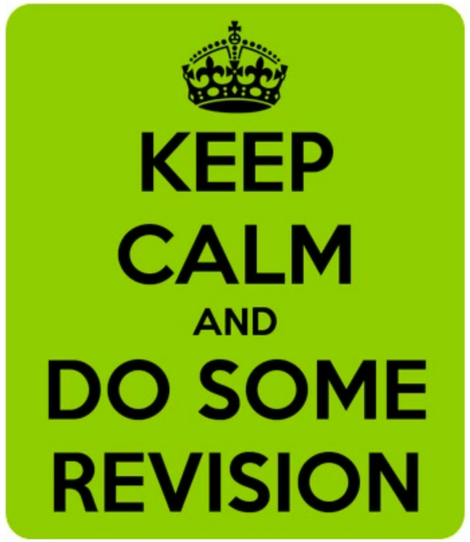
Klingenberger, D. (2008). Health System in Dentistry . In: Kirch, W. (eds) Encyclopedia of Public Health. Springer, Dordrecht. https://doi.org/10.1007/978-1-4020-5614-7_1481
Cynthia Pine and Rebecca Harris, 'The Principles of Organisation and Models of Delivery of Oral Health Care', *Community Oral Health* (Quintessence books, 2007),
Wallace LS. A view of health care around the world. Ann Fam Med. 2013 Jan-Feb;11(1):84. doi: 10.1370/afm.1484.
Australian Medical Association, https://www.ama.com.au/sites/default/files/2023-12/Discussion%20paper_Rethinking%20funding%20models%20to%20align%20with%20population%20health%20goals_0.pdf

Quick revision…

1. Factors that influence development of health systems.
2. Components of a health system.

a. Structure
b. Target population
c. Functions
d. Personnel
e. Funding
f. Reimbursement

3. Oral health delivery models – globally.

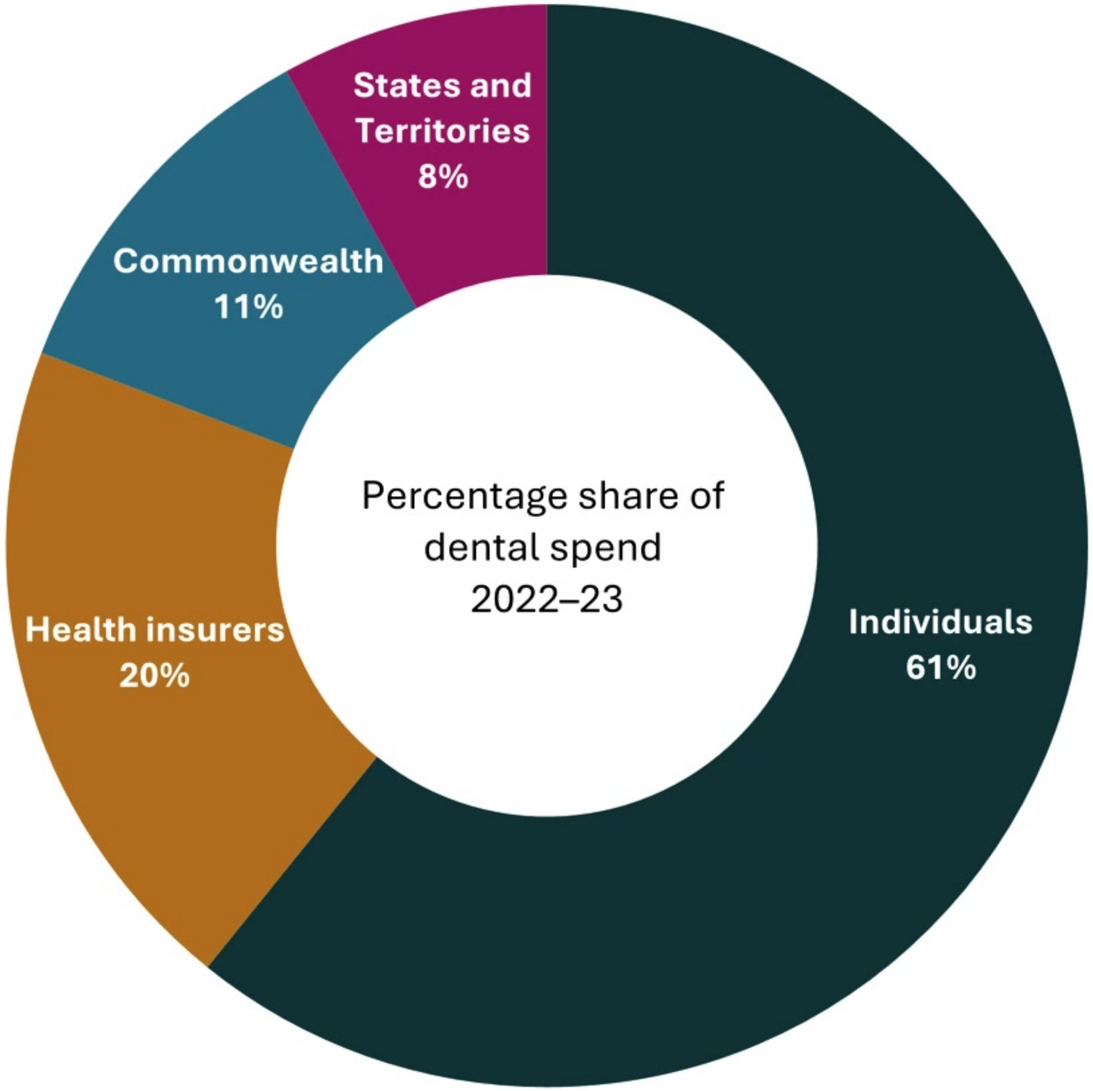


Oral health care system in Australia

Image source: https://www.healthdirect.gov.au/what-is-medicare

Who pays for dental services in Australia?

In 2022–23, $12.5 billion was spent on dental services in Australia. Individuals spent more than $7.6 billion, health insurers close to $2.5 billion, the Commonwealth nearly $1.4 billion, and state and territory governments nearly $1 billion.



Source Parliament of Australia : https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/Research/Policy_Briefs/2025-26/Commonwealthfundingfordental?utm_

History of public dental funding in Australia

A shared responsibility: State delivery, Commonwealth support

Not in Medicare
Unlike medical care, dental care has never been included in Medicare.

State led, Commonwealth supports
States and territories have always delivered public dental services, with funding help from the Commonwealth.

Focus on need
Programs have mainly targeted children, vulnerable people, and those with specific health conditions.

Still evolving
Australia continues to debate how to make dental care fairer, more accessible and affordable for all.

KEY MILESTONES

1900s–1970s — Early public dental services
States establish public dental services, mainly focusing on school children and people in need.

1946 — Commonwealth gains power to fund dental services
A constitutional change allows the Commonwealth to fund dental services, but states remain responsible for delivery.

1973–1981 — National School Dental Scheme
Commonwealth funds a national scheme to improve children's oral health through school dental services.

1973 & 1981 — Medibank (1975) and Medicare (1984) exclude dentistry
Dental care is left out of Australia's universal health insurance and remains mostly a private expense.

1994–1996 — Commonwealth Dental Health Program (CDHP)
First major program for adults. Aimed to reduce public dental waiting lists and improve access for those most in need.

2000s — Targeted programs for specific groups
- Veterans' Dental Program expands
- Medicare Chronic Disease Dental Scheme (2007) provides Medicare-funded dental care for people with chronic conditions (ended in 2012).

2014–present — Child Dental Benefits Schedule (CDBS)
Medicare-funded scheme for eligible children (0–17 years) for basic and preventive dental care delivered by private dentists.

2014–present — Commonwealth–State agreements for adult public dental services
Ongoing funding partnerships to support public dental services for adults, especially concession card holders, and reduce waiting lists.

2020s and beyond — Looking to the future
Growing calls for universal dental care and inclusion in Medicare to achieve better oral health for all Australians.

HOW FUNDING WORKS TODAY

Commonwealth Government
Provides targeted funding and payments (e.g. CDBS) and contributes to state programs.

Funding agreements and payments

$

State and Territory Governments
Plan, fund and deliver public dental services to eligible people.

Australians
Most dental care is still provided by private dentists.

THE BIG PICTURE

- ✓ Australia has never had universal public dental coverage.
- ✓ Funding has focused on children, vulnerable people and those with specific health needs.
- ✓ States deliver the services; the Commonwealth provides support.
- ✓ Better oral health improves overall health, equality and quality of life.

THE GOAL

A fair and accessible dental system where every Australian can get the care they need to keep their mouth healthy and their body healthy.

Source Adapted from Parliament of Australia : https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/Research/Policy_Briefs/2025-26/Commonwealthfundingfordental?utm_

Funding of health care in Australia – a shared responsibility

Table 1: Funding sources for health services in Australia[28]

Commonwealth Government	• Medical services through the MBS (both referred and non-referred medical services, as well as some allied health services) • Limited dental services • Pharmaceuticals through the PBS • Community-controlled Aboriginal and Torres Strait Islander primary healthcare • Aged care services (including residential aged care and home care) through the AN-ACC residential aged care funding model, as well as capital grants and programs • Contributions to support access to private health insurance, such as the private health insurance rebate • Health and medical research through the National Health and Medical Research Council • 45 per cent of public hospital activity service delivery (under the National Health Reform Agreement 2020-2025)
State and territory governments	• 55 per cent of public hospital activity service delivery (under the National Health Reform Agreement 2020-2025) • Ambulance services • Limited dental services • Some community and public health services • Some medical research
Local governments	• Public health promotion • Community health services
Non-government organisations	• Charitable healthcare services, such as medical clinics • Health promotion initiatives and educational programs
Private health insurers	• Private health services delivered in public hospitals • Services delivered in private hospitals • Some community services • Some dental services • Medicines • Some referred medical services • Some allied health services • Some medical research
Patients	• Out-of-pocket expenses (medical, dental, diagnostic investigation and allied health services) • Private health insurance premiums, excess payments • Medicine costs • Medicare levy and Medicare levy surcharge

Australian Medical Association, https://www.ama.com.au/sites/default/files/2023-12/Discussion%20paper_Rethinking%20funding%20models%20to%20align%20with%20population%20health%20goals_0.pdf

Commonwealth (federal) government based dental services

- Child Dental Benefit Schedule (CDBS) and other Medicare schemes
- Federation Funding Agreement (FFA) for adult public dental services
- National Health Reform Agreement (NHRA)
- Private Health Insurance (PHI) rebates
- Grants to the Royal Flying Doctors Service (RFDS)
- The Department of Veterans' Affairs dental program.
- Research
- The Northern Territory Remote Aboriginal Investment Oral Health Program (NTRAI OHP)
- Aboriginal community controlled health services (ACCHS)

Parliament of Australia https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Dental_Services_in_Australia/DentalServices/Interim_Report/Chapter_1_-_Introduction_and_background

State government based dental services (Western Australian context)

1. Dental Health Services

a. School Dental Service

b. General Dental Service

c. Special Dental Service

- i. Aged care facility (visiting program)
- ii. Special Needs Clinic
- iii. Prison dental service
- iv. Disability Service Commission clients
- v. Visiting services to Royal Perth Hospital and Graylands Hospital.
- vi. Specialist services at Fiona Stanley Hospital

d. Dental Subsidy Schemes

- i. Country Patients Dental Subsidy Scheme (CPDSS)
- ii. Metropolitan Patients Dental Subsidy Scheme (MPDSS)
- iii. Private Orthodontic Subsidy Scheme (POSS)

2. Aboriginal Medical Services

3. Oral Health Centre of Western Australia: Only tertiary teaching specialist dental hospital in WA.

WA Department of Health, Dental Health Services: https://www.health.wa.gov.au/en/Articles/A_E/Dental-Health-Services

How much of dental care is covered by Medicare??

Australian Government

Services Australia

medicare

Image source: https://www.healthdirect.gov.au/partners/medicare

How does Medicare work?

1. Funded by Australian tax-payers (2% of their taxable income).
2. Service offered to ANZ citizens, Permanent residents, those applied for permanent residency, temporary residents covered by a Ministerial order, permanent resident of Australian overseas territories, and reciprocal health care arrangement with other country.
3. Parallelly costs for most medicines under the Pharmaceutical Benefits Schedule (PBS) are covered and cost of many prescribed medicines are subsidised by the government.

Payment offered

Full schedule fee for GPs

85% of scheduled fee for a specialist.

75% of scheduled fee for in hospital services.

In addition, a Medicare Safety Net and PBS safety net is provided to individuals with extensive health care needs.

Medicare: https://www.healthdirect.gov.au/what-is-medicare
Pharmaceutical Benefits Scheme, https://www.healthdirect.gov.au/pharmaceutical-benefits-scheme-pbs

Child Dental Benefit Schedule

Child Dental Benefits Schedule (CDBS)

Helping eligible Australian children access dental care

1. WHO CAN GET IT?

Your child may be eligible if they:

- Are aged 0–17 years for at least one day during the calendar year
- Have a Medicare card
- Receive, or have a parent/carer receiving, an eligible government payment (such as Family Tax Benefit A and other eligible Centrelink payments) during the year

Services Australia checks eligibility each year.

2. WHAT IS COVERED?

Basic dental care

- Dental check-ups
- Dental x-rays
- Teeth cleaning
- Fissure sealants
- Fillings
- Root canal treatment
- Partial dentures (when clinically required)

The scheme provides up to **$1,158** over two consecutive calendar years.

3. WHAT IS NOT COVERED?

- Braces and orthodontics
- Cosmetic dental treatment (e.g., teeth whitening)
- Dental treatment provided in hospital operating theatres
- Other services outside the CDBS schedule

Ask your dentist if you are unsure about a treatment.

4. HOW DOES IT WORK?

1. Services Australia checks eligibility each year.
2. Check eligibility through Medicare on myGov or ask your dental clinic.
3. Book an appointment with a participating dentist.
4. Receive eligible dental treatment.
5. The dentist claims directly through Medicare (many clinics bulk bill eligible services).
6. Your available balance reduces as services are used until the 2-year cap is reached.

Up to $1,158 over 2 years for eligible children

Source: https://www.servicesaustralia.gov.au/whats-covered-child-dental-benefits-schedule?context=22426

Cleft and Craniofacial scheme

Cleft & Craniofacial Conditions Medicare Services

medicare

Australian Government
Services Australia

Medicare-funded dental and surgical treatment for eligible patients with cleft and craniofacial conditions.

No age restrictions
Since November 2023, eligible patients of any age can access treatment according to clinical need.

WHO IS ELIGIBLE?

- People with an eligible cleft lip and/or palate
- People with eligible craniofacial conditions
- Must be enrolled in Medicare
- No age limit (since Nov 2023)

Diagnosis must be made by an eligible health professional.

WHAT SERVICES ARE COVERED?

DENTAL CARE
- Dental examinations
- Preventive care
- Fillings and restorations
- Tooth extractions

SPECIALIST DENTAL CARE
- Orthodontic treatment
- Paediatric dentistry
- Prosthodontic treatment (including some prostheses)

SURGICAL CARE
- Oral and maxillofacial surgery
- Surgical dental procedures
- Simple and surgical tooth extractions

Treatment is tailored to individual needs and may involve a team of dental and medical specialists.

WHO CAN PROVIDE TREATMENT?

- Dentists
- Paediatric Dentists
- Orthodontists
- Prosthodontists
- Oral & Maxillofacial Surgeons

Not all providers are registered or familiar with Category 7 claiming – ask before treatment begins.

HOW DOES IT WORK?

1. **DIAGNOSIS** – Eligible cleft or craniofacial condition identified by an eligible health professional.
2. **REFERRAL** – Referral to an eligible dental specialist or provider (if required).
3. **TREATMENT** – Care provided using Medicare Category 7 MBS item numbers.
4. **MEDICARE BENEFIT** – Medicare contributes to the cost of eligible treatment.

IMPORTANT THINGS TO KNOW

- No age restriction for eligible patients.
- Some services require a referral.
- Patients may still have out-of-pocket costs if provider fees exceed the Medicare rebate.
- Providers must use the relevant Category 7 MBS item numbers.
- Not all services or items may be covered in every situation. Ask your provider for details.

CONDITIONS COVERED

In addition to cleft lip and palate, a range of eligible craniofacial anomalies and certain rare developmental conditions are included under Medicare Category 7.

Ask your health professional for more information.

WHY IT MATTERS

- Improves access to specialised oral healthcare
- Reduces financial barriers to treatment
- Supports people with complex congenital conditions
- Integrates dental and medical care across the lifespan

For more information
Visit servicesaustralia.gov.au/cleft-and-craniofacial-conditions
or call Services Australia on 132 011

This information is of a general nature. It does not take into account your individual circumstances. Please visit the Services Australia website for more information.

Current as at May 2024

Image source: https://www.servicesaustralia.gov.au/cleft-and-craniofacial-conditions

Dental Workforce - Dentists

- The number of full-time dentists in Australia was 61.1 per 100,000 population.
- The number of full-time equivalent oral health therapists was 9 per 100,000 population
- 84% of dentists work in private sector and 4.6% public clinics. Victoria has the lowest dentists in public dental service while NT had the highest.
- Five in 10 dentists work part-time (50%).
- Largest group of specialists in Australia are Orthodontists (34%) of all dental specialists with nearly 68% of them were male.

Data as of 2023

Parliament of Australia https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Dental_Services_in_Australia/DentalServices/Final_report/Chapter_5_-_Maldistribution_and_capacity_training_and_workforce_matters
AIHW (Australian Institute of Health and Welfare) (2025) *Oral health and dental care in Australia*, AIHW, Australian Government, accessed 18 June 2026. Available from: https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/dental-workforce

Public dental services – source of funding – A summary

Public dental service	Source of funding
Child Dental Benefit Scheme	Australian Government (Federal)
School Dental Service	State Funded
Cleft lip and cleft palate services	Australian Government (Federal)
Oral and Maxillofacial Services	Australian Government (Federal)
Private Health Insurance Incentive Scheme	Australian Government (Federal)
Aboriginal Oral Health	Australian Government (Federal) → Community controlled Aboriginal primary dental care via National Aboriginal Community Controlled Health Organisations. State funded → Aboriginal Medical Services
Refugee dental care	Australian Government (Federal)
Prisoner dental care	State Funded
Aged care dental services	State (very little) – Sadly very little funding
Disability dental service	National Disability Insurance Scheme does not cover dental but does in exceptional circumstances.
Dental Teaching Hospitals	Mix of State and Federal Funding
Armed forces	Australian Government (Federal) via Royal Australian Army Dental Corps

BUDGET 2026–27
DENTAL CARE AT A GLANCE

What it means for you and your family

1. CHILDREN
Child Dental Benefits Schedule (CDBS)

- Continues for eligible children aged 0–17 years
- Up to **$1,158** available over 2 years (indexed from 2026)
- Covers check-ups, cleans, X-rays, fillings and extractions
- Does not cover orthodontics or cosmetic dentistry

2. ADULTS
Public Dental Services – BIG UPDATE

- **$431 MILLION** federal investment
- **PERMANENT** Commonwealth funding established
- Supports dental care for:
  - Concession card holders
  - Low-income adults
  - Eligible public dental patients
- Services are delivered through state and territory public dental systems

3. WHAT DID NOT CHANGE?

- No universal dental care under Medicare
- No major expansion of dental benefits for adults outside public dental schemes
- No Senior Dental Benefits Schedule announced in the Budget

SHARED RESPONSIBILITY

COMMONWEALTH GOVERNMENT

- Funds the Child Dental Benefits Schedule (CDBS)
- Provides ongoing funding for adult public dental services

STATES & TERRITORIES

- Operate public dental clinics
- Manage eligibility and waiting lists
- Deliver treatment services

KEY MESSAGE

Budget 2026–27 strengthens existing dental programs rather than introducing universal dental care.

- Ongoing support for children through CDBS
- Permanent funding certainty for public adult dental services
- States remain responsible for delivering most public dental care

https://ada.org.au/cdbs-benefits-cap-to-increase-to-1-158-for-2026-2027
https://www.abc.net.au/news/2026-05-12/what-is-in-federal-budget-to-help-cost-of-living-explainer/106671806

Is the oral health system working??

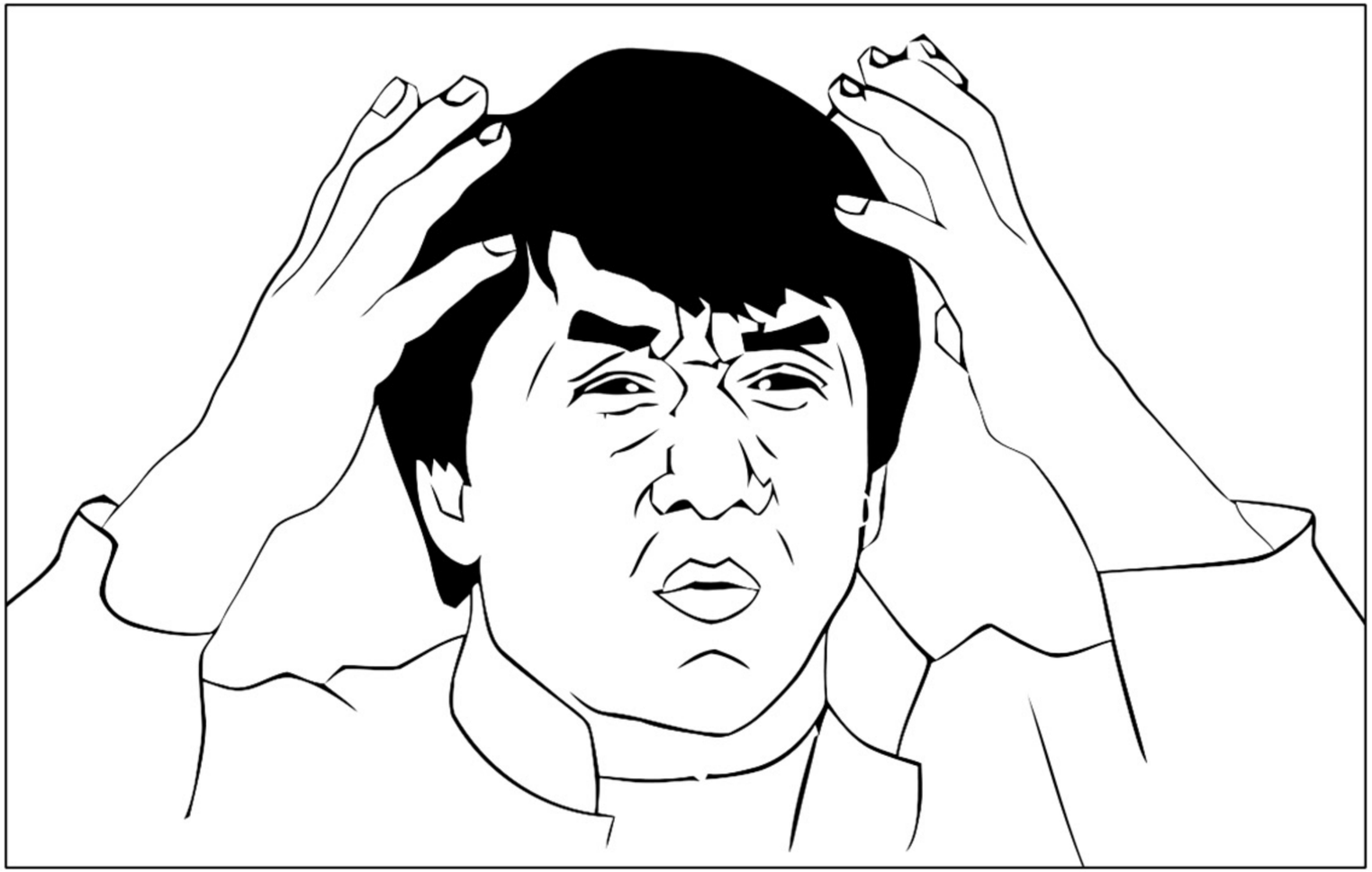
"When we were diagnosed with diabetes, we weren't even told that our teeth were an issue by the doctor"

"Honestly it is too expensive. I have got three holes in my teeth, cavities, and I cannot afford to go to the dentist. Because my money is going on things that I think are more important like my house, power, everything else, food"

"If we look at access to health care – a lot of them won't go to the doctor until something is seriously wrong. So, if they are not going to do that in general day to day health, you've got Buckley's of getting anyone going to see the dentist. 'Oh, I need to go and see a dentist for an appointment just for my regular check-up' – it's not going to happen"

Durey, A., McAullay, D., Gibson, B. *et al.* Aboriginal Health Worker perceptions of oral health: a qualitative study in Perth, Western Australia. *Int J Equity Health* **15**, 4 (2016). https://doi.org/10.1186/s12939-016-0299-7

Now I am Confused….



OVERALL REVISION

1. Factors that influence development of health systems.
2. Components of a health care system.
3. Health care delivery models – global context.
4. Structure of Health System in Australia
5. Medicare and dental care.
6. Funding sources of public dental schemes

Thank you!!

Image source: https://www.hcamag.com/au/specialisation/diversity-inclusion/how-to-get-cultural-diversity-right/162698