



STATE BUDGET SUBMISSION
2007/08
December 2006

Consistent with the concerns highlighted during the recent State Election Campaign by the Victorian Oral Health Alliance (VOHA), this document outlines a number of the key issues affecting the community's access to dental services in Victoria.

VOHA acknowledges that the Labor Government has made a number of significant improvements to public dentistry, most notably a 30% increase in recurrent funding and establishment of a new dental school at LaTrobe University's Bendigo campus. The Labor Party's commitment during the election to spend \$14.5m on new regional training clinics and infrastructure for a new BDDSc course at Bendigo were welcome announcements, as was the increase in funding for another 6000 pensioners to be able to obtain dentures and improve access to dental care for residents of Supported Residential Services.

Despite the State Government's increased recurrent dental funding since 2004, many significant public dentistry problems remain, and some new ones are becoming evident. The report from the House of Representatives Standing Committee on Health and Ageing "The Blame Game: Report on the inquiry into health funding", confirms that public patients are still waiting far too long for access to care, especially in rural areas. While that report argues for the Commonwealth to contribute to the costs of dental care, there are numerous aspects of the Victorian public dental system that present opportunities for improvement.

This submission identifies budget initiatives and needs in the following areas:

INITIATIVES	Capital	Recurrent
• Fluoridation of regional centres – capital funding	\$15m	
• Enhancement of public dental services – recurrent funding		\$24m
• Dental workforce shortages and training places		
○ Capital - New training clinics and chairs required	\$10m	
○ Capital - Infrastructure to support students' rural experience	\$0.5m	
• Oral Health Needs of Residents of Residential Care Facilities		
○ Capital	\$0.5m	
○ Recurrent		\$5m
• Oral Health Promotion - recurrent		\$15m
• Outreach services for remote Aboriginal communities		
○ Capital– van purchase and fitout	\$0.5m	
○ Recurrent		\$1m
• Missing persons dental database – mainly recurrent		\$0.8m
TOTAL CAPITAL	\$26.5m	
TOTAL RECURRENT		\$45.8m

Members of VOHA represent consumer, community and professional bodies, and have joined together to highlight the continuing need for allocation of resources in a manner that will significantly improve access to dental services and reduce dental care problems for disadvantaged and vulnerable members of the Victorian community. By making such investments, we believe there would be long-term savings in stopping or pre-empting future oral and general health problems - as well as improving their quality of life.

Garry Pearson
 CEO, ADAVB Inc, on behalf of

<u>Australian Dental Association Victorian Branch Inc.</u> <u>Australian Dental & Oral Health Therapists Association</u> <u>Brotherhood of St. Laurence</u> <u>Council on the Ageing Victoria</u> <u>Dental Hygienists Association of Australia, Victorian Branch</u> <u>Doctors' Reform Society of Australia</u> <u>Health Issues Centre</u>	<u>Municipal Association of Victoria</u> <u>Public Health Association of Australia Inc.</u> <u>Rural Workforce Agency of Victoria</u> <u>Victorian Aboriginal Community Controlled Health Organisation</u> <u>Victorian Council of Social Service</u> <u>Victorian Healthcare Association</u>
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Fluoridation of regional centres

Identified need: Water fluoridation reduces the socioeconomic inequalities and prevalence of dental caries within the community. The relatively small cost is offset by the huge savings in dental treatment and economic losses associated with pain and suffering.

The Government's commitment to extend the benefits of water fluoridation to all Victorian communities with a population over 1000 has been a key preventive measure underpinning its achievements in oral health policy. Government funding in 2006 allowed the fluoridation of water for Warragul, Moe, Morwell, Traralgon, Wallan, Robinvale and Horsham. With the fluoridation of Wodonga and Wangaratta in February 2007, 3.85 million (about 79%) of Victorians will have access to fluoridated water.

However, significant areas of Victoria remain unfluoridated, and this is a major cause of the differentials between rural and metropolitan dental health, particularly in children. Previously committed funds have now been fully utilised, and a fresh commitment is required for the purchase and commissioning of plant and equipment to enable the remaining major regional towns in Victoria to be fluoridated, namely: Ararat, Bairnsdale, Ballarat, Benalla, Castlemaine, Cobram, Colac, Geelong, Hamilton, Kerang, Kyabram, Maryborough, Myrtleford, Mildura, Romsey and Lancefield, Seymour, Stawell, Swan Hill, Warrnambool, Wonthaggi and Yarrawonga.

Proposed solution: The Government should allocate \$15 million during its current term of government to complete the fluoridation of Victorian water supplies.

Suggested cost: \$15m

Enhancement of public dental service delivery

Identified needs: Waiting times for access to general dental care and dentures have been a matter of growing public concern for some years now. The announcement during the recent election campaign that the overall number of patients waiting for treatment had been significantly reduced was welcome news, however when we analyse the data, it is evident that there are still many public clinics with waiting times greater than three years. We believe a more reasonable target should be to reduce waiting times for all Victorians to less than 6 months.

The following summary highlights the 13 rural and regional clinics with the longest waiting times as advised by the Department of Human Services' Your Hospitals website as at 30 June 2006 (comments regarding movement 'up' or 'down' compare 30 June figures with those applicable as at December 2005). It is noteworthy that in some cases the waiting times grew longer rather than matching the more positive trend for Statewide averages.

Clinic (months)	General	Dentures
<u>Moe</u>	65	39 down 10
<u>Churchill</u>	65	39 down 10
<u>Sale</u>	60 down 02	29 down 01
<u>Warrnambool</u>	55	46 down 07
<u>Portland</u>	52 down 14	24 down 29
<u>Ballarat</u>	47 down 06	39 up 06
<u>Orbost</u>	46 up 05	07
<u>Wangaratta</u>	44 up 01	48 down 04
<u>Echuca</u>	41 up 02	41 down 02
<u>Horsham</u>	40 down 10	29
<u>Bendigo</u>	37 up 03	33 up 03
<u>Bairnsdale</u>	36 down 14	22 up 06
<u>Colac</u>	35 up 03	30 down 01

Waiting time problems are not confined to rural areas, as the following selection of metropolitan clinics shows. A number of these also show increases in waiting times since December 2005.

Clinic (months)	General	Dentures
<u>Cheltenham</u>	40 up 01	15 down 28
<u>Dandenong</u>	40 up 01	15 down 28
<u>Springvale</u>	40 up 01	15 down 28
<u>Rosebud</u>	36 up 03	13 down 21
<u>Epping</u>	35	18
<u>Brunswick</u>	33 up 03	30 down 10
<u>Berwick</u>	32	24 down 15
<u>Cranbourne</u>	32	24 down 15
<u>Frankston</u>	32 down 15	33 down 10
<u>Broadmeadows</u>	30 down 01	34 down 01
<u>St. Albans</u>	29	33 up 06
<u>Fitzroy</u>	27 down 10	20 up 07
<u>Footscray</u>	25 down 17	13 up 04

Cost increases

The Commonwealth Department of Veteran's Affairs (DVA) rates for dental treatment have provided a benchmark for public sector dental schemes in most States, and Victoria has followed this pattern.

DVA dental rates were recently increased by 18% and this adjustment needs to be passed on to both the funding formula for treatment provided in public clinics and to voucher schemes by which private practitioners are able to assist with treatment of public patients.

Currently the percentage of DVA rates paid for items provided via community dental clinics decreases when the DVA rate increases. For example, during year 2005/06, a clinic was funded at an average 59.2% of the DVA rate. For 2006/07, the average funding rate has dropped to 56.5% DVA, because the DVA rate had increased prior to July 2006. With the most recent increase in DVA rates, the percentage rate is likely to fall further when the adjustments are entered into DHSV's software systems.

Allowance needs to be made for new staff, who are often new graduates or dentists who have recently completed their Australian Dental Council exams (many of these have little experience even in their country of origin). Apart from clinical support, they will need support and training in the multiple levels of paperwork and accountability required in the public dental system. Some relief is required from the pressure to provide a high level of clinical output, when clinics are inducting and training new personnel.

Public sector dentists consider that the current funding formula puts unreasonable pressure on clinicians to be consistently very highly productive in doing payable items, at the time when they should also be gaining clinical experience (new graduates) or supporting those less experienced. They note that with pay rates much lower than the private sector, it is very hard to mount a good argument (apart from appealing to altruism) as to why someone should stay in the public sector. They consider that there is no real career path, and little incentive to stay. Some report having a number of excellent and caring dentists leave because, though they “loved” working with a great team etc, they didn’t want to be “trapped” in the public system and wanted more flexibility, and a long term career.

If this is the perspective of an inner metropolitan service, even greater difficulties are likely with staffing rural clinics. DHSV is introducing systems to try to provide new graduates and short term staffing, however we also need ways of keeping experienced clinicians in the system for the benefit of patients and staff.

DHSV has recently piloted a formal mentoring program for overseas trained dentists who have just passed, or are about to sit, the Australian Dental Council (ADC) exams. However, there are no support mechanisms for experienced clinicians or senior dentists (apart from informally within the clinic). A number of senior dentists/ dental managers complain of ongoing stress, of never quite catching up, and of not having means of debriefing or communication between centres.

Staff shortages cannot be fixed properly without taking care of existing staff, i.e. retention is as important as recruitment. A good start would be a realistic funding formula which acknowledges that the dental team is dealing with people who often have very complex needs.

Indexation of the funding formula in line with the new DVA rates would also be accompanied by adjustment of rates for the voucher schemes by which private dentists are able to assist in treatment of public patients.

The integration of School Dental Service Personnel into Community Dental is also leading to shifts in staffing costs as staff previously employed by DHSV become employees of Community Health Centres.

Proposed solution: The funding formula for public dental services and the rates applied to Victorian Government dental voucher schemes should be increased by 18% across the board, to bring them in line with new DVA dental rates, .

Funding provision is required for additional costs arising for Community Health Services where staff transfer across from the School Dental Service. On costs such as leave and staff training need to be provided for in the transfer.

Suggested costs: Given that the current public dental budget is \$129m, a total increase of over \$23m is required. An additional \$1m is also required for integration of school dental service personnel into Community Health Centre staffing.

Outreach services for rural and regional Aboriginal communities

Identified need: Many Aboriginal communities in rural and regional Victoria still have no ready access to dental services. The members of these communities either have to be bussed to a suitable clinic (often in Melbourne) or they go without treatment for years on end. Many of these communities can be considered remote in that they do not have accessible dental and other health services.

An excellent new dental clinic was recently opened at Rumbalara in Mooroopna by the Minister for Aboriginal Affairs The Hon Gavin Jennings. Also recently, Dental Health Services Victoria (DHSV) and North Richmond Community Health Centre developed a regional dental clinic that is providing general dental care in partnership with Murray Valley Aboriginal Corporation in Robinvale, where there is a high regional Aboriginal population. DHSV is also improving access to dentures for Aboriginal people by funding the payment of the dental laboratory fees for dentures at the Victorian Aboriginal Health Service, and similar arrangements are also under negotiation for the ACCHO in Bairnsdale. These steps by the Government are commendable, and should be built upon.

The dental services need to be delivered in ACCHOs regionally so that they are provided in a culturally appropriate manner and in an environment which will increase the use of these valuable services by Aboriginal people. There also needs to be funding to provide cross cultural training for non-Aboriginal people working in the sector.

There are a range of factors that contribute to the poor oral health of Aboriginal Victorians. These include:

1. Access to dental care – many Aboriginal Victorians live in communities where there are fewer dental services and people are required to travel further to obtain care.
2. Common risk factors – many diseases, such as heart disease, stroke, cancer, diabetes and dental caries share common risk factors including poor diet, smoking, , alcohol, stress, poor hygiene and trauma. Aboriginal Victorians experience higher rates of these health risk factors than non-Aboriginal people.
3. Social determinants of health – The socioeconomic status of Aboriginal people has been identified as a major predictor of health outcomes, including dental health, with a strong correlation existing between social inequalities and poorer health outcomes. Indigenous Victorians experience marked inequalities across all the social determinants of health, experiencing social exclusion, poor housing, lower education levels, lower income, unemployment, lack of transport, stress and addiction – all of which are factors that contribute to poorer health, including poor oral health.

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4. Changing lifestyle patterns – a change from a traditional diet (high in fibre and sugar and low in saturated fats) to one high in sugar, saturated fats and refined carbohydrates is reflected in the poor oral health of Indigenous Victorians. Additionally, access to fresh fruit and vegetables is particularly difficult for many living in remote communities (as defined above).
 5. Access to fluoride – fluoridation of drinking water has been shown to be a highly successful public health measure that prevents dental decay. Despite this, rural and remote areas of Australia are less likely to be fluoridated than metropolitan areas, reducing access for many Aboriginal communities. In 2005, Armfield found that decayed, missing and filled teeth (dmft) in 5-6 year-olds was between 47% and 75% higher in non-fluoridated areas compared to fluoridated areas. (Source: Armfield J (2005) 'Public Water Fluoridation and dental health in New South Wales', *Australian and New Zealand Journal of Public Health*, Vol. 29, No. 5: 477-483.

Proposed solution:

Outreach services to be provided by obtaining one or more mobile dental vans and staffing this unit to visit Aboriginal communities where the elders and the local Aboriginal Community Controlled Health Organisation (ACCHO) agree.

Develop an ACCHS dental health unit in an appropriate ACCHS in Western Victoria.

The services provided need to be provided in a culturally appropriately and in the ACCHOs. A relevant proportion of the funding needs to be provided under global funding to be able to be flexible and captive in improving oral health. Enhancement of existing ACCHS dental programs, as “hubs” of dental care. Consideration to be given to appropriate infrastructure, and funding to improve dental care by employing appropriate dental auxiliaries such as dental therapists, dental prosthetists or dental hygienists.

Suggested cost:

Capital costs for van purchase and fitout ~\$0.5m

Recurrent costs would mainly comprise staffing and material costs, and vehicle maintenance – say \$1m

Workforce Shortages and Training Places - Part 1

New training clinics and chairs required

Identified need: VOHA applauds the Government's initiatives to increase the dental practitioner workforce and address projected workforce shortages. The decision to establish a BDS program at LaTrobe's Bendigo campus appears to have addressed the capital cost of building new training facilities. This venture now requires the allocation of Commonwealth Supported Places to ensure that this course does not depend on full fee paying students for its intake.

The University of Melbourne expects significant growth in numbers of undergraduate students there, which raises some issues with regard to training facilities. Increased numbers are not problematic for didactic and group teaching as lecture theatres can accommodate them and extra teaching staff can be engaged. Space for preclinical teaching has been factored into projected increases.

Clinical teaching however is already stretched with existing student numbers. The third year BOH and fifth year BDS students spend the majority of their year in community clinics providing public sector services. This has required a shift in thinking with regard to the interface between education and service delivery models. It also requires differential funding models to accommodate the reduction in output for community dental services as they accommodate students (lower student 'productivity' and impact on staff productivity). Students are primarily there to learn rather than provide a fast treatment rate.

Issues to be resolved include:

- Increasing demand on community clinics for student places
- Competition between University of Melbourne and La Trobe for existing places
- Necessary reductions in 'throughput' arising out of these student placements for DHSV & CHCs
- Requirement for support staff

VOHA is concerned that additional provision will need to be made for clinical training (student chair days) due to a significant increase in the number of students in training across the two Victorian dental schools.

Estimated number of student clinical days required per year

(NB. The academic year runs from February – October)

Current final year community rotations at the University of Melbourne alone require over 10,000 student chair days:

- 3rd year BOH - 30 x 3 student days per week = 90 x 34 weeks = 3060 student chair days per year
- 5th year BSc requires 70 x 3 student days per week = 210 x 34 weeks = 7140 student chair days per week.

This will increase with greater numbers and will become more competitive as La Trobe students come into the equation. It has also not accounted for any other clinical days required for years 1-4 BSc or years 1&2 of the BOH.

Given increased enrolments planned at Melbourne and LaTrobe (estimated in the table below), additional provision must be made for student clinical days, and an equitable distribution ensured between the two dental schools.

Year	Uni. of Melbourne		La Trobe Uni. - Bendigo	
	BOH	BSc	BOH	BSc
2006	50	350	10	
2007	80	350	40	
2008	80	370?	70?	30?
2009	90	390?	100?	60?

Proposed solution:

Increased government investment in providing for student clinical training via

- an increased number of student chairs in community based settings including funding subsidies and supervisory and support staff allocations
- development of new dedicated teaching clinics.

Suggested cost:

Estimated costs of measures to accommodate these increased demands are approximately \$10m.

Workforce Shortages and Training Places - Part 2

Infrastructure to support students' rural experience

Identified need: Vacancies for public sector dentists, especially in rural areas continue to impede access to dental services. There is therefore a need for incentives to encourage greater public sector workforce commitment – as was done in the Dentistry in Victoria project around three years ago.

The maldistribution of dental practitioners which particularly affects rural areas, is being addressed by undergraduate education, and the University of Melbourne's Rural Clinical School at Shepparton is an excellent example. The Bendigo campus of LaTrobe University will also

However, there are a number of opportunities to place students in rural locations which are underutilized at present because of a lack of infrastructure support.

Students need transport and accommodation support to attend rural clinics. Neither the dental school nor the public dental sector has been able to provide this support.

Further incentives to encourage new graduates to work in the public sector should be sought. With support from the Commonwealth Government, one approach could be to institute a national dental intern scheme. Another could be to waive a proportion of their HECS costs for each year of service provided to the public sector.

Proposed solution: Allocate funds to support individual student clinical placements in rural areas

Suggested cost: \$0.5m

Oral Health Promotion

Identified need: The link between oral diseases and general health diseases – referred to as a ‘common risk approach’ – is an important aspect of contemporary oral health promotion. Rather than focusing on single diseases, a common risk approach recognises that many diseases – such as heart disease, stroke, cancer, diabetes and caries – share common risk factors including smoking, poor diet, alcohol, stress, hygiene and trauma and common health factors such as improved diet and exercise.

The State Government has recently committed significant funds to health promotion activities associated with obesity and diabetes, and these initiatives have been praised by groups involved in supporting improvement in dental services because of their wider oral health benefits.

The Healthy Canteens Policy and associated activities recently provided opportunity for the dental profession to applaud the Government for its efforts to improve oral and general health.

Most dental disease is preventable, and with an annual budget of over \$129m for public dental services, Victoria currently allocates only a very small proportion to oral health promotion.

Proposed solution: At least 10% of the annual oral health budget should be allocated in order to make a significant impact on community attitudes to oral disease prevention. This could be usefully targeted at children and Aboriginal communities in non-fluoridated areas of the State. Much can be achieved through effective integration of oral health promotion messages and campaigns in broader health promotion, and disease and injury prevention activities.

Suggested costs: \$5m for preventive dental services for children and Aboriginal communities in rural Victoria
\$10m for the rest of the Victorian population

Oral Health Needs of Residents in Residential Care Facilities

Identified need:

VOHA welcomes the Government's acknowledgement in its election platform that *"Preventative care and oral hygiene helps maintain a person's independence and quality of life, and lessens the need for urgent care"*.

Accordingly, the following funding commitments were also greatly appreciated:

- *"Labor will invest \$1.9 million over four years to fund a team of dental hygienists to conduct oral health instruction for SRS workers, oral health assessment, care planning and other services, including the provision of equipment and electric toothbrushes for residential services to support these activities.*
- *Labor will improve access to public dental clinics to disadvantaged residents in SRS by building on existing programs to enable residents of Supported Residential Services to attend public dental clinics and receive priority access. Funds will include provision of training and support to public dental workforce, SRS workforce/proprietors and other relevant local community programs."*

While these measures will be helpful, they will deal with only a small cross section of the 43,000 residents, 85% of whom are pensioners and eligible for public dental care, in Victoria's 850 nursing homes. According to the Department of Human Services website, there are currently 197 registered SRS's, and their census of 2003 showed 215 SRS's with 7100 beds. In contrast, there are more than 43,000 people in residential aged care facilities, and they generally have more issues with access to services. While dentures are important and there is a substantial waiting list across the State, research (including work done at Melbourne University) shows that edentulism rates are decreasing in Australia. Melbourne University research in Victorian residential aged care facilities also found that around 54% were dentate (had their own teeth with an average of 14.4 teeth per resident), an increase from 23% in 1979 in the general population of 65+ years old. The focus of any program for residents should therefore be health prevention/promotion, and education for carers.

Older people, particularly those with cognitive impairment, are at high risk of developing oral disease. Access to care is difficult for older people living in residential accommodation and for those with limited mobility who live in the community.

Older people experience a range of oral health problems at greater rates than the general population. Prominent amongst these are dental decay, gum disease, dry mouth and oral cancer. Teeth extractions associated with gum disease increase with age. People aged over 65 years have higher rates of edentulism (missing teeth), few sound teeth and more filled and decayed teeth than the general population.

Residents in aged care facilities are experiencing neglect of their oral hygiene with consequential decline in their general health. Because of their advanced age and compromised medical health, it is difficult for many of these people to be taken to a dental practice, and there are no standard facilities generally available in which to provide treatment at these centres.

A systematic review has demonstrated that pneumonia can be reduced by effective oral hygiene and frequent professional oral health care for medically compromised residents in nursing homes and intensive care units. ('Systematic review of the association between respiratory diseases and oral health.' A. Azarpazhooh and J Leake *J Periodontol* 2006;77:1465-1482)

Standards for Aged Care Facilities (effective 22 September 2004) state.

“Standard 2.15: Oral and Dental Care

Expected Outcome - Residents' oral and dental care (health) is maintained.

Criteria - Policies and practices provide:

- that residents' oral hygiene is assessed, documented, regularly reviewed and acted upon;
- that residents have timely access to treatment for oral and dental conditions; and
- appropriate procedures for oral and dental care in accordance with each resident's needs and preferences.”

The main problem with this standard is that it requires that 'oral hygiene' is regularly assessed and monitored, but does not require 'oral health' to be assessed and monitored i.e. a dental examination prior to or at admission, and at regular intervals.

We suggest that the Commonwealth be encouraged to replace the word 'care' with the word 'health' in the Standard. Effective care is simply the means to the desired end of oral health.

There are presently very few members of Nursing Home staff who have the knowledge and training to fulfill the requirements of this standard. There are not enough publicly salaried dentists, hygienists, prosthetists and dental chairside assistants to provide expert care in Nursing Homes. There are also no dental surgery facilities in nursing homes.

Proposed solution:

- It is necessary to include in the training programs for Division 2 nurses and personal care workers a module that explains dental diseases, various prostheses and the oral hygiene measures and techniques required to maintain oral health.
- The dormant chair of Geriatric Dentistry at The University of Melbourne should be filled so that the existing and future dental workforce can be educated to effectively treat mentally and physically challenged elderly and frail residents of residential; care facilities.
- South Australia are piloting a funding model where private dentists/hygienists provide care to nursing home residents (on a part-time basis), and are funded on a fee scale similar to that used by the Department of Veterans Affairs. We believe that the Victorian Government should consider adoption of a similar model in order to better facilitate service provision from the private sector. Melbourne University research shows approximately 50% of private dentists provide care to nursing home residents, but at an average of 1 hr/week, with one of the main barriers being the lack of portable equipment. This recognises that treatment is best performed in the residents' own beds, which can generally be raised to an appropriate height. This is also generally the way the DHSV Domiciliary Service operates. In the SA scheme, the SA Dental Service provides portable equipment on loan for the private providers, and we therefore suggest that funding be provided for several sets of portable equipment (or equipped vans as per the Domiciliary Service) which could be used by private dentists, that a special funding model be introduced so private practitioners could be reimbursed for providing care to eligible residents, and also perhaps some funding for additional training for dental professionals in geriatric dentistry.

Suggested costs:

Capital

Supply of say 10 portable dental units @ ~\$50,000 = \$0.5m

Recurrent

Funding for private dentists and hygienists to provide basic treatment to 20,000 patients each year at an average cost of \$250 per patient, would result in an annual expense of approximately \$5m.

Commonwealth contributions to these costs should also be sought.

Forensic Odontology and Missing Persons Dental Database

Identified need: While the media presents DNA evidence as the most reliable form of victim identification, the fastest, most reliable and cost effective method remains the use of dental records. Following the recent Tsunami, around 60 percent of identifications were based on dental records compared with around 5% based on DNA processing.

The process of victim identification was recently the subject of a coronial finding into the death of Matthew Bibby. The Coroner urged that a national dental database be established to avoid repetition of the problems that led to Mr Bibby being unidentified for almost 10 years after he went missing in 1996. It is understood that there are between 40 – 50 cases of unidentified people where dental records could be used readily for identification. It is further understood that there are more than **400 cases** where identification probably could be achieved if funds were available.

Victoria has a small unit within the Victorian Institute of Forensic Medicine (VIFM) called the Centre for Human Identification, which distinguished itself during the recent Tsunami, and this has since led to an MOU with the Australian Federal Police as preferred provider of forensic expertise in all their many overseas deployments. The team has worked in Timor, the Solomons and is currently working in Tonga following civil unrest in that community.

The VIFM is apparently unable to pay the forensic odontologists for much of the work required of them, and with pressure from the Coroner for improved speed of victim identification, a solution is readily available - provided adequate funding as assigned.

Proposed solution: The unit has developed software in-house to help match antemortem and postmortem dental records. This package called "DAVID web" (web-based Disaster And Victim Identification), recently received a commendation in the "Safer Australia Communities Awards" run by the Federal Attorney General's office and is being tested by the Canadian DVI team based in Vancouver. This software should form the basis of a functional Victorian Dental Missing Persons database, which could then emulate the National Coroners information System (which also started at the VIFM/Monash University in Victoria) in becoming the basis of a progressive National roll-out.

For any of this to get off the ground (and even for the unit to maintain what it has been able to achieve since 1989) it is essential that funding for forensic odontology be increased dramatically.

The issues to do with Missing Persons alone require an additional full-time position at the VIFM

The incumbent (or incumbents - if the duties were shared) would be required to continue the refinement of DAVID web, oversee its implementation within the VIFM in conjunction with Victoria Police, organise the repository of hard copy dental records, upload the enormous backlog of existing dental records into DAVID web, liaise with the police and local and interstate professionals on a regular basis, and write reports for the coroner, amongst other duties.

Finally, some administrative support staff and essential IT support and hardware would be needed. Later increases in IT support will then be required as more and more States are brought into operational alignment using the (Victorian hosted) National Missing Persons dental database (recognising that population based co-contributions may also be sought from participating States). Victoria has the capacity to provide national leadership on this vital forensic activity, and the allocation of appropriate funding will both serve the interests of justice, and also assist relatives of victims and missing persons to know much sooner if death has occurred.

Suggested cost:

Funding sought:	
Senior Odontologist	\$170,000*
2 X Odontologists	\$280,000*
Admin support staff	\$50,000*
IT support	\$100,000
Other expenses	\$200,000
TOTAL	\$0.8m

* Total employment costs i.e. salaries plus on costs